

# *v e t n*

*viennese ethnomedicine newsletter*



Mami Wata by Cheri-Cherín



INSTITUTE FOR THE HISTORY OF MEDICINE, MEDICAL UNIVERSITY OF VIENNA  
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# Frontispiece

The concept of Mami Wata is very common in West Africa but recently it penetrated also Central Africa, especially the region between Northeast Congo and Sudan. In this painting by the famous Congolese artist Cheri-Cherin the perceived sexual aggressivity of the Mami Wata is well depicted. The Mami Wata becomes alive through the painter. She is at the same time attractive, as shown by her large lactating breasts, and threatening. Because her lower body has the feature of a fish sexual contact is impossible. Among the Azande in Northeast Congo and South Sudan concepts around Mami Wata play a prominent role in how people explain the appearance of severe infectious diseases such as Ebola (see the contribution of Armin Prinz in this issue). (Photo: collection Ethnomedicine)

## Viennese Ethnomedicine Newsletter

is published three times a year by the Department of Ethnomedicine,  
Institute for the History of Medicine, Centre for Public Health, Medical University of Vienna, Austria.

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**ISSN 1681-553X**

## *Dear Professor Prinz, dear Armin!*

*We all wish to congratulate you on your 60th birthday on July 29th! We thank you for your commitment in establishing ethnomedicine in Austria and Europe. For all of us and for the coming generation you will continue to be a leading model. Your amazing biography is proof that interdisciplinarity is not just a catchphrase.*

*This was not too obvious in the beginning...*

*When you dropped out of high school at the age of 15, very few could possibly imagine where this would lead to. As it is told, one half of your teachers shed tears of joy because they were relieved you went (obviously because they thought you were a nuisance at school), the other half cried, as they were truly unhappy that such a promising and intelligent pupil left school. But you started training on board of a German windjammer, finally graduating as an able bodied seaman. After some years travelling international coasts, especially in South America, you caught severe malaria and due to working regulations were later on restricted to ships crossing only through the Mediterranean and the North Sea. This was obviously not up to your desire. You decided to go back to school again and, working as an unskilled labourer, finally graduated. Then you began to study social anthropology at the University of Vienna. When a friend uttered the opinion that you could not judge ethnomedical issues lest you understood medicine, you also started to study medicine, graduating in both disciplines. While studying, you found the time for research projects in Zaire (now Democratic Republic of Congo), a country which should never loosen its grip on you and where you subsequently stayed more than four years. These two fields of study finally led you to work in the two professions you still hold: as emergency doctor and head of the travel medicine at Vienna airport and as professor of ethnomedicine at the Medical University of Vienna. Often you jokingly complain that anthropologists are considering you only as a medical doctor, while your medical colleagues are seeing you solely as an anthropologist. In fact you are able to apply the knowledge of both sciences in each profession.*

*This proved especially fruitful for introducing “Ethnomedizin” (ethnomedicine/medical anthropology) in Vienna as an obligatory subject for medical students in the new curriculum. You were the first one (and are still the only one) in the German speaking countries able to establish ethnomedicine as an academic institution, supported by the then Head of the Institute for the History of Medicine, Professor Helmut Wyklicky, and the then Minister of Education, Erhard Busek. This achievement was well prepared: You published more than 120 scientific articles in German, French and English, and produced several films in the fields of ethnomedicine, nutritional anthropology, ethnopharmacology, visual anthropology, history of medicine, tropical medicine and travel medicine. You founded the Austrian Ethnomedical Society, and in 1998 you started the Viennese Ethnomedicine Newsletter, which is distributed worldwide. At the same time, you are board member of several scientific societies (e.g. the Germany based AGEM Arbeitsgemeinschaft Ethnomedizin, co-founder of the European Society of Ethnopharmacology) and, cooperating with the International Commission on the Anthropology of Food of the International Union of Anthropological and Ethnological Sciences, you organised an international symposium in Austria.*

*This is the moment to express our gratitude and thankfulness, together with our best wishes for future achievements and due recognition of your work.*

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# External Treatments at Kumbum Monastery Hospital

Katharina Anna Sabernig

## Introduction

Orally applied pharmacological treatment is the main therapy at Taersi Hospital, better known as Tibetan Hospital of Kumbum Monastery (Sku-vbum dgon-pavi bod-sman-khang)<sup>1</sup> or Kumbum Monastery Hospital, for short. This paper, however, deals with less frequently and externally applied medical therapies. In Tibetan medical classification, they are usually part of the “stem of external treatment” (*dpyad kyi sdong-po*)<sup>2</sup> which is one stem within the ‘tree of therapy’ of the *Four Tantras* or *Rgyud-bzhi*. The *Rgyud-bzhi* documenting the historical medical knowledge of Tibet can be seen equal in importance as the frequently referred book *Huangdi neijing suwen* on Traditional Chinese Medicine (TCM). Its contents have become well-known through the medical thangka of the famous 17<sup>th</sup> century commentary, the *Vaidurya sngon-po* (Blue Beryl) composed by Sde-srid Sangs-rgyas Rgya-mtsho (1653-1705). Modern editions and translations of this work are by Parfionovitch et al. (1996) and Byams-pa Vphrin-las et al. (1994), the latter being in common use among the monks at the Kumbum Monastery Hospital. The focus on external treatments in this article goes along with these classical medical descriptions and practical applications of moxibustion (*me-btsav*), incense (*spos-sman*), medicinal baths (*chu-lums*), massage with medicinal oil (*snum-vchos*), and ointments (*byugs-pa*). In ethnomedical terms these treatments belong to so-called ‘minor surgery’, generally referring to any minor intervention applied onto the surface of the body in order to influence internal functions. After presenting my research agenda, I will briefly introduce the local situation of public health care in the area. A portrait of the physicians and staff working at the Kumbum Monastery Hospital, mainly of Tulku Tashi Rinpoche (Sprul-sku Bkra-shis Rin-po-che), and a report on the observed clinical encounters complete this presentation of my field research.

Between 1995 and 2004, and especially in 2000 and 2001, I had the opportunity to do fieldwork

in Amdo, the north-eastern region of the Tibetan plateau, several times. The main part of the information presented here was gathered during my participant observation of clinical encounters at Kumbum Monastery Hospital in summer 2000. During that period, I documented the cases of 355 patients who were treated in the outpatient department of the Hospital, among them 185 female and 170 male individuals, belonging to different ‘nationalities’, i.e. Tibetan, Mongolian, Han, Hui, Tu and other ethnic groups. The common language between clients and physicians was usually Chinese. Tibetans coming from far away places who visited the ambulatory mostly communicated with the monks in Amdo-Tibetan (*xa-mdo-skad*). Tulku Tashi Rinpoche spoke also Mongolian with his Mongolian clients.

In my interviews with Tulku Tashi Rinpoche and other hospital staff, I focused on discussions about Tibetan medical theory and practical problems as well as clinical case studies. The cases were documented in my field diary. Earlier notes written down in 1999 and later in 2001 confirmed the observations made in 2000. Interviews with Tibetan doctors were mainly conducted in Chinese translated into English. The reference works consulted during our discussions included Dgav-bavi Rdo-rje (1995), Byams-pa Vphrin-las (1994), Bsam-gtan (1997) as well as some medical thangkas which were in general use at the hospital; these were modern copies of the famous set of thangkas which illustrate the *Blue Beryl*. A particular useful tool was also Tashi Tserings English-Tibetan-Chinese Dictionary (1997) and Nigel Wisemans English-Chinese Chinese-English Dictionary of Chinese Medicine (1995). The patients themselves were not interviewed directly nor recorded on tape, with some of them nevertheless freely communicating information on an informal basis. As a matter of respect and sense of decency in general it does seem important to me not to go beyond limitations of privacy (Domokes-Cheng Ham 1993: 35f). I always tried to adopt a careful approach with regard to such matters, herein following the attitude of the Tibetan physicians

I met. Their genuine way to deal with their patients is something I sensed as truly inspiring, maybe best described by the term ‘empathy’.

### History of the Medical College and Present State of Medical Care

Kumbum monastery which is located near Huangzhong village in Rushar County, Qinghai Province, has a medical college, called the Kumbum Medical College (Sku-vbum sman-pa grwa- tshang), established in 1757, as is commonly assumed (Meyer 1997: 118; Gyurme Dorje 1996: 578). Some local publications give 1711 as the foundation date (see for example Li Zhiwu 1982: app. 9). Today, the small temple at Kumbum Monastery remains a place of treatment and medical education within the monastery. It includes a consulting room, a pharmacy and another room housing equipment for medicinal production. During the time of my visits the number of patients frequenting this place, however, was rather unsubstantial.

Both Evariste Huc, passing through the area in the mid 19<sup>th</sup> century, as well as later Wilhelm Filchner, reported on medical activities in the temple where the college (*grwa-tshang*) is situated. They also mention a place they call “Tschogortan” closely located to the monastery; this was where the monks stayed during summertime in order to gather herbs and other ingredients necessary for pharmaceutical production (Huc 1966: 229f; Filchner 1906: 90). Today a hermit lives in the rock-cut temple which is called “Chos-dkar-thang”. I was told that the temple is the destination of a procession organized by the hospital once a year.

The present Kumbum Monastery Hospital which was founded in 1980 by Tulku Tashi Rinpoche, is situated outside of the monastic compound and shows a much higher frequency of patients. The large area that it covers includes an outpatient department where patients are diagnosed. It also has a pharmacy, an inpatient department, a sanatorium for medicinal baths and a few rooms where pharmacological substances are produced and stored. At the other side of the road, there is another Tibetan hospital that is run by the state. A number of small pharmacies selling biomedicine can be found in the village, too,

and there is also a hospital offering treatment with Traditional Chinese Medicine (TCM). Yet another medical institution in the village is a biomedical clinic where acute diseases or cases of emergency are treated. If surgical intervention or modern diagnostic methods like computer tomographic scanning becomes necessary, people normally go to a People’s Hospital in Xining, the capital of Qinghai, about 25 km away. Even if there remain some problems with health care in general, the area around Kumbum certainly offers one of the best and most developed health care systems in the whole of Qinghai, with Tibetan medicine playing a significant role therein.



