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HEALING BODIES, SAVING SOULS

MEDICAL MISSIONS IN ASIA AND AFRICA

Edited by David Hardiman

Amsterdam – New York, NY 2006

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A medical missionary attending to a sick African.
Oil painting by Harold Copping, 1930. Courtesy: Wellcome Library, London.

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37. Archdeacon John Briggs, CMS, 20 July 1934, TNA AN450 178/3, 2.
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51. Interview with Dr Leader Stirling, Dar es Salaam, January 2000.

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Curing Bodies to Rescue Souls: Health in Capuchin's Missionary Strategy in Eritrea, 1894–1935

Uoldelul Chelati Dirar

The chapter focuses on the role of health care in the missionary practice of Capuchins in Eritrea between 1894 and 1935. Their activity in this field is analysed with regard to its role in proselytising activities as well as in its interaction with local notions of health, disease and the body. On one side it is shown how, in conformity to a wider mission strategy, curing diseases was perceived as instrumental in acquiring new converts. On the other side it is discussed how little knowledge missionaries had of local medical traditions and how this knowledge was often flawed by stereotypes and prejudices.

Indigenous Christianity and missionaries

The region corresponding to the present state of Eritrea, the youngest African nation, has a very long history of missionary endeavours that goes back to the early contacts with Jesuits missionaries in the sixteenth century.[1] The continuity of this interest is also shown by a copious literature of travel[2] – sometimes of a highly imaginative nature[3] – that was kept alive also by an ancient tradition of pilgrimages of Orthodox monks to the main centres of Christianity.[4] Two main factors contributed to determine this strong missionary attraction to the region. On one side, the existence in the region, since the fourth century, of a lively autochthonous Christian tradition[5] and, on the other side, the strategic location of Eritrea and the Horn of Africa, which made it a potential gateway for further missionary penetration into Central Africa.[6] The ancient local Christian tradition was expected to provide a good platform for an easier evangelisation of Africa. In fact, missionaries believed that due to the common monotheist and biblical background, the followers of the Christian orthodox tradition could easily be converted either to Catholicism or to Protestantism. According to Catholic missionaries it was a matter of bringing back what they defined alternatively as heretics or lost brothers to the original pure *Ecclesia*.[7] On the

Protestant side the aim was to reform the Orthodox tradition, and this was expected to be achieved facilitating access to the Holy Testament by translating it into vernacular languages.[8] Both missionary groups perceived the conversion of Orthodoxes as a crucial step in the further spreading of Christianity in Africa. From this point of view the similarity of perceptions on both Catholic and Protestant side with regard to the missionary potential of the region is quite striking.[9] Both also perceived medicine as being of instrumental value in forging the first contact with the indigenous population and in obtaining their sympathetic reception.

At the same time, missionary activities in the region created a fascinating contradiction that does not appear to have much troubled either the missionaries in the field or their authorities in the metropolis, but which, to a certain extent, helps to make the Eritrean and Ethiopian cases peculiar in the history of Christian missionary endeavours in Africa. This was the anomaly of missionaries working among people whose conversion to Christianity dated back to the Apostolic period.[10] This contradiction left its mark on missionary activity in the region since early Jesuit endeavour in the sixteenth century and it helps to explain the relatively limited success of missionary penetration in the region.

This paper will focus on the role and use of health in the missionary practice of Capuchin fathers in Eritrea between 1894 and 1935. Priority has been given to Capuchin fathers because to extend it also to Protestant missionaries would have enlarged the analytical spectrum excessively and made the paper too general. The analysis of the activity of the Capuchins, who were Italian missionaries in an Italian colony, also provides an opportunity to analyse the interaction between colonial authorities and Christian missions in the domain of health. The rationale for choosing the period 1894–1935 as the chronological span of the present paper lies in the fact that, on one side, 1894 marked the arrival and official beginning of Capuchin activities in Eritrea, following the expulsion of the Lazarist fathers. This was an important development of missionaries activities in Eritrea as it meant the end of the presence of the French-based Congrégation de la Mission of St Vincent de Paul, better known as Lazarists, and the 'nationalisation' – in the sense of Italianisation – of Catholic missions in Eritrea.[11] On the other side the year 1935 is also a crucial date, as although it did not represent the end of Capuchins presence in Eritrea, it saw a radical change in Italian colonial policies that had a strong impact on health policy. The main factor in this was the fascist invasion of Ethiopia, which led to a substantial change in Italian colonial strategy in the region. This change can be noticed in the more active and organic involvement of the colonial state in all aspects of social policies, including in the health sector. After a brief summary of the main medical traditions and practices in pre-colonial

society, the paper will deal with Capuchins' medical theories and practices in Eritrea and with their interaction with pre-existing local traditions.

Health, healing and medicine in pre-colonial society

There has been little historical research on nineteenth century's concepts of health and medicine in the region that corresponds to the present state of Eritrea. This is partially due to the fact that most of the relevant literature tended to focus on the Christian orthodox tradition of the Abyssinian highlands paying little attention to non-Christian areas. This is to a great extent the legacy of the general attitude of the so-called Ethiopicist scholarly tradition,[12] which tended to emphasise the written tradition of the region marginalising, at the same time, those cultures which were not inscribed into this tradition. It is, therefore, important to define pre-colonial medical knowledge and practice in Eritrea.

In the pre-colonial period it is possible to identify three main medical traditions which are: the Christian Orthodox, the Islamic, and a set of different traditions which I shall provisionally indicate as 'others'. It is, however, important to emphasise that this classification reflects more a need for clarity in the present study rather than a set of clear-cut distinctions that existed at that time. In people's daily lives the boundaries among those three traditions tended, and still tend, to be much more fluid and porous than such a classification would suggest. As discussed by many authors, popular choices in matters of therapies and therapists have a degree of creativity and flexibility that frequently transcend religious, ethnic or linguistic identities. Moreover, those choices have never been bounded by colonial administrative or cultural boundaries. In fact, as a rule, effectiveness and availability are the two main criteria that influence people's choice.[13] As a rule, effectiveness and availability are the two main criteria that influence choices.[14]

In this section there will be a broad description of indigenous concepts of health, healing, and therapy in the years immediately before the coming of missionaries to the region. Being mainly a broad sketch of pre-colonial local medical traditions, there will not be a discussion of complex issues such as changes in local therapeutic systems, nor transformations in local medical taxonomies, all of which would require a deeper diachronic perspective.[15]

The Christian tradition

With regard to the Christian tradition, Eritrea undoubtedly shares many aspects of the broader Abyssinian Christian tradition.[16] There was a commonality in religious and medical training, for although local churches and monasteries provided a basic education in literacy and a broad familiarity with religious literature, the only place where people could obtain a higher education was in Central Ethiopia. The town of Gondar was the

main centre of Christian religious learning in the region where learned religious people as well as aspiring students used to gather.[17]

In the Christian society of the Abyssinian highlands the Church had a central role in defining and implementing social norms as well as in regulating the flow of daily life. Health and medicine belonged to this domain. Therefore, a preliminary step is the definition of health and medicine in this context, a definition that cannot be separated from environmental factors. In fact, in the climatically harsh and resource-poor environment of northeast Africa the Church played a crucial regulative role in determining working rhythms[18] and food-consumption, through the introduction of a strict religious calendar.[19] In this calendar a central religious as well as 'medical' practice was fasting, which could be considered as a local cultural marker reflecting the need to introduce some standard social behaviours in order to cope with extremely harsh environmental conditions.[20]

With regard to health and medicine the local Christian orthodox tradition had developed a very complex and sophisticated tradition in which the medical and religious dimensions were intertwined. In this context religion provided both the cultural framework for the definition of health and disease as well as the social actors in charge of curing and healing. This tradition developed a holistic approach based on the perception that health was embedded in a sound religious and social order and that disease was a perturbation of it. Moving from those assumptions it is possible to identify two levels in the local Christian medical tradition: aetiology and therapy. At an aetiological level disease is considered as an expression of disorder in the complex network of relations between individual and group, living and dead, human and divine which concurs with the definition of what we can tentatively and inadequately define as social order. Fetching from a wide and rich cultural tradition inclusive of Hellenistic, Judaic, and Arab contributions,[21] the definition of this order is based on the representation of a mythical past where, at the beginning, humans and spirits co-existed and interacted peacefully.[22] This idyllic order has been disrupted by human greed and lust. As a result, the original harmony has been substituted by hostility and anger and nowadays the only relation between the two is a negative one and sickness is the metaphoric as well as real locus of this encounter. Referring to Biblical passages,[23] the local Christian tradition identifies as a crucial factor for the development of this pattern of disorder the revelation of the art of writing to human beings by corrupted angels. Those former angels, now demons, used to strike in disguised form and the only protection against them is the use of talismans and prayers.[24]

Apart from very few diseases such as skin ailments and gonorrhoea which could be easily detected and cured at a purely pharmacological level,[25] the

majority of illnesses were tackled by traditional aetiology at a dual level: the level of soul and the level of body. In this context, aetiology requires special expertise and a certain degree of specialisation. Having said that, therapy remains a social and collective exercise that involves the whole community to which the sick person belongs. In fact, if sickness is the locus of encounter between humans and demons or fallen angels, the triggering factor in attracting the demon's strike ultimately has to be found in the behaviour of the sick person within his community, which might have engendered irritation in some of its real or disguised members. Arguments in the market, rows about land, interrupting a spirit's siesta when fetching water, walking through the village in a provocative way, could all be causes for provoking a hidden demon. With the spectrum of diseases so ample and difficult to identify, specialisation was required and patients were recommended to make recourse to more than a 'practitioner.' However, in this holistic approach the quest for symptoms, though undertaken by the expert, involved the whole community that, along with observations, comments, and recollection of details of the social life of the victim, all contributed in the aetiologic enquiry.

When symptoms were identified the therapy began, involving a dual and parallel process aimed at healing the soul and curing the body. The therapeutic moment was probably the event that revealed the complexity of the cultural and social praxis underlying the concept of health, disease, and medicine in this tradition. Healing the souls was a spiritual process based on the use of images and words. Behind this practice there was the assumption that fallen angels, by revealing the art of writing to human beings, had caused the original rupture of harmony between human beings and spirits. The ultimate factor in creating disorder and re-establishing order has, therefore, to be found in the art of naming.

Names in fact, were considered to be an integral part of human beings and as such they could be the privileged target of negative forces through the evil eye (or *buda*), charming, or other devious practices.[26] For that reason when baptised, individuals were given two names, a public one and a secret one, which was only known to the closest members of the community.[27] Similarly, the agents of the invisible world were also believed to have their own secret names. By knowing this name, the evil that demons generate could be restrained. As a form of naming associated with writing, this special healing power was attributed to *däbtäras*, learned people trained in religious tradition but not fully fledged priests.[28]

Däbtäras, thanks to their mastery of writing and their religious education, were assumed to be able to see spirits and consequently have the power to move in that grey area created by the disruption of the original harmony between humans and spirits. *Däbtäras* acted as if inspired and

assisted by God in their practice. This special protection enable them, to see spirits, identify them and neutralise their malign power by naming them. To this end they used to produce two kind of protective devices, namely books containing collections of protective prayers,[29] and a wide range of talismans and amulets. The first were produced for literate customers, while the second were for the majority of illiterate or semi-literate customers. Both books of protection and talismans were based on the principle that naming has a healing power. Through the listing and graphic representation of the names of God and of demons, *däbtäras* provided spiritual protection to the sick from the disruptive infiltration of demons.

Däbtäras were nevertheless often in an ambiguous position, as there was a fine and poorly defined line between ecclesiastical approval and condemnation. The Church acknowledged the therapeutic value of reading the Gospel and the *Psalms of David* when washing a sick person with holy water. It also tolerated reading about lives of saints or the *Homilies* of Michael. However, it disapproved of, though did not openly condemn, reciting the names of God for healing purposes and the resort to divinatory techniques.[30] Parallel and organic to the healing of souls was the cure of bodies. *Däbtäras* also had a rich and longstanding knowledge of herbalism, based in part on local experience and in part on medical treatises inspired by the Greek–Arab medical tradition – in particular the *Canon* of Avicenna, the *Thesaurus* of al-Khwarizmi, and the medical treaty of 'Ali ibn Rabbân.[31] This medical tradition, which had been codified in a written form since the fifteenth century, covered a wide spectrum of diseases ranging from migraine, cardiovascular, and respiratory problems to insomnia, amnesia, evil eye, anxiety, insanity, and spirit possession.

A crucial issue still not tackled by scholars dealing with the social history of the region is the level of social sharing of this complex, medical knowledge. In fact, as discussed by Helen Lambert with regard to Rajasthani popular therapeutics, there is a general tendency to assume that when there are complex and possibly written medical traditions, they are easily and uniformly available to the whole population.[32] However, in a context marked by a strong hegemony of orality over literacy, it remains to be assessed how much of this rich codified tradition was really accessible to the majority of the population and how much popular medicine relied rather on alternative and probably syncretistic practices.[33]

Cases of possession or problems related to mental diseases represent the best example of the complexity of the aetiological and therapeutic approach of popular medicine. In fact, the wide range of diseases that, for sake of brevity I will define as mental diseases, are normally tackled with a multifaceted approach based on the social identification of the source of unbalance. As mentioned earlier, this process involves not only patients but

also their families and local communities at large. Once the problem has been identified, the therapeutic intervention depends on the complexity of the case.