Fig. 1: The hospital of the Kumbum monastery welcomes its patients in three languages (Tibetan, Mongolian and Chinese) (photo: Katharina Sabernig)

### Physicians and Clients at Kumbum Monastery Hospital

#### Tulku Tashi Rinpoche

The main authority in medical affairs at the Hospital is Tulku Tashi Rinpoche. Born in 1936, in March 1939 he was identified as the fourth incarnation in his spiritual lineage and an emanation of an old master of medicine. With only four years of age, he entered the monastery. In the years between 1958 and 1980 his biography is similar to that of most of his



colleagues during that time (Dkon-mchog Rgyal-mtshan 1996: 50; Holmes 1997: 144). In 1980 he started to renovate the College of Medicine and Astrology at Kumbum Monastery. He taught theory of Tibetan medicine to many students of different nationalities (Dkon-mchog Rgyal-mtshan 1996: 50ff). Knowing Tibetan, Chinese and Mongolian he is able to speak to most of his patients in their mother tongue. Sometimes he leaves the monastery in order to visit villages in Inner Mongolia (Nei Menggu) or Xinjiang where he diagnoses and treats patients as well. As soon as he returns, many patients flock again to the hospital. An old woman described the situation in these words: “He is like a smoke signal – everybody knows where he is and when he comes.”

No doubt, Tulku Tashi Rinpoche enjoys high prestige and respect. Next to his medical knowledge and experience, a prominent aspect of his personality lies in his compassion and empathetic behaviour. On 26<sup>th</sup> July, 2004 a new temple in Kumbum Monastery which was initiated by him was inaugurated. People from all over the country, even from Beijing, came in order to take part at the consecration ceremony of the Tara-Tempel (*sgrol-mavi lha-khang*).

Once he felt sorry for me because he did not always explain what he was thinking about and doing with the patients and so he said to me: “I would like to tell you much more about what we are doing here, but in the presence of a patient I only say what is also good for the patient to hear” – meaning that his explanations were also part of his therapy. Since sometimes more than twenty people came to the hospital in one morning, the Tulku did not have much time for each single patient, but during those maybe five to ten minutes he was totally committed and paid full attention. Sometimes he behaved more like a monastic authority, giving blessings and so on, at other times he acted as a medical professional, depending on the situation and the patients’ illness. Towards me he behaved more like a gentle grandfather, who wants to show his grandchild as much as possible about his work.

### **The Team Around Tulku Tashi Rinpoche**

The Hospital staff consists of traditional Tibetan monk doctors, monk students and assistant health workers. At the time of my research, two of Tashi Tulku’s monk students

who had already completed a three-year medical training course at the Qinghai Tibetan Medical School in Xining were allowed to treat patients. One of the students had decided to enter Kumbum Monastery because he wanted to become a traditional Tibetan physician, the other one was asked by some medical authority in the monastery whether he would like to study traditional medicine there. In 2004, the number of former monk students now treating patients rose to eight. Besides traditional Tibetan medical knowledge, their medical training included the fundamentals of Western medical anatomy, patho-physiology and hygiene. They also helped producing complex remedies like *Ratna sampil* (in Tibetan: *ra-tna bsam-vphel*) or different types of “jewel pills” (*rin-chen ril-bu*). The easy parts of pharmacological production were conveyed to monks at lower stages of education. Some simple tasks, such as gathering plants were also taken on by men or women living in Huangzhong village. Also working in the Hospital, mainly in the spa department, was a female physician who was educated in Western Medicine. She took care of the bath temperature and the physical condition of the patients by taking their blood pressure and inquiring after their health, especially during the bath procedure. The executive director of the hospital, Kunchog Gyaltsen (Dkon-mchog Rgyal-mtshan), is a former disciple of Tulku Tashi Rinpoche and studied several years abroad to complete a masters degree in primary healthcare management and international and intercultural management.<sup>3</sup>

### **Clients’ Disorders**

As my research was carried out during summer, the following profile of patients’ discomforts gives an impression of what Tibetan doctors were mainly dealing with at that time. However, this cannot be read as a general statistic of pathologic cases throughout the whole year or in the region. Also, many patients confronted the physicians with more than one kind of discomfort. Out of the 355 patients, 169 patients – roughly half of all visitors to the ambulatory – named problems related to the gastrointestinal system. However, only one person was offered moxibustion treatment at the epigastrium. 150 patients suffered from some specific kind of pain but, in all, only two of them received moxibustion, and at the place

where the pain was felt. These treatments will be described in more detail in the chapter dealing with that kind of therapy. Out of the health problems documented, 67 problems concerned neurology, 38 disorders of the urogenital system, 43 people complained about heart problems, including the popular syndrome “being nervous in the heart”. The doctors explained that this syndrome can indicate physical heart problems but that it more often simply means a general discomfort that makes patients feel worried about something. 24 people had obvious lung problems, but many more were suffering from a cough which curiously was not mentioned during the anamnesis. It seems to be part of the generally weak condition of many people living in the region, as it was explained to me. Besides other disorders, insomnia and serious skin disorders were documented as well. Most of the diseases mentioned were treated with pharmaceuticals which had been produced by the hospital (Sabernig 2004). Details on the setting of clinical encounters and why a Tibetan doctor is consulted by patients in the first place have been published already (Sabernig 2001: 28f), and form part of my thesis in ethnomedicine.

### External Therapeutic Methods

Traditionally, four groups of treatments are distinguished in Tibetan medicine: behaviour, dietetics, pharmacology, and external therapy. External therapies like compresses, medicinal baths, moxibustion, bloodletting, cauterization and surgery are indicated in cases of complex diseases or if pharmacological therapy did not help (Meyer 1997: 138). Depending on the climate or other local factors, different regions developed external therapies with different priorities. Concerning this issue, Wang Lei claims that the so-called “Northern School” which developed in the fourteenth century had influenced the medical theory and practice in Amdo: “The scholastic characteristics of this school were: expert in using warm and hot-natured drugs, with many kinds of medicinal ingredients in a prescription, skilled in such techniques as moxibustion, bloodletting and treatment of rheumatic illness.” (Wang Lei 1994: 9)

Even though pharmacotherapy administered orally constitutes the main type of treatment at

Kumbum Hospital, external treatments are still practiced in cases of complex diseases or special indications. During the time of my research two pharmacological products were prescribed to be applied externally. In these cases the remedies are not absorbed by the gastrointestinal system but by the skin. Other therapies like bloodletting, cauterization with hot metals or soft methods like massages, as well as the application of cupping were not carried out during my visits. Either the physicians do practice them very rarely or not anymore, due to safety reasons, or they do not have the capacity to apply them. In the following, however, I will document several case studies of patients who received treatments with moxibustion, medicinal incense, medicinal baths, ointments and medicinal oils.

### Treatment with Moxibustion

Moxibustion is a popular treatment in Tibetan medicine but is also known in other Asian medical systems. During my research, it was practiced several times at Kumbum Hospital. Before starting the treatment, the physicians prepared a few moxa-cones. Usually one cone was about at least one centimeter long and less than half a centimeter in diameter. Not only Finckh (1990: 74) but also Parfionovitch et al. (1996: 155) described different types of quite big moxa-cones but the physicians of Kumbum explained that in present-day practice moxibustion according to tradition would be too intensive (and also too painful) for the patients. In the Hospital of Kumbum ‘direct moxibustion’ is applied; this means that the moxa-cone is put directly onto the skin without any intermediate material such as ginger (see Wühr 1988: 337; Stux 1985: 70). Usually the leaves of mugwort *Artemisia sp.* (phur-nag) are required for moxibustion. The physicians told me, however, that traditionally they used parts of *Leontopodium sp.* (spra-thog rigs-gsig) and *Helichrysum sp.* (spra-g’yung).<sup>4</sup> Spra-ba means “tinder” (Jäschke 1998 [1881]: 335) due to the furry structure of these plants. In Byams-pa Vphrin-las’ translation of the medical thangkas [the *Vaidurya sngon-po*], time and place for collecting mugwort, *Artemisia sp.*, is described as follows: “Collection arranged at optimal time of the first quarter of the moon collected by a neat child, at a beautiful scenic spot, under the guidance of a doctor in the autumn season.” (Byams-pa Vphrin-las et al. 1994: 465)<sup>5</sup>

Byams-pa Vphrin-las (et al.) translates the “main indications for a treatment with moxibustion” (*me-btsav dngos byed-pa mtshon-pa*) as follows: “dyspepsia” (*ma-zhu-ba*), “coldness of the stomach” (*me-drod nyams-pa*), “dropsy” (*skya-rbab*), “edema” (*dmu-chu*), “lumps” (*skran*), “cold mkhris-pa disease” (*grang-mkhris*), “yellow fluid disease” (*chu-ser*), “malignant ulcers” (*vbras*), “carbuncles and boils” (*lhog-pa*), “void fever” (*stongs-tshad*), “insanity” (*smyo-byed*), “forgetfulness and hysteria” (*brjed-byed*), “diseases of the blood vessel” (*rtsa-nad*), “advanced stage of high fever” (*tsha-rjes phal-cher mtshon-pa*), “disease of bad-kan” (*bad-kan mtshon-pa*), “diseases transformed from rlung element” (*rlung las gyur-pa*), “cold disease of the whole body” (*grang-nad kun mtshon-pa*), “yellow fluid invading the vessels” (*rtsar chu-ser yod-pa*). The contraindications (*mi-rung-ba*) of moxibustion are: “disease of mkhris-pa” (*mkhris-pas na-ba*), “feverish diseases” (*tshad-pas na-ba*) and “blood disease” (*khrag-nad*) (Byams-pa Vphrin-las et al. 1994: 465f).

Besides, Bradley (1998: 140) warns against performing moxibustion directly on the five sense organs or the genitalia. The most relevant divergences to the translation of Parfionovitch et al. show the interpretations relating to the expressions *chu-ser* and *lhog-pa*. Parfionovitch et al. translate *chu-ser* with “serum”, Byams-pa Vphrin-las et al. with “yellow fluid”. Yellow fluid seems to be more appropriate because forming the physiological basis for the blood, serum is well defined by biomedicine. According to Jäschke (1998: 602) the expression *chu-ser* also implicates pus. *Lhog-pa* is translated by Parfionovitch et al. as “muscular spasm” while Byams-pa Vphrin-las writes “carbuncles and boils”. The disease *lhog-pa* will be discussed somewhat more detailed in the chapter treating the indications of the medicinal bath. In the following, I will describe present-day moxibustion treatments at Kumbum Hospital which were applied on a patients’ neck, on the stomach in a case of pathogenic cold, on the knuckle, and at the breastbone in a case of infant insanity.