The easiest cases are normally treated with a combination of pharmacological and thermal treatments. Many springs or thermal waters – known as *may chelot* – are believed to have therapeutic power. Normally, those springs are associated with the name of a famous local saint celebrated for his thaumaturgic powers. In Eritrea some fifty holy waters were in use till recent time and each of them was renowned for a specific therapeutic power.[34] What is worth mentioning is that the resort to these springs was not a prerogative of Christians alone; it was common to have Muslims enjoying their therapeutic benefits by simply renaming them in honour of a Muslim holy man.[35]

Another more complex aspect of healing, which to a certain extent includes many of the themes discussed up to now is associated with the tradition of *zar*, a tradition which is shared with different local variations through the whole of north-east Africa[36] and part of the Middle East.[37] *Zar*, which will not be discussed here in detail,[38] can be summarily described as a complex ritual of healing marked by possession often associated with phenomena of glossolalia, and based on a practice of ritual dances and singing. This ritual involves specialised healers, the sick person and its community, and imply also a codified set of actions, which has led scholars to talk in terms of a theatrical component.[39] Also, in the case of *zar* it has to be emphasised again, that this ritual can be defined as cross-religious as it involves both Christians and Muslims.

The Islamic tradition

Islam in Eritrea has a very long local presence that dates back to the early years of the Prophet Muhammad's preaching.[40] However, one of the strongest impulses to the Islamisation of Eritrea came much later during the nineteenth century, with the Egyptian penetration of the region and the spread of brotherhoods such as the Mirghaniyya and Qadiriyya from the Middle East.[41] The brotherhoods in particular encouraged the development of an esoteric form of religious practice – quite far from orthodox Islam – which affected also the approach to the issue of health and healing.[42] In fact, as mentioned earlier with regard to the Christian medical tradition, it is difficult to assess how much of the highly sophisticated Islamic medical tradition actually reached Islamic communities in the region. In Eritrea, similarly to the case of Hausaland discussed by Ismail H. Abdallah,[43] nineteenth century sources shows that little of that prestigious tradition became an actual part of a shared medical knowledge in the region. Islamic medical practices, rather than being based on the humoral tradition of the

Dar al-Islam, relied on the assumption that supernatural elements were to be considered the main actors both in diagnostic and healing process. Paradoxically it is possible to say that the main beneficiary of the 'official' Islamic medical tradition has been the Christian Orthodox society of the Abyssinian highlands, which, through translations from Arabic, incorporated it into its medical corpus.[44] With regard to the concept of health and the practice of medicine among Muslim communities, European sources of the nineteenth century report of a common use of amulets (*higiâb*) made with passages from the Holy Quran written on small pieces of parchment kept in leather boxes.[45] Those small amulets used to be worn on the arms or around the neck, never being removed. Again, this reveals a strong belief in the curative and protective power of words, being in this case sentences from the Holy Quran. In a society marked by the prevalence of orality, with a limited level of literacy, this practice is also evidence of a persistent perception of a 'magic' relation between writing and naming. Other common practices were divinatory rituals (*istikhâra*)[46] supported by an ancient local herbalist tradition, often shared with the Christian population.

Key personalities deputed to the application and transmission of this social knowledge for medical purpose were the *sheikh* (community or spiritual authority) or the *faqîh* (expert of Islamic jurisprudence or *fiq*). They were frequently revered particularly after their deaths, with their tombs becoming places of pilgrimage.[47] In fact, many of those *shekhs* were believed to have thaumaturgic powers due to their special holy spiritual status (*barâka*). However, what is striking in the literature of the nineteenth century is the fact that while such beliefs and practices were distant from or marginal to 'official' Islamic devotional practices, they tended to be shared by the population at large and had also many elements in common with Christian practices.[48]

Other medical systems

Certain communities, such as the Kunama and the Nara, were relatively peripheral to the main tradition of Abyssinian highlands. They lived in a different region, and they were outside the Semitic tradition linguistically and culturally. Both populations lacked a written tradition, and for this reason their religious beliefs and practices tended to be confined by the European regard to an area of autochthonous tradition that colonial and missionaries sources were inclined to classify generically and mistakenly as animist.[49] Nevertheless, both societies had and still have a highly developed herbalist tradition covering a wide range of illnesses. Unfortunately, we are limited in our discussion of those traditions by the fact that little ethnomedical investigation has been done so far in those societies, so that we still depend for our knowledge on the strongly biased colonial literature or

on few, equally biased missionary sources.[50] It is nevertheless clear that these people had a fluid and pragmatic approach towards healing that allowed them to shift between different medical systems regardless of religious, regional, or economic identities.

Finally, when discussing issues of health and healing in the Horn of Africa in the nineteenth century, it is important to take into account the role played by political instability, warfare, and ecological imbalance in this region. A devastating sequence of conflicts, epidemics and famine ravaged the region through the second half of the century and into the early years of the twentieth century, leading to massive depopulation and to the dislocation of entire communities.[51] As will be discussed later, all those major troubles also had a direct impact on the very concept of health and healing, and affected missionary medical work in the region. In fact, often the main 'disease' was hunger and the main therapy or *materia medica* was food.

Missionary theory and praxis

It is in this complex and often hostile environment that both Catholics and Protestants competed fiercely and with different fortunes to establish missionary stations. Health issues played an important role in this competition, providing both an opportunity to offer free services to the neophytes as well as a powerful instrument of proselytism among the indigenous population. From this point of view the Eritrean experience falls into the paradigm developed by Megan Vaughan when she suggests that missionary doctors competed with local medicine in an effort to transform local societies, challenging them in one of their most vital aspects, the concept of body, health, and sin.[52] However, in the Eritrean case there is little evidence that this was done consciously and I would rather suggest that this relation might be defined in terms of an unconscious competition. In fact, as I will discuss in this section, on one side, health was considered as an area where missionaries could easily attract and contact local populations and from that point start their proselytising mission. On the other side, in spite of the admitted relevance of health and medicine as tools for proselytism, there is little evidence that missionaries made any real effort to understand the cultural complexity underlying local concepts of health, medicine and body.