### Moxibustion on the Neck

A rich man of Han Chinese nationality, middle aged and of Buddhist confession, visited the hospital and gave some financial contribution to the institution. He was suffering of pain in the

neck that radiated into the arms, feeling numb in the fingers. When driving his car over long distances the pain became worse. After palpation of the pulse and the neck, the physician decided to prescribe some pharmaceuticals to be taken orally and suggested moxibustion on the place of irritation. Some small moxa-cones containing *Artemisia sp.* were prepared. At the beginning one cone was put directly on the neck at the position of Vertebra prominens. As the top of the cone was burning down, it was blown upon. Then he pressed the residual cone into the skin until the glow became extinct. The same procedure was repeated four times in a cross formation around the first position. Small blisters appeared. The physician explained that the liquid in the blister will take away the “bad water” from the deeper tissue, bringing it to the surface. The smoking cone was blown upon in order to allow the skin to absorb the smoke. The ash of *Artemisia sp.* is seen as a disinfectant and should not be taken away from the place of treatment. A week later the patient came back enthusiastically and informed the doctor that the condition of his neck was much better. He asked to buy some moxa-wool to have the treatment prepared by his family. The cross formation around the Vertebra prominens is not represented on the thangkas illustrating the Blue Beryl, but the five point grouping on other places of the body can be found repeatedly (e.g. Parfionovitch et al. 1996: 91,157; Byams-pa Vphrin-las et al. 1994: 276, 468).

### Moxibustion at the Epigastrium

A poor nomad had trouble with his stomach and a sense of fullness in the abdomen. At the corresponding area on his back he was in pain. After careful anamnesis including palpation of the pulse and the upper abdomen the diagnosis was “accumulation of cold” in the stomach region caused by cold damp living conditions and nutrition of inferior quality. The patient received a prescription of Tibetan medicine to take orally and moxibustion was applied on the epigastrium. He was advised to avoid cold beverages and to drink warm tea instead.

The moxa-cones were placed at the pit of the stomach while the patient was sitting on a chair. A cone in the cross formation was removed immediately after the patient gave a signal that he felt a hot pain. Due to the patient’s weak

condition and the sensibility of the region the doctor tried to shorten the treatment and practiced it less intensively. He explained, however, that the traditional treatment should be performed with nine moxa-cones, three in a row forming a square, but patients must be in a very good condition to have it done this way. Thangka no. 38 and no. 72 of the Buryat thangka set and thangka no. 40 and no. 74 of the Mentsikhang in Lhasa show the formation of nine cones on the epigastrium (Parfionovitch et al. 1996: 91,157; Byams-pa Vphrin-las et al. 1994: 276, 468). Although the doctors did not explicitly explain the meaning of these formations it is obvious that the theoretical roots are based on the numeric system of the "magic square" (Granet 1985 [1936]: 127-155). The nine sectors on the basis of interrelation among the "five evolutive phases", better known as the "five elements", and the "12 animal symbols" forming the divination diagram of urine examination also show the structure of the "magic square" (Parvionovitch et al., Thangka 64-66, [1996: 143-148, 299-304], Byams-pa Vphrin-las, Thangka 66-68, [1994: 425-444])

### Moxibustion at the Knuckle

An old woman complained about a stiff numb knuckle. She suffered from itching, insomnia and stomach pain. A former treatment of pruritus with conventional medicine had failed. The physician prescribed some medicine and gave her the advice to avoid intensive spices, vinegar and soy sauce. He diagnosed the problem with her knuckle as an invasion of damp cold wind. Moxibustion was applied to warm up the cold and to eliminate the 'bad liquid'. First he fixed one moxa-cone at the back of the hand, then he put another cone at the corresponding place at the palm of the hand. The cone was not lighted by a match as usual but by applying a glowing stick of incense in order to set the moxa-cone on fire. This method is indicated to work more gentler and have a longer lasting effect. Again, the smoke was not allowed to rise up but was blown into the direction of the knuckle.

### Moxibustion at the Breastbone

A Muslim woman of Hui nationality visited the outdoor patient department with her son, about seven years of age, who was visibly impaired by a mental handicap. She explained that the boy



Fig. 2: Dried *Artemisia* sp. ignited by an incense stick (photo: Katharina Sabernig)

had eaten a watermelon three years ago which caused serious diarrhoea and during this incident he even lost consciousness. Since then he had been fearful and had fever quite often. His legs were cold and while sleeping he lost urine and 'sperm'. The physician explained that the emissions were caused by general weakness and an influence of pathogenic cold. He prescribed some remedies.

Some three weeks later they both came again to the hospital. The mother reported that enuresis was much better now and that the boy's lips were smoother since he was taking the medicine. Then she told more about the case history of her son. The boy was the weaker one of a pair of twins. When he had been a small child, he was already given a lot of biomedicine against his brain damage. Suspecting that this type of medicine had worsened the boy's general condition of weakness due to its side effects, the doctor applied moxibustion at the breastbone in height of the Corpus sterni. A single small moxa-cone was burned to strengthen the 'spirit' and inner organs. Yet it was clearly perceptible that most people present in the room felt that in this case healing was very difficult.

### Treatment with Medicinal Incense

Medicinal incense is prescribed to nearly every patient with skin problems. According to the doctors, the Tibetan point of view on the efficacy of incense is seen in the averting of pathogenic or evil external influence, including both demons and infections by microorganisms. The smoke generally has a positive influence on the patient's mood and will also be used in cases of dizziness or problems with the sense organs



such as being hard of hearing. In cases of ‘psychosomatic disorders’ incense was always indicated. Many disorders relating to *rlung* (wind humor) are indications for incense.

In the “Vaidurya sngon po” medicinal incense is not explicitly mentioned as external therapy but since in Kumbum it is applied as one, it should shortly be discussed here. Like with moxibustion, the smoke of incense enters the body through the skin and the sense of smell. Usually incense is only prescribed as an additional measure, and pharmaceutical treatment is the main therapy. There are different kinds of incense, yet the hospital of Kumbum Monastery produces only one specific version. Usually 19 different kinds of ingredients are used in order to prepare medicinal incense. They are stored in huge quantities in store-rooms at the hospital, and each single component is prepared according to its mode of action. The substances are then mixed and pulverized, following the prescription. Then some water is added to the powder. The resulting paste is placed in a machine that forms it into rippled plates which are then dried in the sun. It is the job of village women to separate each piece of incense and pack sets of them into boxes for sale at the Hospital pharmacy.

### A Case Study

One day a young girl and her parents came to the hospital for treatment. The parents reported that she had fallen into a cesspool (Chin. *cesuo*) one year ago. Since then she was not able to walk properly, but biomedical diagnosis could not help identifying the cause. After the girl had been diagnosed by pulse palpation and her family had been interviewed to establish the anamnesis, the girl received some Tibetan medication and incense to burn in order to re-establish her psychic integrity.

People who experienced fatalities, such as the sudden death of a relative, and developed symptoms, such as insomnia or tiredness, are typical patients for whom incense is prescribed. Medicinal incense is also indicated if a patient is obviously afflicted, but no diagnosis can be found or it remains unclear. A physician gave me this example: A young woman visited the Hospital to buy some more incense, which helped to reduce her stomach trouble. She had

gone several times to a biomedical hospital where gastroscopy and X-ray examination was done, but the cause of the discomfort was not found. In the Tibetan Hospital, it was explained that no diagnostic cause (such as dyscrasia) could be found either, but it was supposed that there was some spiritual or social problem in the background. Medicine and incense were administered successfully, and so the woman wanted to buy some more incense. As for the young girl who fell into the cesspit, I do not know if the incense helped in the end, as she and her parents did not come back to the Hospital during my stay.

### Medicinal Drug Baths and their Applications

To administer medicinal drug baths is a widespread traditional therapy in Amdo and other parts of the Tibetan cultural sphere in China. However, it became modified by modern techniques, at least at Kumbum Hospital. In the Blue Beryl, more specifically the commentary of the 23<sup>rd</sup> chapter of the Fourth Tantra (*phyi-ma-rgyud*), Byams-pa Vphrin-las names the main indications for a “medicinal bath” (*lums-dngos rung-ba*)<sup>7</sup> as follows: “rigidity of extremities” (*yan-lag rengs-pa*), “spasm of extremities” (*vkhum-s-pa*), “lameness” (*zha-ba*),<sup>8</sup> “malignant ulcers” (*vbras*), “anthrax” (*lhog-ba*), “old wounds” (*rma-rnying*), “new wounds” (*rma-gsar*), “swelling” (*skrang-s-pa*), “serious gynecological diseases” (*tshabs-nad*), “crooked back” (*sgur-po*), “yellow fluid invading muscles and bones” (*sha-rus chu-ser yod-pa*) and “rlung disease” (*rlung-nad*). The contraindications (*mi-rung-ba*) are “epidemic infectious diseases” (*rims*), “undulant fever” (*vkhrugs*), “hyperpyrexia” (*tsha-ba rgyas-pa*), “edema” (*skya-rbab*), “general weakness” (*nyams-chung*) and loss of appetite (*dang-ga vgags-pa*) (Byams-pa Vphrin-las et al. 1994: 475, 478). Parfionovitch et al. translate the indication *lhog-pa* as “muscular spasm”. Thangka 74 (Parfionovitch et al. 1996: 162, 319) and thangka 76 respectively (Byams-pa Vphrin-las et al. (1994: 475) show the suffering person with carbuncles or at least having a severe skin disease. So the translation of Byams-pa Vphrin-las as “anthrax” might be right. Jäschke translates *lhog-pa* as “anthrax”, too, offering another expression as well: carbuncle or cancerous ulcer “against which they employ the *Aconitum ferox* ...” (Jäschke 1998: 602). Anthrax of the skin is an endemic

disease in nomad areas. However, today anthrax would not be treated with a modern Tibetan medicinal bath. Antibiotics and corticosteroids would be the main therapy.

Renzeng Duoji and Qi Xiaohui from the traditional Tibetan Hospital in Shannan presented the modern Tibetan medicinal bath at the International Congress on Traditional Medicine in Beijing 2000 with the following therapeutic mechanism and indications:

“Its mechanism is that the drug solution acts on the organism through stimulating body surface and sweat pores, resulting in increase of temperature, strengthening of heat dissipation and acceleration of blood circulation in local tissue to stimulate cerebral cortex and sub-cortical centers, respiratory center, cardiovascular center, and so on, so as to reach the purpose of preventing and treating diseases [...] it has obvious therapeutic effects for rheumatism, rheumatoid arthritis, ankylosing spondylitis, hemiplegia and hypertension.” (Renzeng Duoji and Qi Xiaohui 2000: 536).

The medicinal bath at Kumbum Monastery Hospital is applied in a specific way. The monks mentioned the following main indications: arthritis, joint pain, and dermatological problems. The widespread syndromes “damp cold wind” and “wind after birth” will be treated by this therapy, too. A major principle of the therapy is the idea to eliminate toxins or “poisons” (*dug*) from the body. Contraindications are hot diseases, many syndromes relating to *mkhris-pa* disorders, and hypertension. According to the hospital’s regulations, children and old people should not be prescribed a medicinal bath. In general the contraindications mentioned by the doctors are not inconsistent with the traditional point of view but Renzeng Duoji and Qi Xiaohui write that the biomedical syndrome hypertension is an indication for administering medicinal baths (see above). However, contrary to this statement, the monks of Kumbum Hospital warn against a medicinal bath in case of hypertension. Bühring (1990: 185) points out that in case of treatments with systemic exogenous hyperthermia the diastolic pressure is going down while the systolic pressure might go up. As systolic values of 220 mm hg had been taken from quite a few patients during my research, the opinion of the

physician working in the Kumbum Hospital should be taken serious: hypertension is a contraindication.



Fig. 3: Facility for the modern Tibetan medicinal bath (photo: Katharina Sabernig)

According to the doctors in the monastery the best time to take a medicinal bath is either spring or autumn. Although this kind of treatment is a warming therapy and is indicated in case of cold diseases, winter is a disadvantageous time because the skin is ‘closed’ and the body is defensive against influences coming from outside. In springtime the skin ‘opens’ to external influences while the summertime is too hot and undesirable side effects might appear. A medicinal bath in autumn is not only good from a medical point of view (for a similar reason as in the case of spring); it is also practical from a patient’s point of view. As I was told, many people like to take a bath after hard physical work when the harvest season has ended in order to be well prepared for the winter.

People who are taking a medicinal bath stay in the hospital at the inpatient department for one week. In this building they are given a simple but clean place to stay that includes a bath facility consisting of a tiled room including the bathtub and the thermostat to regulate the temperature of the water. The cycle of therapy lasts seven days. The temperature and duration of the hydrotherapy is rising every day until the fourth day. From that day onwards, temperature and duration of the bath water drop in the same way as they were rising before. It should be mentioned that the temperature on the fourth day is close to the physiological border of pain. The bath temperature is regulated by the thermostat. A bath will take place twice a day, once in the

morning and once in the afternoon. During the whole week patients are advised not to leave the area of the hospital, to rest and to stay in warm blankets. They receive food which is easy to digest and are told to drink enough in order to balance the natural loss of body fluid caused by exogenous hyperthermia. A female physician educated in Western medicine controls the patients' blood-pressure and their general conditions while being responsible for the correct progress of the medicinal bath.

Therapeutic scheme						
day 1	day 2	day 3	day 4	day 5	day 6	day 7
			30 min.			
		25 min.	44°	25 min.		
	20 min.	42°		42°	20 min.	
15 min.	40°				40°	15 min
38°						38°

There are different standardised remedies, which will be prepared by cooking and added to the spa. Usually, one main medicine is administered to treat the prevailing syndrome and another medicine is taken to balance the individual dyscrasia. The formula of the remedies will not be changed during the process. Renzeng Duoqi and Qi Xiaohui (2000: 536f) refer to a popular medicine used as medicinal drug bath called *wu wei gan lu tang*. Lachen Tsering (2000: 977) describes a medicinal bath with similar indications applying a “Nectar with Five Ingredients” while Tsering Thakchoe Drungtso (2004: 472) knows a mixture including ingredients such as rhododendron, juniper, ephedra, tamarisk and tansy with boiling water. Furthermore, some modern publications on the Tibetan medicinal bath are available in China (e.g. Bsod-nams Tshe-ring 1999: 117-148).

### Ointments and Medicinal Oils

The prescription of an ointment could be documented twice during my visits. Once, a female patient of about 70 years of age was having troubles with her knee as a result of an accident. Painkillers or antiphlogistic agents eased her discomfort but the situation did not get better. The joint was still red, hot and swollen – all signs of an inflammation. The physician mixed up some powder, gave advice to complete it with yak butter or lard every day, and to apply the ointment by massaging it into the knee. Since it should be applied quite

liberally, the joint should be wrapped with some gauze. Additionally, she was given different kinds of remedies to take.

The process of mixing up different powders individually for a patient is quite unusual at Kumbum Hospital, since medicinal powders will normally be produced in huge amounts and are available at the hospital's pharmacy. In this case, however, the doctor prepared the mixture individually, and by hand with a mortar, for the old woman. The ingredients used were *gur-gum* (either *Crocus sativus* L. [kha-che gur-gum] or *Carthamus tinctorius* L. [ldum gur-gum]; see: Dgav-bavi Rdo-rje [1998, ill. 189-191]) and the bile of a bear (*dom-mkhris*) or probably its common substitute, the bile of a cow.



Fig. 4: The pharmaceutical base of an ointment prepared by a monk (photo: Katharina Sabernig)

Medicinal oil was also prescribed in the case of a woman, who, since her childhood, was nearly deaf on one ear. She was given a prescription for external application of some powder which she had to prepare herself. The medicine which the patient had bought in the pharmacy had to be mixed up with radish seeds and then needed to be powdered. Two spoons of the prepared substance had to be cooked with rapeseed oil in a pot (usually a wok) for about a minute or two until the foam had disappeared. Two drops of the medicinal oil derived from this process had to be trickled into her ear.

### Conclusion

In relation to pharmacological prescriptions external therapies are not applied frequently at Kumbum Hospital. The reasons not to do so are

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# Contributions to Visual Anthropology

## Ethnomedical Background of the Ebola Epidemic 2004 in Yambio, South Sudan

Armin Prinz

### Background

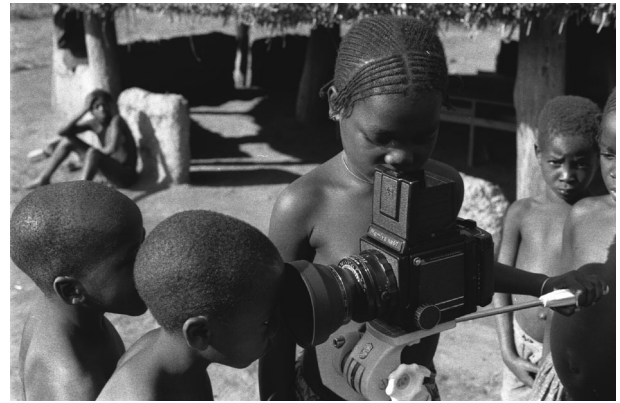
In the summer of 2004, Pierre Formenty, project leader for Viral Haemorrhagic Fever at the World Health Organization (WHO), Geneva, asked me to undertake investigations into the outbreak of Ebola in Yambio, South Sudan, that was just declared officially terminated. Several problems/issues were encountered during the Ebola outbreak investigation:

- (1) It was not possible to discover how a radio technician from the small town of Yambio, the index case of the epidemic, became first infected with the Ebola virus, his family was not cooperative enough with the medical teams,
- (2) Non-compliance of the Azande population with the control measures instituted by Ministry of Health authorities, “Médecins sans Frontières” (MSF) and WHO; notably some patients and their families refused to be isolated in the MSF isolation ward of the hospital; there were rumours that people in the area had hidden their infected relatives,
- (3) The medical teams were unable to understand why the chief nurse of the government hospital – who had survived the infection – had left his job and vanished for some days.

### Anthropological Investigation

With the relevant knowledge of the Azande concepts of witchcraft and magic and by using narrative interviews and focus group discussions, it was relatively uncomplicated to answer these questions.

1. In the beginning it was not clear how an urban resident became infected with Ebola in the first place. Because of the civil war and the relatively dense population, the amount of game in the area surrounding Yambio is very limited. Apes and monkeys as an intermediate host or reservoir for the Ebola virus are almost extinct. Medical teams were therefore wondering how



Our logo for this series: Azande children inspecting the camera of a visual anthropologist.

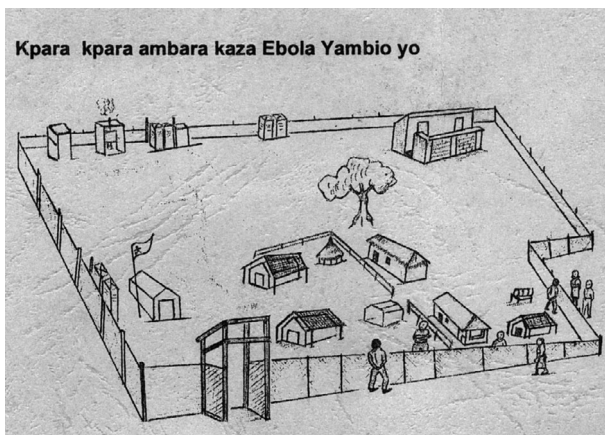
Photograph: Manfred Kremser

an urban resident could possibly come into contact with apes or monkeys. Because the family of the victim was mistrustful of the state authorities or any organization associated with them, it was not possible to obtain sufficient information where the deceased had stayed during the past fourteen days before becoming sick. It materialized, however, that on the weekend of 9-11 April, 2004 the victim crossed the border to the Democratic Republic Congo (which lies about 40 km from Yambio, and is inhabited by the Azande as well) to go hunting with his self-made shotgun (as shown in Fig. 1 and 2). Probably he was also registered as a refugee in the RDC – as many Southern Sudanese are – to receive UNHCR aid like food, medicines and seeds. In the night of 10 April, with a torch bound to his head, he killed two baboons (*Papio anubis*). These monkeys usually sleep on the top of trees, only the sick and weak animals stay on the ground and are therefore easy prey. They are less difficult to kill, especially for an “unskilled” hunter like the radio technician. Among the Azande it is custom to consume a piece of the hunted animal either raw or barely grilled just after the hunting party (Fig. 3). With high probability this is what the hunter also did. Five days later, on the 15 of April, he fell sick and was brought to the Yambio hospital on the 18th. Amongst other people he had contact with, he infected the chief nurse and his wife who was also working in the hospital as a nurse.

2. There are various reasons why the Azande hide their sick. This is partly due to their traditional Azande notions of disease causation, partly due to misunderstandings regarding the staff policy of MSF. “Médecins sans Frontières” recruited their personnel from the nurses of the



hospital who spoke English well and who generally made a good impression. They were paid extra (incentives) for their assistance – informants spoke about the enormous sum of 100 USD paid per day. Jealousy arose among those who were not considered. The rumour spread that the disease was not really Ebola but something else and that MSF faked the diagnosis only to earn a lot of money.



Plan of a quarantine station as drawn on an information leaflet on Ebola

A further source of suspicion were the “extraordinary quarantine measures”. When the patients were brought to the camp the relatives were not allowed to stay with them anymore. As soon as the sick had passed away they were buried by members of MSF in protection gear, without allowing relatives to be present. Only when half a metre of earth was piled on the corpse were the relatives allowed to gather and mourn around the grave and finally cover it up (Fig. 5 and 6).

These measures stand in stark contrast to the needs of the Azande who, like many societies in Africa, want to lovingly care for their sick and dying. Because the deceased is now an ancestor, he has to be given the impression that his death is a severe loss for his family. This is expressed by staying as near to the dead body as possible.