Missionaries, both Protestant and Catholic, had engaged in healing from the inception of their activity in this region. The German Lutheran Peter Heiling, the first Protestant missionary to visit this region in the seventeenth century – is reported to have practised medicine at the royal court of Gondar,[53] and other missionaries such as Samuel Gobat and Johannes Ludwig Krapf of the Church Missionary Society obtained considerable success through their medical activity.[54] Similarly, the first Catholic

missionary congregation active in the region in the nineteenth century – the Congrégation de la Mission or Lazarist Fathers – gave frequent medical assistance, and by the 1880s – through the services of nuns of the order of the Sisters of Charity – ran two dispensaries in the towns of Keren and Massawa.[55]

However, for the period covered by this paper the dominant missionary presence in Eritrea was that of Capuchin fathers. Their presence was strongly supported by the Italian government and by some representatives of the Italian Catholic intelligentsia, which was not at ease with the presence in the colony of missionaries of other nationalities as they were suspected of acting as agents of their respective governments.[56] For this reason, in 1894, the French Lazarists were expelled and the Protestant presence, which by this time had switched to the Swedish-based Evangeliska Fosterlands-Stifelsen – better known in Eritrea as the Swedish Evangelical Mission (SEM) – was increasingly marginalised. The latter were finally expelled in 1935.[57]

In discussing the medical work of the Capuchins it is crucial to identify the beneficiaries of their medical treatment as well as the approach they had to the organisation of health services. At the beginning of their presence in Eritrea there were three main beneficiaries: Italian settlers, Italian soldiers, and Eritrean communities. The initial Italian colonial plan to make of Eritrea a colony of settlers led to the establishment of a small community of Italian settlers scattered over the highlands. By this means, and through the use of large subsidies, the Italian state sought to divert the endemic flow of Italian immigrants traditionally attracted by the Americas or Australia to a territory under the political and economic control of the Italian state.[58] This plan did not enjoy the full support of important segments of the Italian entrepreneurial sector, which envisaged the development of a capitalist-oriented colonial agriculture.[59] In the end, the settlers, who were prevalently from the poorest rural areas of Italy, were sent to Eritrea without adequate planning and, moreover, with very few resources. The missionaries, in consequence, often beside their spiritual services also had to provide medical assistance to the settlers, at least in term of basic treatments.[60]

The army provided the other major Italian presence in Eritrea. Though Italian soldiers had their own medical facilities, the protracted and intense war between Italy and Ethiopia in the years 1894–7 saw a massive involvement of missionaries in spiritual and medical work amongst wounded Italian soldiers. This work reached its height with the Italian defeat at Adwa in March 1896, in which the Italian army was annihilated by the Ethiopian Army led by Emperor Menelik, with thousands of casualties on both sides.[61] In this context, the efforts of the missionaries were not motivated only by compassion or national solidarity, but were aimed also at using medicine as an opportunity to contact and possibly redeem a segment

of the Italian population that was traditionally pervaded by anticlerical and even atheistic feelings.[62] Through the dispensation – often surreptitiously administered – of the extreme unction to the moribunds or through the patient and careful assistance to the wounded, Capuchin missionaries tried systematically to re-claim lost Italian souls to their flock.[63]

The last and, for the sake of this presentation, more important section of the population that was the object of missionary medical attention were the Eritreans themselves. In the period from 1894 to the close of the first decade of the twentieth century, there were many obstacles to such work and Capuchins were faced with a situation of great political and social instability. There were repeated droughts, protracted warfare, and internal anti-colonial rebellions, all of which made of Eritrea an unsafe territory for missionaries, so that their work was discontinuous and precarious.[64] There were also material and human constraints on their activity. Because of this, their medical work was extemporary and lacking any organic link with their global missionary strategy. There were no clear instructions to missionaries to undergo medical training or to carry medicines with them, and such work appears to have relied on the initiative of individual missionaries. Moreover, the absence of reliable statistical data makes it hard to assess its impact on the region. Lastly but not least, it has also to be stressed that in those years personal health was in itself a 'mysterious intangible enemy'[65] for the missionaries, as malaria, sunstroke, and other maladies claimed the life of many of them and forced many others into premature retirement. In particular a heavy toll in missionary lives had to be paid to keep operational their stations of Assab on the Red Sea, and Barentu in the western lowlands, which were notorious for their insalubrious climate. All of this prevented any substantial gains for the Capuchins in the early years of their presence in Eritrea.[66]

A substantial change can be noticed starting from 1912 when Monsignor Carrara took over the leadership of the Capuchin mission in Eritrea. He organised the mission in a more structured way and launched a more aggressive proselytising campaign. This included a more systematic approach towards medical work.[67] Beside a renewed and more intense missionary effort among the Orthodox and Islamic communities, a particular attention was now given to populations such as Kunama, Blin, and Mensa', which were relatively more peripheral with regard to both traditional highlands and colonial centres of power. I have already discussed the religious and social status of the Kunama in the nineteenth century. The case of Blin and Mensa' is much more obscure and complex. Originally Christian, they had been alienated by the political instability and warfare of the nineteenth century, and as a result they had either converted to Islam or maintained a vague and

superficial Christian practice, in the process losing much of their original Christian identity.[68]

The main missionary efforts of the early twentieth century focused on those populations, which is also a sign of the fact that the consolidation of colonial rule and the 'normalisation' of the territory were reducing missionaries' chances to gain a hold among the Christian Orthodox and the Islamic segment of the population.[69] Moreover, the missionary literature of those years shows clearly that those populations, and particularly the Kunama, as will be discussed later, were perceived as the embodiment of the perfect stereotype of missionary expectation. However, in a broader perspective, this impressive Catholic missionary revival cannot be understood properly without connecting it to the papacy of Pope Pius XI (1922–39),[70] who had ignited a season of missionary zeal in which, for the first time in the Catholic tradition, the issue of medical missions was discussed as a structural component of missionary endeavours. In his famous encyclical *Rerum ecclesiae*, published on 28 February 1926, the Pope sanctioned the moral duty of healing as a key component of missionary evangelical efforts. A direct result of this new attitude toward missions – and medical missions in particular – can be seen in the fact that in those years, for the first time, medical manuals specifically designed for missionaries were published,[71] medical courses tailored for missionaries were opened,[72] and also detailed statistical studies on the impact of diseases and morbidity on missionary activities were carried out.[73] These new efforts to revivify Christianity through missions and medicine were publicised through media events, such as the impressive Missionary Vatican Exhibition that was held in Rome in 1925 to celebrate the Jubilee, in which a whole section was dedicated to medical issues, with the declared aim of arising missionary enthusiasm among visitors either in terms of recruitment or financial support.[74]

A very interesting source that sheds light on the unfolding of those events in the Eritrean context is the by-weekly missionary magazine *Annali Francescani*, published in Italy and widely distributed in parishes and other Franciscan networks with the aim of disseminating information about Franciscan missionary endeavours and, ultimately, to raise financial support from its readers.[75] Through this magazine it is possible to follow the main lines of missionaries activities in Eritrea and also to reconstruct missionaries' perception of their fieldwork. It is significant that one of the main subjects of reports coming from Eritrea in those years was the Kunama population. In missionaries' perception the Kunamas seemed to fit into the stereotypes of the backward, hopeless, and eternally childish African tribe waiting for missionary enlightenment.[76] To win the Kunama to the Catholic flock, missionaries adopted a strategy of itinerant proselytism by touring from their

stations, from village to village. In this effort, medical assistance was clearly defined as the key instrument in contacting those populations and winning their hearts. To this end, instructions were given to missionaries to always carry with them basic medicines for the most common diseases such as malaria, eyes diseases, and skin infections.[77] In fact, these illnesses were relatively easy to cure both in terms of medical skills and pharmacological and medical equipment and such treatments were expected to have a strong impact on the Eritrean population.