The fear that the Azande would not be able to protect their sick relatives against the bad influences of magic and witchcraft contributed even more to their non-compliance with the quarantine measures. Due to their concepts of the bicausality of disease, measures have also to be taken against these evil influences to protect the patient from further disaster. This counter-magic, however, can only be done in close contact to the sick person.

3. The chief nurse of the Yambio hospital survived the infection. His wife, however, who was working in the hospital as a nurse, and their baby died. After the wife’s death three aunts cared for the sick child and also became infected. Two of them did not survive. After this incident the chief nurse disappeared. It turned out that he was accused by his in-law to have “sold” the lives of his wife, child and two sisters-in-law to a “Mami Wata”. This mystical figure – comparable to a mermaid – aggressively approaches men to sexually tease them (Fig. 4). She promises them all kinds of advantages and money, but also demands the lives of humans which the men have to present to her. Shortly before the outbreak of Ebola the chief nurse was promoted to head of the hospital and his wife was also only recently appointed assistant to the chief doctor. This career aroused the envy of some. It was said that the chief nurse received this promotion through contact with a Mami Wata, for which he had to sacrifice four lives. His in-laws finally reported him to the police. The only possibility he had was to collect evidence of his innocence before he was summoned to the traditional court. He consulted several known diviners whose positive testimony would have carried enough weight to drop the charge. He covered 600km by bicycle to obtain these positive “expert’s report”.

## Conclusion and Recommendations

What measures should be taken to avoid similar problems in the future?

- From the very beginning a medical anthropologist who is an expert on the affected population should be part of the emergency team. He/she should make contact with local authorities and traditional healers who for their part could influence the population to cooperate with the emergency team.
- Case management, „transparency of activities: the closest relatives of the patients should be provided with protective clothing so that they can help taking care of their sick. Using “transparent quarantine containers” of soft plastic to be able to touch the sick person is another option.

Not until the ethnomedical and socio-cultural backgrounds are taken into account, will it be possible to prevent misunderstandings like these in Yambio.



Fig. 1: Azande hunter with his homemade shotgun and torch bound to his head. Hunting habits, especially to eat raw meat from the prey, is one of the main reasons for the infection of humans with Ebola among the Azande. (photo: Armin Prinz)



Fig. 2: The prey from the nightly hunt is carried on the bicycle. Also antelopes are able to transmit the Ebola virus to humans. (photo: Armin Prinz)



Fig. 3: Slightly smoked chimpanzee meat on an Azande market. The most important source of infection with Ebola is contact with infected apes. (photo: Armin Prinz)



Fig. 4: Mami Wata painting by the Congolese painter Bodo. If a man is not obeying the promises he has given to a Mami Wata he will be destroyed. Often the Mami Wata asks for human lives as a compensation for her help (detail).



Fig. 5: Disinfection of dead Ebola victims by sanitary staff. Painting by Kiloko Chai. (courtesy of WHO Brazzaville, Congo)



Fig. 6: Burying Ebola victims by sanitary staff without the presence of relatives. Congo Brazzaville (photo: A. Epelboin, CNRS-MNHN Paris, WHO Geneva)

**External Treatments  
at Kumbum Monastery Hospital**  
*continued from page 15*

mainly reasons of safety, as in the case of bloodletting, or a general lack of time on the part of the physicians. However, there is a still tendency to practice therapies with a warming effect, such as medicinal baths, moxibustion or incense. The personnel of the hospital tend to believe that a better infrastructure and better working capacities would give more room for external therapies. With the textual knowledge of Tibetan medicine in mind, which seems to be primarily based on the *Four Tantras* and the *Vaidurya sngon-po* or on modern Tibetan literature such as Dgav-bavi Rdo-rje (1998) or Bsam-gtan (1997) the monk doctors feel relatively free to modify the applications in order to both adapt the treatment to the individual condition of their patients and cope with modern technology. Moxibustion is practiced in a way relatively close to how it is described in the classic texts of Tibetan medical literature. However, there is a clear tendency to use smaller and fewer moxa-cones (e.g. five instead of nine cones). This approach does also seem to be more acceptable for the patients since it is less painful. The medicinal bath is carried out with modern technical devices using modern know-how and knowledge. Combining traditional baths with thermoregulation seems to be a good example for a successful synthesis between traditional Tibetan medicine and Western science and technology.

As long as we still do not know enough about how suffering people are cured successfully, medical scientists from different cultures can learn a lot from each other by exchanging their experiences. Even though it is difficult to transfer concepts of healing from one culture into another, the application of external treatments might be less complex and therefore easier to adopt than Tibetan pharmacology. Empathy and physical touch are therapeutic skills which are often felt to be lost in biomedicine and Western science. The affectionate attitude of Tulku Tashi Rinpoche when treating his patients was something I see as an inspiring example for any other physician elsewhere.

**Acknowledgments**

Expression of my gratitude goes first of all to

Tulku Tashi Rinpoche, his team at the hospital, and my translator. I am much indebted to Mona Schrempf who helped me with a wealth of important instructions and brushed up my English substantially. During the years 2000 and 2001 my research was financially supported by the Austrian “Büro für internationale Beziehungen” and my mother. A thank also goes to Michael Balk for his linguistic support and patience.

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## Notes

<sup>1</sup> The Transliteration in this paper follows the Wylie system but makes use of "v" instead of the apostrophe for *va-chung* and "x" for *xa-chen* (cf.: Balk 2005).

<sup>2</sup> The stem of "external treatment" illustrating the therapies in the Root Tantra in case of diseases of the three *nyes-pa* has only seven leaves. In the fourth volume of the Subsequent Tantra, we find some further details on these applications (Parfionovitch et al. [1996: 23-24, 155-164, 179-180, 311-320], Byams-pa Vphrin-las et al. [1994: 82, 463-478]). Some of the discussed treatments such as the modern medicinal drug bath are not mentioned in the classical literature but still must be considered "external treatments".

<sup>3</sup> See [www.TibetanHealingFund.org/KumbumMonasteryBrochure 04.04.04](http://www.TibetanHealingFund.org/KumbumMonasteryBrochure04.04.04)

<sup>4</sup> Cf. Dgav-bavi Rdo-rje (1998, ill. 501) and the herbarium of the Museum of Natural History, Vienna, Herbarium No. L10, L11. A number of medicinal plants that I collected in 1999 and 2000 are stored in this museum. They were identified and tagged by Dr. Bruno Wallnöfer.

<sup>5</sup> Cited from Byams-pa Vphrin-las et al. (1994: 465). The corresponding Tibetan passage reads thus, *yar-ngovi dus-bzang gtsang-mavi byis-pa sogs mtshon-pa / gnas-gtsang bu-ddhas bcags-pa / sman-pas byis-par spra-ba ston-pa / ston-pa btus-pa* (Byams pa vphrin las et al. 1994: 466).

<sup>6</sup> Tibetan doctors use both systems of the "five evolutive phases": the Indian system consists of the elements: water, fire, earth, air and space. The Chinese system which is the dominant one in Amdo refers to the elements wood and metal instead of air and space.

<sup>7</sup> In contrast, Parfionovitch et al. (1996: 319) translate it as "fomentation". However, the modern application of the medicinal bath as it is practiced in several Tibetan Hospitals in Amdo today differs from both interpretations.

<sup>8</sup> Byams-pa Vphrin-las et al. (1994: 475) translating *zha-ba* as "lamb" by mistake.

# **Factors Contributing to Low Levels of Teenage Pregnancy: A Comparative Analysis of the Netherlands and Uganda.**

Paul Bukuluki

## **Introduction**

The motivation to undertake this study was ignited by my first lecture at Medical Anthropology Unit, University of Amsterdam in 1998. In a presentation it was shown that the Netherlands have the lowest rate (10 per 1000) of teenage pregnancies in the world (Berne and Huberman, 1999, Haffner and Wagoner, 1999, Family Education Trust, 2003). This puzzled me because in Uganda (my country of origin), the teenage pregnancy rate is over 40% (Uganda Demographic and Health Survey, 1995/2000), which is one of the highest in the world. I therefore carried out a study to find out what had led to such a discrepancy in the levels of teenage pregnancies in the two countries.

The key research question was: what factors make the sexual and reproductive behaviour of adolescents in the Netherlands 'better' in comparison to their counterparts in Uganda, relating to the prevention of teenage pregnancies?

The methodology used for the study was qualitative and ethnographic in nature. Primary data was collected from the city of Amsterdam in The Netherlands. Adolescents aged between 13 and 21 years, parents and service providers were the major study participants. Focus group discussions, in-depth interviews, key informant interviews and participant observation were the major techniques of data collection employed. Participant observation was especially carried out in entertainment places, at condom vending machines, in bars, students' hostels, at parties, colleges and at service delivery agencies. Secondary data to complement the primary data sources was collected through review of literature, newspapers, Internet search and journals.

## **My Experiences in Conducting a Study in a Foreign Country as a Black Young Man (26 years of age)**

It was exciting on one hand but a challenge on the other to carry out research among adolescents in a foreign country on a very sensitive topic which involved them sharing very intimate feelings about their personal sexual lives with me.

In a number of cases, I got the addresses of young people through the internet or through friends, members of staff who had adolescent children and who had neighbours with adolescent children. At the beginning of interviews, many parents and adolescents had a lot of suspicions about my motives for conducting the study. Some parents asked me questions, which indirectly indicated that I might be looking for chances of getting at their girls, and entice them into sexual relationships, but they were reluctant to say "no" to my requests to interview their adolescent girls. In fact some parents and adolescents shut me out completely. However, as time went by, adolescents I had interviewed, who had had an interaction with me became so helpful and supportive. They indeed played a big role in locating for me other adolescents in their localities whom I could interview. They gave me feedback that they had actually enjoyed the interviews and enjoyed my company. Some adolescents started inviting me to parties in their hostels or the apartments of their parents and through this I managed to get in touch with so many adolescent boys and girls that finally I could not handle the numbers. Some adolescent girls in fact helped me to get to their parents for an interview.

There was a number of cases where I had to get interpreters because some adolescents, especially those who were in technical institutions for hair dressing, designing etc., could not communicate effectively in English.

To make it worse my English accent was as strange as my colour to some of them. Although this eased the tension between adolescents and me it sometimes interfered with their free communication with me. It was only very productive in focus group discussions when we were discussing about quite generic issues. Boys were often more free to talk to me during focus group discussions but compared to the girls they revealed quite less in individual interviews. My observation was that girls were more free and willing to share their intimate experiences than the boys. Once I had established a rapport with them and they had understood my study objectives, girls became much more open than I had expected. I also noted that my colour could have been an advantage. Although I asked obvious questions, many parents and adolescents felt that I did not know what is going on in their society and that I genuinely and innocently would like to learn from them. Towards the end of my fieldwork period, I became more and more cautious, because quite a number of adolescents who had been my respondents started making passes at me. I was discussing issues just like an adolescent and actually looked like one of them due to the fact that I look younger than my age (26, but some of them thought that I was actually 18 years). For ethical reasons, even when I appreciated that they were very beautiful and attractive, I had to avoid any intimate relationships lest I would be accused of using my position of a researcher for other motives. Actually during my graduation ceremony, a number of “my” adolescents, mainly girls, turned up and showered me with flowers and kisses on my cheeks as per the Dutch tradition.

### **Brief Description of Adolescent Reproductive Health in the Netherlands and Other Countries in the North**

The Netherlands have the lowest proportion of unplanned pregnancies among the countries in the North (Delbanco et al. 1997; Berne and Huberman 1999). The United States and the UK have the highest compared to other countries in the North such as France, and Germany (Haffner and Wagoner 1999, Family Education Trust 2003). In 2000, the live birth rate for young women aged 15-19 was 37.7 per 1000 in England and Wales, compared to 5.5 per 1000 in the Netherlands while the

conception rate was four times higher at 62.2 per 1000, compared to 14.1 per 1000 in the Netherlands (ONS-Birth Statistics 2002, Rademakers 2002). The United States and Canada were reported to have the highest rates (94.8 pregnancies per 1000 and 72 per 1000 respectively). Delbanco et al. (1997: 3-4) state that the overall US abortion rate (25.9 per 1000 women aged 15-44) is 1.7 times that of Canada (15.3 per 1000) and more than four times that of the Netherlands (6.0 per 1000). It is claimed that the disparity in rates of unplanned pregnancy and abortion is largely due to dissimilar levels of access to contraceptives, approaches to sexual education and sources of information about pregnancy prevention (Delbanco et al., 1997).

This assertion has been, however, criticised by the Family Education Trust (2003) for giving little attention to the socio-cultural factors like socialisation, analysing the character of sex education in the Netherlands and other countries in the North and not considering structural factors that may account for the differences in teenage pregnancy rates. The Family Education Trust (2003) argues that Dutch teenagers appear to be guided by moral principles to a greater degree than their British counterparts and abstain from sexual intercourse until a later age. A study of sexual attitudes among teenagers shows that in the Netherlands, a majority of both males and females gave ‘love and commitment’ as their primary reason for sexual intercourse, with ‘opportunity’, ‘physical attraction’ and ‘peer pressure’ scoring much lower (Ingham 1998).

Irrespective of the differences in academic arguments on why the Netherlands has the lowest rates of teenage pregnancy compared to other countries in the North, there is an overwhelming difference between most Northern and Southern countries in the prevalence of teenage pregnancies, abortion and STDs (sexually transmitted diseases).

### **Reproductive Health Situation in Developing Countries**

85 in every 100 adolescents worldwide live in developing countries (WHO 1996). In sub-Saharan Africa, it is estimated that 8 out of 10 young people below the age of 20 years and

at least half of all teens in Latin America are sexually experienced (UNFPA/IPPF 1997). In West Africa and South Asia, around 50% of the young women have a child by the age of 20.

The disproportionately high level of teenage pregnancies in developing countries is worrying as early pregnancy carries many health risks. Girls aged 10-14 are 5 times more likely to die during pregnancy or child birth than women aged 20-24. Early motherhood not only entails an enlarged risk of maternal death but also the children of young mothers have higher levels of morbidity and mortality (WHO 1996). The same source noted that pregnant adolescents are more likely to suffer eclampsia, obstructed labour and obstetric fistula than women who become pregnant in their early 20s. Similarly, girls who become pregnant in their teens are less likely to seek prenatal care.

In quite a number of cultures, although early marriage is common, social sanctions may be severe and induced abortion may seem to be the only way to avoid public shame and rejection, *if pregnancy occurs outside marriage*. Adolescents account for a very high proportion of abortion complications primarily because they are likely to indulge in clandestine illegal abortions or to delay seeking abortion till late in the pregnancy (WHO 1996).

In fundamentalist religious (Christian or Islam) families, these adolescents are ostracised and rejected by parents, relatives and friends. For young mothers overall, early motherhood curtails their educational and employment opportunities with adverse consequences on their own and the child's quality of life (WHO, 1996). Also chances of getting married are reduced. The young mother is most likely to live in absolute poverty and to suffer a web of interlocking disadvantages of vulnerability, physical weakness, isolation, powerlessness and poverty (Chambers 1997). Therefore teenage pregnancy is a monster that ought to be addressed in developmentally challenged countries through evidence-based interventions. Learning about what is done in the north to avert teenage pregnancies may promote interventions in the south and if adjusted to the socio-cultural, economic and political realities of the south, these interventions may bring positive changes in the teenage pregnancy situation.

### **Socio-Cultural and Service Delivery Factors Contributing to Low Levels of Teenage Pregnancies in the Netherlands**

Overall the study established the fact that the low levels of teenage pregnancy in the Netherlands are largely attributed to a pragmatic attitude towards sexuality and reproductive health issues. Rather than taking a moralistic and conservative approach towards sexuality, early pregnancy and STDs, the Dutch largely go for whatever works to save and protect their young generation. This finding is similar to the argument put forward by Ketting (1996: 14):

*“If we want youngsters to prevent unplanned pregnancies effectively, we should make them feel strong, confident and at ease in doing so. We should basically accept the feelings of adolescents regarding sexuality. Without that, youngsters will feel confused, embarrassed and guilty about their sexuality and thus will not have sufficient confidence to act in their own interest. After all, prevention does mean planning and rational behaviour, and that is difficult to put into practice if mixed and confusing feelings are involved”.*

An interview with a Dutch mother of three adolescents in which she shares her experiences with the first sexual experience of her daughter puts Ketting's argument in perspective:

*“It was very difficult; I thought that she was quite young for such an intense relationship. But she obviously had a different opinion. I tried to respect what she wanted. I can say, you can't be alone in that room. But then she goes in another room or to the park and that is exactly what I do not want. So I said it is all right but in my heart I hoped it would end. It was my mind over the feeling. My mind said you have to let go, my feeling said she is quite young”.*

The Dutch combine their rather liberal attitude towards sexuality with a well-developed information system. They provide adolescents with a lot of information and easy access services. The most important issue to them was for the young people to take conscious decisions. Adolescents are generally socialised to be autonomous (and not necessarily to be obedient) and to feel



responsible for their own actions regarding sexuality. The role of parents, service providers and other actors is to provide easy access to most of the needed information and services.

Most of the adolescents involved in the study had a very low opinion of girls that became pregnant at a young age. Their peers perceived them as stupid, naive and not responsible. The priorities of adolescents were described in terms of good education, good job and career in life. Having babies was ranked last. It sounded as if children were preferred only when one is “at the end of the road”. Becoming pregnant at a teen age was equated to robbing oneself of one’s life and all opportunities for social development.

*“Well if a girl of 18 or 19 years is pregnant, I would think that oh! You are stupid. I would not choose to be pregnant. I wouldn’t do it on purpose. I think it is stupid, you have to take care of yourself”* (18 year old female)

*“If one gets a baby, you cannot pay much attention to yourself. So you cannot learn and you lose part of your youth. If you have a baby, you cannot go to the disco, you cannot work hard, and you do not finish your studies”* (Roos, 18 years)

The adolescents had also developed a slogan: *‘I will have safe sex or no sex’*.

Adolescents have easy access to most of the information and services and the attitude of service providers including General Practitioners is supportive. The service providers developed and marketed a message named ‘Double Dutch’ which means “use contraceptives to avoid pregnancy and use the condom to prevent HIV/AIDS” (Rademarkers 1991).

The pill was very popular among adolescents, parents and General Practitioners. It serves both as a medicine and an instrument of birth control. The stigma associated with use of contraceptive pills among adolescents was reduced by the fact that in the Netherlands, pills are used for several purposes other than preventing pregnancy. For example they are used to regulate menstrual periods or the management of pimples and other skin problems associated with adolescence.

Adolescents start using pills in some cases way before they become sexually active. This demystifies the whole attitude of ‘sexualising’ use of contraceptive pills.

*“There are several reasons why adolescents use the pill. If you have some menstrual side effects like headaches ... you go to the GP and you say I have menstrual problems and the doctor will prescribe you the pill. Doctors think it is the best solution to the problem”* (female key informant)

*“When the doctor told me to get the pill, I thought oh! Not me. I am just 13 years old. I thought it was about pregnancy and I never thought that it was for the stomach pain (in the abdomen). I thought ok, what is happening to me. I am only 13 years and I am beginning to think about sex and boyfriends but not doing it. But the doctor is giving me the pill. I was surprised”* (18 year old girl)

Thus for the adolescents, the major issue was contraception and in particular the pill that fits one’s body best. It was established that in the initial stages of a relationship, adolescents tend to use both the pill and the condom (“Double Dutch”) but when the relationships become stable, they tend to mostly use the pill. This notwithstanding, there were a number of adolescents who reported to have persisted with both the pill and the condom.

*“My girlfriend takes pills but we also use condoms. She is more comfortable when we use condoms because when my sperms go to her vagina, they leave a mess she says. It is just easy for convenience”* (male, 17 years).

The insurance pays for the pills but the condoms are completely a responsibility of the users. Younger adolescents perceived this as a negative discrimination of their needs. Younger adolescents perceived the cost of the condom as high while the older adolescents felt that the cost was not as high as to inhibit them from using condoms. In a focus group discussion with girls one of them commented:

*“If you want pleasure, you should be prepared to pay for it. Compared to what one gains from the condom in terms of protection, I cannot rate its price as expensive”*.

Condom vending machines were common on the streets of Amsterdam, close to bars, disco places and cinemas.

Nevertheless, alcohol and sometimes drug abuse was singled out as an important factor predisposing young people to teenage pregnancies and STDs. They became vulnerable to either forgetting the pill or not being strict about using condoms. However even in such cases services like an after ‘morning pill’ are available and can be easily accessed by the young adolescents. This can therefore protect them from teenage pregnancies but not from HIV/AIDS.

*“Many youth drink alcohol and it is accepted. If you drink much, you could throw away some of your principles. Girls who drink are very easy to go with men and kiss. You may say, I do not sleep with any one but when you are drunk, you don’t seem to see things right”* (20 year old female adolescent)

There was relativity in openness of parents towards their children. Whereas some parents were open, others were not open at all to discuss sexual issues with their children. Communication of parents and children about sexuality was characterised by talking about tools to foster safe sex rather than making jokes. It was spontaneous. I prefer to call this “openness and liberalism of purpose”. This is similar to what Rademakers (1996: 1) called “restrictive permissivity”. It means that parents and other adults generally accept that adolescents are interested in sex and that they are sexually active. They don’t encourage it, often they are actually ambivalent about it, but they do not condemn it either.