Contemporary sources reveal a fierce struggle unfolding among Capuchins, Protestants and Muslims to win the allegiance of the few remaining potential proselytes, with health becoming one of the main areas of this competition. Capuchin missionary sources of those years clearly state the urgency of providing more qualified medical assistance in order to contain the advance of rival groups. The Swedish missions in particular were accused by the Capuchins of taking unfair advantage of their stronger network of financial and logistic support from the motherland.[78] The competition with the Protestants was described in terms of rivalry between cultural systems similar in their common Christian foundation, but divided by different confessions. Ironically enough, Protestants were often vehemently accused of making an instrumental and not genuinely Christian use of their medical services.

The other main rival to Capuchin missionary endeavours in those years appears to have been Islam. Contemporary missionary sources frequently describe Islam in terms of a corrupted and barbarian religion, and accuse it of winning the hearts of the local population resorting to superstitious practices. As an example of this practice missionary often mention the use of amulets and talisman containing short passages from the Holy Qur'an.[79] In the competition with Islam differences were much more marked and no room appears to have been left for any possible conciliation. For complex historical reasons Christian orthodoxes appear to have been marginal in this competition and were not the main target of missionary medical zealotry. This can be partially explained by the fact that in Eritrea, as in the rest of Africa, Christian missionaries considered Islam their fiercest and most dangerous rival.

Missionaries and colonial health

A final point which deserves attention in the discussion of missionary theory and practice of medicine, is their interaction with colonial authorities. Relations between Catholic missionaries and the Italian colonial administration were never straightforward, due to the projection in the colony of the traditional rivalry between State and Church in the Italian liberal state.[80] Many colonial civil servants had strong liberal and secular

convictions,[81] which in some cases could give room to openly anticlerical attitudes. This generated a pattern of uneasy relations marked by repeated attempts, on the missionary side, to establish a more organic and structural relation with the colonial administration and an ambiguous series of responses by the administration.[82] This pattern can be detected also in the field of medicine. In fact, according to the Royal Decree of 30 December 1909, note 845,[83] nobody was allowed to practice medicine in the colony if not provided with a formal medical training, which had to be certified officially. This provision applied to areas in which medical facilities provided by the colonial medical service were available, which meant all main urban centres and many villages. However, the text was ambiguous and appeared to have been devised mainly to protect the medical rights of European patients living in the colony rather than of the entire population. A further element of ambiguity was introduced by article 391 of the same law, which called for some degree of respect for indigenous medical traditions, so far as they were not patently detrimental to the maintenance of health and hygiene, and with the assumption that such remedies were availed of only by indigenous patients. At the same time, colonial legislation – at least in its formal expression – appeared to be conscious of the complexity of medical systems present in the colony and it was also quite careful in delineating clear boundaries for areas of medical intervention along racial or, more subtly, 'cultural' divides. In this respect, missionary medical services were sanctioned primarily as a frontier activity in peripheral areas where the colonial administration had not established its own hospitals or clinics. Otherwise, due also to the lack of a consolidated tradition of Catholic medical missions in the colony, missionaries were allowed to operate in colonial medical institutions only as nurses – an area of work associated in particular with Catholic nuns, as was common in Italy at that time.

The predominance of the colonial state over Catholic missionaries in the health sector is revealed also by the amount of medical literature produced by the two institutions in the field of tropical medicine. On the missionary side only two significant publications can be noticed. The first one is a short manual of medicine and surgery for use by missionaries and rural parishes, published in 1924.[84] The second is a more ambitious treaty of tropical medicine for missionaries which, however, was published only in the post-colonial period, in 1957.[85] On the other side, the massive involvement of the colonial state in the health sector is paralleled by an impressive scientific production, which is attested by the publication of ten different journals and bulletins and 197 articles and monographs dealing with tropical medicine.[86] Two aspects deserve particular attention in those publications. The first is the fact that it is possible to notice a direct correlation between the increase in the Italian population in the colony and the growth of interest in medical

issue. Evidence of this is the fact that 135 of the above-mentioned 197 scientific contributions were published between 1930 and 1938 when there was renewed fascist interest in colonial expansion, due to the military preparation for the impending fascist invasion of Ethiopia in 1935, and the subsequent massive effort for the occupation and colonisation of the territory. This all led to an impressive increment of the presence of Italians in the region. Secondly, in the colonial medical literature we can detect an attempt to co-opt the local population in the colonial medical discourse. This is reflected also in the publication of bilingual manuals aimed at the technical and 'ideological' training of Eritreans in the health sector, though always in a subordinate position, in observance to the principles of racial prestige.[87]

Apart from addressing medical issues according to European aetiological perspectives, these manuals also pursued two other important goals. First, they attempted to develop through a translation in Tigrinya – one of the most widely spoken Eritrean languages – an indigenous medical vocabulary reflecting European concepts of body and health. In this, they sought to redefine indigenous perceptions and representations semiologically and, therefore, structurally. This literature included also a short but ideologically dense introductory section, which openly called for the abandonment of local medical practices and which urged Eritrean nursing personnel to act as propagators of civilisation and progress among their fellow compatriots.[88] This call for a medical crusade was made even more explicit in the manuals compiled for Eritrean midwives in which special emphasis was placed on the 'privileged' role that women were expected to play in society by procreating and raising children.[89] Colonial medical literature is openly nurtured by a strong feeling of superiority and by a clear perception of medicine not only as a branch of sciences but also as a cultural force through which to assert European superiority over colonised populations.[90] However, what is less evident but rather expressed in form of nuance is the fact that this dismissive feeling of superiority seems to refer also to missionary medical practices which both legal regulations and sundry contemporary sources tend to define as amateur medicine.

Missionary education and health

The predominant role of the colonial state in the health sector was partially balanced by the fact that missionaries were allowed, and to certain extent invited, to play a major role in the education of Eritreans. In fact, until the coming of Fascism, budgetary constraints, together with a deliberated refusal to allow the formation of an educated local élite, had led to a neglect in substantial investments in this sphere by the Italian colonial state. This area was left as a prerogative of Catholic missionaries who designed the curricula,

provided the teaching staff, and also drafted the teaching material.[91] Therefore, it is in the domain of education that it is possible to detect another significant dimension of missionary interaction with the colonial state in the field of health. In fact, all the teaching material drafted by the Capuchin missionaries, between 1912 and 1939 included a section on hygiene and basic health notions, and one on superstitions. Drafted both in Italian and in Tigrinya, these materials deserve particular attention not only from an educational perspective, but also as part of the campaign launched by Capuchins to win souls by curing bodies. In them, we find clearly expressed, a structured missionary challenge to local belief systems and therapeutic practices.