*“I do not tell my children that; sit down, it is now time to talk about sex. It just comes up like anything else. It is not a special thing. It happens spontaneously, when they are curious and they want to know, I tell them”* (mother of adolescent children)

Communication between adolescents in relationships was relative but it was observed that the longer the relationship, the better the communication among couples. With a long period between courtship and penetrative sex, adolescents reported that there would be

enough opportunities for the couple to communicate and make necessary preparations for safer sex.

Compared to the media, peers, school and parents, role of the church in shaping adolescent sexuality has sharply declined especially in the more urbanised areas of the Netherlands. Study participants did not think that having sex before marriage means committing a sin, nor did they believe that there was hell waiting for those who have pre-marital sex.

On the whole, adolescents reported that the reproductive health services were available, accessible and perceived to be of high quality. It was noted, however, that the prices for consultation are on the rise because the government is withdrawing most of its subsidies from many social sectors including sexual and reproductive health.

The low levels of teenage pregnancy in the Netherlands cannot be attributed to a single factor. The study established that several factors worked in partnership, reinforcing each other to produce this desirable situation. These ranged from historical, socio-cultural to quality and functional adolescent-friendly service delivery systems. The most outstanding feature however, is the Dutchs’ pragmatic approach, which deliberately seeks practical actions. This was reflected in openness and the liberalism of purpose as well as establishment of a well-organised and functional health system that is able to respond to the needs of adolescents.

### **An Analysis of Socio-Cultural and Service Issues Leading to High Levels of Teenage Pregnancies in Uganda**

When the adolescent reproductive situation and associated factors in the Netherlands are compared with the Ugandan situation, most of the issues seem to be the reverse. Uganda has a high proportion of the population under 25 years. This is about 68.9% of the entire population (MoH 2000). Adolescent pregnancy rates stand at 43% (UDHS 1995) and have reduced only to 37% (UDHS 2000/01). There are higher rates of STDs and HIV infection in the adolescents than in the general population (MoH 1999). Epidemiological data show high levels of HIV infection and teenage pregnancies

among the 15-24 age groups (Kengaya-Kayondo et al. 1989, MOH 2003). The status of adolescent reproductive health in Uganda is poor. It is characterised by early pregnancy, unsafe abortion, maternal mortality, high infant mortality and STI/HIV/AIDS (Kivumbi and Mpabulungi 1999, Kurikiko and Ampaire 1999, Arinaitwe and Turinde 1999, UDHS 2000/01).

In Uganda, the initiation into sexual activity begins as early as 10-14 years of age with an average age of 15 years (UDHS 2000/01). Studies carried out in Uganda indicate a high level of sexual activity among adolescents (Ankrah and Rwabukwali 1987; Bagarukayo et al. 1993). Most adolescents' sexual activity is unprotected resulting into pregnancies and unsafe abortions. In Mulago National Hospital, 44.7% of women who died as a result of abortion complications were adolescents (MoH 1999). Interventions aimed at delaying first sex and reducing the number of partners do not seem to have an effect on the attitudes and behaviour of adolescents. Attitudes and forms of sexual behaviour that are risky are part of an adolescent ideal of modernity and sophistication. Many adolescents still place value on having sexual experience and multiple partners (Nyanzi et al. 2000). Thus adolescents are at a risk of unprotected sex combined with low contraceptive use, leading to adolescent pregnancy with often poor obstetric outcomes and high rates of often unsafe abortion (WHO 1993b).

The major factors influencing adolescents' sexual behaviour have been found to include need to experiment, peer pressure, lack of guidance and poor modelling by adults, lack of access to cash and employment opportunities, breaking down of traditional institutions, socialisation and media influence on the changing patterns of sexual activity (Bohmer and Kirumira 1997, Busulwa and Neema 1999).

The Ugandan communities though heterogeneous are largely taking a moralistic rather than a pragmatic approach to the issues of adolescent sexuality and teenage pregnancy. The key emphasis was on abstaining from sex. Those who use condoms and even pills are stigmatised and condemned by religious leaders, parents, elders, teachers, and politicians and in a number of cases service providers. Religious

bodies though not directly influencing and controlling the sexual behaviour of adolescents publicly condemn pre-marital sex and de-campaign the use of condoms. The religious movement is still strong and in some cases quite fundamentalist so that adolescents known for having premarital sex are liable to ambivalence and stigma. The churches admit that adolescents need sex but they deny this reality by emphasizing that it was immoral and a sin to engage in premarital sex. The emphasis is thus on abstinence until marriage. Young people are not seriously targeted for the use of contraceptives; instead, public health institutions and Faith Based Organisations (FBOs) are advocating abstinence.

Early marriages, linked to social and religious customs contribute to high numbers of teenage pregnancies, since young brides become mothers soon after marriage. UDHS (2000/01) shows that 17% of the women aged 20-49 at the time of the survey were married by the age of 15 years while more than half of the women in this age group were married by the age of 18 years. This has been exacerbated by the 18-year-old civil war in northern and north-eastern Uganda, which has contributed to an increase in the number of child mothers. Girls are vulnerable to sexual violence and abuse and generally at the age of 12 or 13 years, are forced to become "wives" of rebel commanders (Human Rights Watch 2003). These and other factors have contributed to poor reproductive health outcomes.

### Case Studies – Coping with Teenage Pregnancy in Uganda

The following case studies illustrate some of the manifestations and impacts of teenage stigma and social exclusion in the lives of adolescents in Uganda.

*"I am not supposed to see other members of my family at all; my father considers me a disgrace to the family. When I discovered that I was pregnant, I had to drop out of school. Studies were over for me."*

– Nampijja, a 15 year old mother, living on her own (Action Aid Uganda, Mubende reports)

*"I lived in shame," says Nakamya. "I was now out of school, and even my family blamed me*

*for the pregnancy. They said I was paying for my sins” (Matsamura 2004)*

Nakamya had her first baby after leaving school at the age of 16 years because of her pregnancy. Preparations were made with the birth attendant in the village. Nakamya's labour lasted almost four days. When she finally pushed the baby out, it was dead and Nakamya was not well. She “leaked” and smelled of urine and faeces all day, every day. The teenager had obstetric fistulas. Fistula is a shameful thing; often the patients lack the knowledge that the condition can be repaired and are too ashamed of their condition to seek help.

Child bearing poses many risks in Uganda, a largely rural country where the average number of children per woman is 7. Trained medical professionals assist an estimated 4 in 10 births and an estimated 500 women die of childbirth related complications for every 100,000 live births (UDHS 2000/01).

Like Nampijja, education for countless Ugandan girls comes to a standstill when they get pregnant. In most cases, people well known to them including teachers, relatives and close family friends impregnate them. Even after giving birth, these girls cannot go back to school. At such a tender age, some of them are forced to marry the same man who defiled them while others are forced to take responsibility of their children and are resigned to a life of domestic chores. Apart from the exclusion from school and termination of all opportunities for self-development, such girls are at risk of unsafe abortions, infection with HIV and other STDs. Meanwhile, as the girl suffers these consequences, most times the father of the child is left unaccountable.

In Uganda, adolescents are known to be poor users of contraceptives. Their contraceptive prevalence rate is reported to be 7.2% (UDHS, 1995). While awareness about the existence of contraceptives is high among adolescent females and males, the level of actual use among sexually active adolescents is very low due to their little practical knowledge on how to correctly use them and their perception that they are expensive (Arinaitwe and Turinde 1999). Fewer than 25% of all sexually active

males and females actually use a method of contraception, the prevalence being highest in urban areas (30% males and 35% females). In rural areas, only 13% males and 5% female youth use contraceptives. The use of contraceptives is highest among educated adolescents (15-18%). Unmarried adolescents cannot easily obtain family planning supplies and services (UDHS 1995, MoH 1999). Studies have found out that the parents do not want their children to be exposed to contraception especially condom use because this would encourage adolescents to try out more sexual practices. The beliefs that contraceptives are unsafe also discourage some intending users. Using pills was sexualised? and in some cases demonised. In schools distribution of condoms was prohibited and use discouraged. This creates a fertile ground for teenage pregnancies.

Public Service delivery systems are in many cases dysfunctional, poorly funded and not adolescent friendly, especially as you move from the centre to the semi-urban and rural health units. The capacity of the existing infrastructure and service providers is largely limited. A study carried out by Africa Alive/DISH II project in 1999/2000 established that there were no services in a number of districts especially designed for adolescents. Studies have revealed that services are not oriented to offer adolescent friendly reproductive health services (MoH 1999). A study by DISH (1998) in Jinja found gaps in service delivery, inadequate skills of health workers and prevailing negative attitudes between health workers and adolescents. However, various providers had a component for adolescent sexual health services in their programs but young people do not make much use of the existing services for contraception and STD care (WHO 1993a) due to lack of confidentiality, rudeness among service providers, myths about contraceptive use and ignorance about the existence of these services. Adolescents rarely utilised government health facilities because of inaccessibility due to distance, poor reception by health workers, inconsistent supply of drugs at the health units, and lack of financial support (Arinaitwe and Turinde 1999, MoH 1999).

NGOs like Naguru Teenage and Information Centre, AIDS Information Centre, Straight



Talk Foundation and the Family Planning Association of Uganda are trying to bridge the gap to provide information and services to adolescents but their scope and coverage is still limited. Where they have services, however, they are more adolescent friendly than in most public health care facilities. These marginal and fragmented efforts to provide adolescent reproductive health services are however, focussing more on the youths in school, leaving out many adolescents who dropped out of school and those who have been victims of sexual abuse in stable and unstable environments.

A study carried out by Koenig et al. (2004) among adolescent women (15-19 years) in Rakai district, Uganda, showed that 14% of the young women reported that their first sexual intercourse had been coerced. Similarly, Matasha et al. (1998) observed that forced sex was reported by a large number of primary school and secondary school girls (47% and 37% respectively) and was the first sexual experience for 31% and 20% of primary school and secondary school girls respectively. The consequences for disclosing sexual victimisation may be disastrous and can include rejection, “social death” and further violence. It is generally acknowledged that the shame and stigma associated with the experience of rape, together with perceived or genuine obstacles at every step of the judicial process, result in a significant degree of under reporting. Victims of rape and sexual assault may be made to feel some degree of responsibility for “provoking” the attack, or guilt for being unable to defend themselves. For some, violence may be perceived as inevitable. Adolescent sex workers, for example, are unlikely to receive a sympathetic hearing or justice when assaulted. Therefore, enforcement of laws and statutes against rape is poor and affected by culture, attitude and poverty especially in the communities and families involved.