Firstly, the section of these manuals dealing with hygiene and health classified diseases according to the aseptic medical concepts of the Western tradition. Banal diseases like cough or flu were deliberately listed together with other more complex, and in the local perception, more frightening and culturally connotated maladies such as epilepsy, fainting, or convulsions. A neutral scientific description, together with basic remedies, was provided for each of these diseases. Secondly, the textbooks sought to substitute local concepts and praxis of health and medicine with European ones. This attitude was most evident in the section on hygiene, which was generally marked by a strong eugenic discourse, where hygiene was described as:

> [T]he science which teaches us how to keep ourselves healthy. Health is a treasure, but to maintain it we have to fight against filth. Filth is the source not only of physical diseases but also of moral diseases; it is clear evidence of rudeness and incivility. The civilisation of peoples is rooted in cleanliness. Therefore children must learn to love cleanliness.[92]

However, in suggesting behavioural models those manuals were also generating unsolvable contradictions. In fact, the main emphasis in the definition of hygiene was on the centrality of healthy living spaces, more precisely of houses defined along parameters and standards unlikely to be met by the majority of the Eritrean population, which was mainly destitute and either living in rural areas or squeezed into segregated urban spaces.[93] To this regard, there seems to be some similarities between the eugenic concept of urban space theorised and partially implemented by Italian colonial authorities in urban areas and the representation of healthy spaces in mission textbooks. In fact, colonial administrators also tended to represent Eritrean indigenous districts as places that: 'for congenital dirtiness and lack of any sense of hygiene [are] frequently a repository of viral and infectious diseases.'[94]

Some of those themes were already anticipated and embedded in missionary teaching materials by 1916. However, there is an important area where the eugenic discourse developed by the Italian colonial administration in the late 1930s clashed with missionary strategies. In fact, there was tension over the racial regulations that were experimented in the colony from 1936, and introduced as the Racial Laws in 1938, as these discriminated against the offspring of mixed couples – *meticci* in the Italian literature[95] – who represented a privileged field of social and religious intervention for Catholic missionaries, particularly in urban areas.[96]

A second important section of these textbooks – under the heading of 'Errors and Prejudices' – deals with beliefs about the evil eye, charms, and the protective and therapeutic value of amulets. Interesting enough, the main targets of this mission literature were practices attributed primarily to Muslims. One of the textbooks states:

> Amulets, from the Arabic *hamlet* (pendant), are all sorts of objects kept around the neck or on the body that are believed to provide protection against witchcraft, spells and other evils. Those hamlets are particularly common among Mohammedans and they are in the form of stones, rings, pieces of paper and other objects all bearing sentences from the Quran or magic formulas. It is not even worth demonstrating that these things are the result of human credulity and superstition.[97]

It is notable that Orthodox Christians are omitted from such statements, even though they shared similar views and practices. It is also notable that the missionaries presented as examples of superstition notions the alleged bad luck brought by breaking mirrors or scattering salt,[98] popular believes common in Italy but not in Eritrea. In this respect the Capuchin missionaries appear to have been carrying over to their civilising and medical crusades in Eritrea conceptual models and strategies rooted in their experience of struggle against 'paganising' popular culture in their motherland.

The interaction with local cultures

Up to now, the main focus of the discussion has been on indigenous and missionary concepts and practices of medicine as separate phenomena. However, it is important to analyse patterns of creative interaction between the two. This may help us towards a better understanding of crucial issues such as the interpretation and retention by local populations not only of concepts related to health, but also, in a broader perspective, of important Christian dogmas like the resurrection of soul and the definition of sanctity.

On the missionary side, there was a failure to comprehend the complexity of local concepts of health and medicine and a tendency to dismiss them in terms of primitive beliefs and superstition. A sort of cultural blindness prevented any grasp of the dense network of symbolic values that underlay local medical practices. In the case of the Orthodox tradition, there was a shared culture rooted in the Judaic–Christian tradition, with many practices that were echoed in 'unofficial' practices in the Italian countryside. Despite this, the missionary literature seemed largely unconcerned with Orthodox medical practices. The main reason for this attitude lies in the fact that the Orthodox Church was at this time on the defensive, and therefore not seen as a major competitor. Mission propaganda was directed primarily at forces that were seen to constitute the greatest obstacle to the expansion of Catholicism, namely Islam and the so-called 'primitive' religious cultures. Islam was subjected to a particularly violent critique, with its medical practices being stigmatised as backward and also as a source of moral and spiritual corruption. Others were depicted as stereotypical African 'savages'.[99] The Kunama people who, from 1914 onwards, were the object of intense Catholic missionary efforts, were described as 'our poor savages' or generically 'our poor Kunamas'.[100] Missionary activities among them were defined in terms of the:

> [W]ork of redemption from errors and superstitions and an uplift to the first stages of Christian civilisation and also a work of conquest as, otherwise, those poor savage would be continuously lured by Protestants who want to make them sons of Luther and by Muslims who would be happy to make them followers of Muhammad.[101]

The missionaries ridiculed rituals involving possession and trance as cheap stratagems staged by shrewd individuals to get free food from the community and avoid their community work and daily routine.[102] The overall Kunama perception of health and medicine was dismissed in patronising terms as a congeries of childish superstitions.[103]

The Capuchins also misjudged the set of reasons behind popular use of the medical facilities they provided. Their literature is full of triumphant reports of frequent and numerous visits by local people to missionary stations and the enthusiastic gatherings around missionaries during their visits to remote villages. Sick people are reported to have come to them begging for medical treatment, which missionary sources interpreted as evidence of the success of their strategy.[104] However, when these reports are examined carefully, it is evident that the kind of treatments requested and administered were limited predominantly to the treatment of skin infections, extraction of spines, and administration of tablets against malaria or other

forms of fever. It appears that in Eritrea, as in other parts of Africa – as is clear from various other studies – mission medicine was preferred to local therapy in a pragmatic and selective way, based on principles of effectiveness, cheapness and a relatively easier availability of missionary medical treatments.[105]

This pragmatism can explain the striking absence of Capuchins' healing intervention from the sphere of mental diseases as well as from the wide range of illnesses that were considered related to a more complex level of intervention, and that normally required the involvement of *däbtäras* or other similar experts. It is apparent that in the more complex and socially connoted aspects of health, Eritreans still resorted to their traditional therapies. Often, the missionaries achieved their greatest success in medical work at times of particular social or economic crises, when the failure or collapse of local mechanisms of crisis-management gave them a comparative advantage. This was true in the case of the famines, droughts, and epidemics that repeatedly ravaged the social landscape of Eritrea in this period. A case in point is the devastation experienced in the years 1918–21 as a result of the combined effect of drought and the long term consequences of the Spanish Influenza which ravaged great a part of the world. Missionary sources reveal clearly that, in that tormented time of devastation and destitution, the very meaning of health and medicine had changed radically. Reports such as those of *Annali francescani* drew an appalling picture of Eritrea, with thousands of starving people in the countryside wandering in search of food, trying to move to urban areas and often collapsing on their way. In this context it appears evident that health was equivalent of nourishment and, consequently 'medical' intervention consisted mainly of providing food to starving people.[106]

On the whole, the missionaries failed to change patterns of belief and gain converts on a large scale through their medical work. On the other side, local communities exploited, quite cleverly, the chances presented by the increased offer of medical services brought by the arrival of missionaries, limiting their level of interaction prevalently to the technical dimension and generally rejecting the religious and proselytising aspect associated with it. From this point of view, again, Eritrea shows a behavioural pattern that confirms Ranger and Arnold's analysis of colonial and missionary medicine in colonial Africa.[107] Evidence of this attitude can be found in many missionary sources. For instance, there are complaints from missionaries stationed in Assab about Afar people who used to send their children to the missionary station to get food or medical treatments and then withdrew them without allowing them to stay in the mission and attend its school. Similarly, a missionary stationed among the Kunama population, reported of his proselytising efforts:

> [T]hey listen to you carefully and they appear doubtful when we say that God does not make rain, provide wheat, or send locusts, but they burst out with laughter when we describe them Hell, which corresponds to saying 'Poor Father, he wants us to have only one woman, wants to prohibit us to go with other [women]'.[108]

Medical man or holy man? The case of Angelico da None

As a conclusion of this discussion on Capuchin missionaries' medical endeavours in Eritrea, I would like to focus on the activity of the Capuchin missionary, Father Angelico da None, which could be considered paradigmatic of the many contradictions described in previous pages. The relevance of this missionary is due to the fact that he was one of the first Capuchin fathers to develop medical work as a central component of his missionary activities. To a certain extent Father Angelico da None embodied and also anticipated the new consciousness of the Catholic church about the relevance of medical missions in missionary strategy, which has been discussed in previous pages.

Born on 6 May 1875 in the village of None (province of Turin) Father Angelico after receiving his religious training, opted for missionary activity and was sent to Eritrea in March 1914. From the very beginning, he insisted on the necessity of providing basic medical training to all missionaries. He himself had some broad knowledge of hygiene, first aid, and pharmacology, due to the fact that his brother owned a pharmacy in the village of None.[109]

In his writings Father Angelico made clear that the theology of *curate infirmos*, which was later elaborated in an organic way by Pope Pius XI, had to be one of the main pillars of missionary proselytising strategies.[110] Medical intervention was described as a privileged ground from which to mount a challenge to both local beliefs and Islam.[111] According to contemporary sources and also his biographers, the success of Father Angelico's missionary strategy in Eritrea – particularly in the area of Keren, where he was based for a long time – was impressive and was openly acknowledged by Catholic authorities and held up to be an example of successful missionary work.[112]

As pointed out with a certain amount of pragmatic cynicism by Father Angelico da None himself, an important element in his success in proselytising was the ravaged situation of Eritrea at that time. Indeed, the crisis of 1918–21 was particularly severe in the area of Keren,[113] where he worked. In a report under the explicit title *Non tutti Mali Vengono per Nuocere* (Not all Evils Come to Harm) Father Angelico openly stated that:

> [T]he famine which has tried our people so hard may, to a certain extent, be defined as a flagellation by God, but at the same time it can be described as

> an expression of his mercy, through which he has attracted to himself many souls.[114]

However, the same missionary sources disclose a more complex reality and a wider range of reasons for the success of Father Angelico's missionary exploits. In fact, it appears that more than the display of Western medicine and the provision of food, what really earned the Capuchin father the respect of the Eritrean population was the spread of a belief in the thaumaturgic power of his hands. It seems in certain respects that in the perception of his patients Father Angelico had been incorporated into the model of the holy man of both the Christian and Muslim traditions. This came about as a result of his tireless efforts to help sick and disadvantaged people, and in particular because he was in the habit of placing his hands over the people he was curing.[115] Therefore, his acceptance and success among local communities was due not so much to his status as a Catholic Capuchin missionary but rather to his assimilation into a local therapeutic model. This is confirmed by the way the local chief of the village of Mahelab, *käntiba*[116] Mohamed Bula introduced him to his fellow villagers:

> 'People of Mensa': the Catholic *sheikh* who will cure the plagues and diseases of whoever would like to take advantage of his expertise has arrived from Keren. He will do this for no charge. With my permission he will come here to the village of Mehelab once a month and will stay here for a few hours. He has to be respected as a benefactor of our tribe. This is what we *Kantiba* Mohamed Bula order to you.[117]

In his prominent essay 'The Work of Art in the Age of Mechanical Reproduction', Walter Benjamin, discussing the mutated rules regulating the accessibility to Art in the industrial society through the introduction of serial reproduction, used the metaphor of modern medicine. According to Benjamin, modern medicine, by breaking the aura which surrounded magicians and traditional doctors with an appearance of closeness, has somehow increased the distance between patient and doctor.[118] The case of Father Angelico, I would say, shows an opposite development in which the aura has been re-established through a creative redefinition of Western therapeutic procedures and their reception through their adaptation into a local framework of medical practices. This can be considered as a metaphor of the complex relationship between medical missionary intervention and indigenous medical knowledge.