The life skills such as assertiveness, negotiation, decision-making and problem solving are largely undeveloped among adolescents especially in relation to sexuality and pregnancy. Adolescents in Uganda often lack basic reproductive health information, skills in negotiating sexual relationships, and access to affordable and confidential reproductive health services.

Talking about sex is still treated as a taboo in many communities. Many adolescents do not feel comfortable discussing sexuality or their reproductive health concerns with parents or other adults, thus limiting their opportunity to learn.

It is important to note, however, that in recent years Uganda with the support of the political leadership, development partners and the private sector has made some strides in its efforts to develop adolescent sensitive policies and is moving towards empowering its community and health institutions to address adolescent reproductive health problems especially HIV/AIDS and sexually transmitted infections and teenage pregnancies. It is now one of the countries that have succeeded in reversing the trend of HIV/AIDS and STDs.

However, a lot remains to be done. In spite of the fact that some progress has been made in behavioural change and enacting of policies that are pro adolescent reproductive health, a review of several studies indicates that the reproductive health status of most adolescents in the country needs to be addressed:

- The coverage of adolescent reproductive health services is still limited; some districts have not been reached by these services. The Northern and North-eastern region has been scantily covered.
- Most services are not friendly to adolescents in terms of services, environment, personnel, hours of service, alternative sexual and reproductive health services.
- Health care services are still inadequate with limited and inconsistent supplies of drugs for sexually transmitted diseases, condoms and contraceptives.
- Most information, education and communication materials for adolescents are general and fall short of recognising the heterogeneous conditions of adolescents that the programs need to target.
- Although the media and peers are important sources of information, they have a number of times given misinformation, inaccuracies and myths
- Studies have indicated that the environment in which most adolescents live is not supportive. This includes among others: the negative parental, religious and community attitudes towards unmarried adolescents seeking reproductive health services.

- Marginal efforts have been made to reach the “hard to reach groups” of adolescents such as internally displaced, refugees and adolescents in child headed families due to wars and AIDS, and those involved in drug abuse.

Conclusively therefore, a combination of several factors accounts for the differences in adolescent reproductive health in adolescents in the Netherlands and Uganda respectively. They range from socio-cultural factors, level of sophistication of services, sensitivity of service providers, differences in the nature of support that social environments offer, to the pragmatic versus the moralistic and value laden nature of approaches to sexual and reproductive health issues. Discrepancies in the availability and utilisation of resources for provision of appropriate quality and quantity of reproductive care needed by adolescents in the Netherlands and Uganda) also account for differences in levels of teenage pregnancy.

Although the approaches and policies in the Netherlands cannot be fully embraced by Uganda because of the differences in the socio-cultural environments and availability of resources, Uganda can learn a lesson from the Netherlands’ experience and adapt them to their own needs for the benefit of Ugandan adolescents.

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## Report on the ICUAR Conference “Strategies for Development of Indigenous People”

Stephanie Wiesbauer-Hohenwart

At the 15<sup>th</sup> International Congress of Anthropological and Ethnological Sciences in Florence in July 2003 it was decided that the International Commission on Urgent Anthropological Research (ICUAR) should organise an International Symposium in Ranchi, Jharkhand, India, devoted to the problems of Indigenous Peoples at the end of the UN Decade of Indigenous People (1994 – 2004).

Ranchi is the capital of Jharkhand, the ‘Forest State’, founded in 2000 within the Indian Union, formerly part of Bihar. A historical outline can be found in Internet under the heading <http://www.ranchiexpress.com/maindocs/history.htm>.

The department of anthropology at Ranchi university has a long tradition; established by Professor Vidyarty and developed to a well-know centre of research and study, cooperating always with the Anthropological Survey of India. The new state of Jharkhand shows many problems which the

indigenous people have to deal with currently. It has a long tradition of fighting for independence from the time of the British colonial rule until its present status. The national hero is Birsa Munda, a tribal, who died in a British jail at the age of 25 years. Though the average income of the population is low (US\$ 90), the country is rich in minerals, as said in Wikipedia: 'it is a rich state of poor people'. <http://en.wikipedia.org/wiki/Jharkhand>.

The Conference in Ranchi took place from December 16 – 18, 2004 in the location of Xavier Institute of Social Service, Ranchi, and was well organized by Vijay Upadhyay, head of the Commission's Centre for Southeast Asia, and former head of the department of anthropology at Ranchi University. There were international contributors as well as Indian, and students from Ranchi and other Indian cities were invited to attend the Conference, joining in discussions after the presentations and in coffeebreaks. At the Opening Ceremony the Prime Minister of Jharkhand, Shri Arjun Munda, of tribal origin himself, gave a speech on tribal policy in Jharkhand, then spoke the President of the International Union of Anthropological and Ethnological Sciences, Luis Alberto Vargas from UNAM, Mexico. The Vice-Dean of Ranchi University welcomed the participants coming not only from India, but also from many parts of the world and outlined the importance of anthropological research in his university. As Indian people have a special feeling for beauty and pleasant ceremonies, it is a custom to light a candle at the inauguration, and I was appointed to do so. This photo appeared with the press release in local newspapers, where the conference met constant interest.

International contributions came from Yolotl Gonzales-Torres, INAH, presenting the situation in Mexico: only in 2001 it was declared a pluri-ethnic nation with indigenous groups having specific autonomic cultural and linguistic rights. Wembah-Rashid from Tanzania reported on the RIPS project empowering local communities which has been helpful not only in improving the situation of the people, but also in reducing corruption, Werner Zips and Manuela Mairinger spoke on indigenous land rights and the National Park dilemma in southern Africa, and Scott Simon presented films from Taiwan, also dealing with the problems of land rights of indigenous people, a major problem throughout the world. Questions were also answered by both ladies that had made the films. From the Netherlands M.K. Gautam, Head of IUAES Commission on Museums and Cultural Heritage, presented vividly concepts on indigenous people.

Of course most papers were presented by Indian scholars coming not only from Ranchi but from all parts of this large and very complex state. Most interesting was the presentation by A. Sharma on the fighting of tribal people for their land rights in India from the British period until today, followed by B. Narayan saying that from 4% of the people displaced because of development projects 40% were tribals. Development is especially hindered by the practice of child labour (children working under compulsion), contributing 20% to the Indian GNP; this problem concerns especially India, Pakistan and Bangladesh. This theme was raised both by M.V.N.L. Damayanthi and Anjuli Chandra.

As to ethnomedicine, health practices and traditional knowledge on herbal medicine are of special importance, as it has been shown in the approach of Mitashree Mitra from Chhattisgarh, declared 'The Herbal State' because of its plant biodiversity. In a different way, P. Dash Sharma from Ranchi University pleaded for health-oriented action research studies among the tribal groups. Pravin Kumar Jha from the same university presented the outcome of a project he conducted among the Sauria Parharia living in Damin-I-Koh and Rajmahal hills: As they live in remote areas, they have no access even to basic health care and hundreds of them are dying due to malaria, kala-zar, cholera and malnutrition. Severe problems arise in the mining areas, where heavy metal poisoning is affecting large parts of the population as a consequence of polluted drinking water, as documented by Nitish Priyadarshi. Special care is furthermore needed when dealing with problems of identity and mental disorders, as shown by Geetika Ranjan. Jayanta Sarkar from the Anthropological Survey of India summarized the research he conducted at Andaman Islands highlighting the difficulties in health care and the decline of population, pushing the small tribes at the brim of cultural and biological extinction. The theme was completed by the works of Shri Krishna Mohan Sinha Roy and Anstice Justin on the Nicobar Archipelago.



It is impossible to cite in detail all the papers dealing with the different facets of development problems in general – aspects of environmental safeguarding and knowledge as well as indigenous technology, of empowerment of tribal peoples and especially of women, of marginalization, and of the role of NGOs. Basic for ongoing discussions in the sessions and especially animated during the coffee breaks were not only the Indian documents of Tribal policy, as published in September 2004 in the Delhi Declaration of the Tribal, Indigenous and Adivasi peoples of India, but also the international documents, as the Declaration on Human Rights and the Millennium Goals building a framework for peace as a precondition for sustainable development. It was agreed that indigenous people have to play the decisive role in the development process, without their consent and contribution development projects would be in vain.

Though these three days had a very dense program, we all enjoyed the friendly and constructive atmosphere. Conference badges as well as conference bags were handmade by the tribals and liked by everybody. The members enjoyed the wonderful evening invitation in the beautiful garden of Prakash C. Oraon, Director of the Jharkhand Tribal Development Society, and the last day the excursion by bus in the countryside which was most interesting and to the native village of Birsa Munda, where we admired tribal dances.

The symposium has been sponsored by ICUAR and Austrian private sponsorship and documented by Brigitte Oberegger's filming with her videocamera. The papers of the symposium will be edited by Professor Vijay Upadhyay as a special issue of Bulletin of the International Commission on Urgent Anthropological Research.



Fig. 1: The film-maker Brigitte Oberegger, conference chairman Prof. Vijay Upadhyay and chairperson (ICUAR) Stephanie Wiesbauer-Hohenwart (photo: Brigitte Oberegger)



Fig. 2: A traditional dance in Birsa Munda village (photo: Brigitte Oberegger)

## Forthcoming Conferences and Congresses

18th Conference Ethnomedicine “Threatened life-worlds – herausforderungen to Medical Anthropology” in Kassel, Germany, October 21-23, 2005.

World Congress “Health challenges of the third millenium”. August 21-26, 2005, Istanbul, Turkey. [Ifssh.2005@yeditepe.ed.tr](mailto:Ifssh.2005@yeditepe.ed.tr), [www.ifssh.net](http://www.ifssh.net).

Formation continue: Ethnopharmacologie appliquée. De la plante médicinale aux médicaments. September 12-17, 2005, Metz, France. [www.ethnopharmacologia.org](http://www.ethnopharmacologia.org)

Locating the field. The Ethnography of medical research in Africa, Kilifi, Kenya, December 4-9, 2005. [Trials-ethnography@lshtm.ac.uk](mailto:Trials-ethnography@lshtm.ac.uk)

The 4th Biennial Conference of the European Network of Medical A nthropology at Home. Seili, Finland, March 16-18, 2006. [medanthro@luukku.com](mailto:medanthro@luukku.com), [www.medanthro.kaapeli.fi](http://www.medanthro.kaapeli.fi)

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## **Photograph last page**

**Medicinal incense getting packed at the pharmacy of Kumbum Hospital**

**(Photograph: Katharina Sabernig)**



## Pharmacy of Kumbum Hospital

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