Notes

1. A recent extremely detailed study on those relations in H. Pennec, *Des Jésuites au Royaume du Prêtre Jean* (Paris: Centre Culturel Calouste Gulbenkian, 2003).
2. C.O. Crawford (ed.), *Ethiopian Itineraries, circa 1400–1524* (Cambridge: Cambridge University Press, 1958); C. Conti Rossini, 'Geografica I. L'Africa orientale in carte arabe dei secoli XII e XII. II Carte Abissine. III Gli itinerari di Alessandro Zorzi', *Rassegna di Studi Etiopici*, iii (1943), 167–99; B. Hirsh, 'Cartographie et Itineraires: Figures Occidentales du Nord de l'Ethiopie aux XV° et XVI° Siecles', Paper presented at the 9th International Conference of Ethiopian Studies, Moscow, August 26–9, 1986
3. An example of this is the myth of the so-called 'Prester John', a Christian king who was allegedly living surrounded by pagans somewhere in Abyssinia. This myth polarised the imaginative attention of generations of European Christians and played a crucial role in arousing missionary interest over the region. On this and similar themes: F. Alvarez (edited by C.F. Beckingham and G.W.B. Huntingford), *The Priester John of the Indies* (Cambridge: Cambridge University Press, 1961); C. Conti Rossini, 'Leggende geografiche Giudaiche del IX Secolo (Il Sefer Eldad)', *Bollettino della Reale Società Geografica Italiana*, ii (1925), 160–90; C.E. Nowell, 'The Historical Prester John', *Speculum*, xxviii, 3 (1953), 1–11; G. Melville, 'Le Prêtre Jean Figure Immaginaire du Roi Sacré', in A. Boureau and C.S. Ingerflom (eds), *La Royauté Sacrée dans le Monde Chrétien, Colloque de Rayaumont, Mars 1989* (Paris: 6, École des Hautes Études en Sciences Sociales, 1992), 81–90.
4. E. Cerulli, *Etiopi in Palestina*, 2 vols (Roma: Libreria dello Stato, 1943–7); R. Lefevre, 'Roma e la Comunità Etiopica di Cipro nei Secoli XV e XVI', *Rassegna di Studi Etiopici*, i (1941), 71–86; R. Lefevre, 'Note su Alcuni Pellegrini Etiopi in Roma al Tempo di Leone X', *Rassegna di Studi Etiopici*, xxi (1964), 16–26; R. Lefevre, 'Presenze Etiopi in Italia prima del Concilio di Firenze del 1439', *Rassegna di Studi Etiopici*, xxiii (1967–8), 5–26; G.S. Khoury, *The History of the Ethiopian Community in the Holy Land from the Time of Emperor Tewodros II till 1974* (Jerusalem: The Ecumenical Institute for Theological Research Tantum, 1983).
5. Sergew Hable Sellase, *Ancient and Medieval Ethiopian History to 1270* (Addis Ababa: Addis Ababa University Press, 1972), 97–105. Please note that for Ethiopian and Eritrean names there is no notion of surname; full names are therefore listed where appropriate.
6. D. Comboni, *Piano per la Rigenerazione dell'Africa proposto da D. Daniele Comboni, Missionario Apostolico dell'Africa Centrale* (Torino: Falletti, 1864); J.L. Krapf, *Travels, Researches, and Missionary Labours, during an Eighteen Years Residence in Eastern Africa* (London: Trübner, 1860), 24.

7. G. Sapeto, *Viaggio e Missione Cattolica fra i Mensâ i Bogos e gli Habab con un Cenno Biografico e Storico dell'Abissinia* (Roma: Sacra Congregatione Propaganda Fide, 1857), 260
8. G. Aren, *Evangelical Pioneers in Ethiopia* (Stockholm: EFS, 1978), 42–4.
9. Uoldelul Chelati Dirar, 'The Nile as a Gateway for Missionary Activity in Abyssinia', in H. Erlich and I. Gershoni (eds), *The Nile: Histories, Cultures, Myths* (Boulder: Lynne Rienner, 1999), 139–49.
10. In fact, the earliest spread of Christianity in the region is dated back to the beginning of the fourth century; see Sellase, *op. cit.* (note 5), 24.
11. Lazarist fathers were expelled under allegation of fomenting anti-colonial feelings among the local population. On this episode see: C. Marongiu Buonaiuti, *Politica e Religioni nel Colonialismo Italiano (1882–1941)* (Milano: Giuffrè, 1982), 50–2; C. Betti, 'Missionari Cattolici Francesi e Autorità Italiane in Eritrea negli Anni 1885–1894', *Storia Contemporanea*, v–vi (1985), 905–30; C. Betti, *Missioni e Colonie in Africa Orientale* (Roma: Studium, 2000).
12. According to different scholarly traditions the terms 'Ethiopisants', 'Ethiopicist' and 'Ethiopianists' have been used with more or less interchangeable meaning. On this issue see: B. Tafla, 'Interdependence through Independence: The Challenges of Eritrean Historiography', in H.G. Marcus (ed.), *New Trends in Ethiopian Studies, Papers of the 12th International Conference of Ethiopian Studies, Michigan State University 5–10 September, 1994* (Lawrenceville: Red Sea Press, 1994), 497–514.
13. T.O. Ranger, 'Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900–1945', *Social Science and Medicine*, xvB (1981), 261–78; G. Prins, 'But What was the Disease? The Present State of Health and Healing in African Studies', *Past and Present*, 124 (1989), 159–79; D. Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), 2–44; M. Vaughan, 'Healing and Curing: Issues in the Social History and Anthropology of Medicine in Africa', *Social History of Medicine*, vii (1994), 283–95.
14. J. Orley, 'Indigenous Concepts of Disease and their Interaction with Scientific Medicine', in E.E. Sabben-Clare, D.J. Bradley, and K. Kirkwood (eds), *Health in Tropical Africa During the Colonial Period: Based on the Proceedings of a Symposium held at New College, Oxford 21–23 March, 1977* (Oxford: Clarendon Press, 1980), 127–34.
15. Key references to this issues remain S. Feierman, 'Change in African Therapeutic Systems', *Social Science and Medicine*, xiiiB (1979), 277–85; and J. Janzen, 'Ideologies and institutions in the precolonial history of Equatorial African therapeutic systems', *Social Science and Medicine*, xiiiB (1979), 317–26.

16. With Abyssinian Christian tradition I am referring here to the broad cultural and religious tradition shared among the prevalently Semitic-speaking Christian populations of the highlands of the present states of Eritrea and Ethiopia.
17. Teshome Wagaw, *Education in Ethiopia* (Ann Arbor: University of Michigan Press, 1979), 11.
18. A. Pollera, *Lo Stato Etiopico e la Sua Chiesa* (Roma: SEAI, 1926), 295–9.
19. Dejene Aredo, 'How Holy are Holidays in Rural Ethiopia? An Enquiry into the Extent to which Saints Days are Observed among Followers of the Orthodox Christian Church', in R. Pankhurst, A. Zekaria and T. Beyene (eds), *Proceedings of the First National Conference of Ethiopian Studies* (Addis Ababa: Institute of Ethiopian Studies, 1990), 165–76.
20. I. Taddia, *L'Eritrea colonia* (Milano: Franco Angeli, 1986), 153; J. McCann, 'History, Drought and Reproduction: Dynamics of Society and Ecology in Northeast Ethiopia', in D.H. Johnson and D.M. Anderson (eds), *The Ecology of Survival: Case Studies from Northeast African History* (London: Lester Crook Academic Publishing, 1988), 283–303.
21. On those influences a key reference remains the work of Claude Sumner: C. Sumner, *Ethiopian Philosophy*, 5 vols (Addis Ababa: Addis Ababa Central Printing Press, 1974–86). On this issue in relation to healing see also J. Mercier, *Ethiopian Magic Scrolls* (New York: George Brazille, 1979), 8–10; R. Cacciapuoti, 'Medicina e Farmacologia Indigena in Etiopia', *Rassegna di Studi Etiopici* i, 3 (1941), 323–29.
22. For this section I draw heavily on the fascinating work of Jacques Mercier, see particularly J. Mercier, *Le Roi Salomon et les Maitres du Regard: Art et Médecine en Ethiopie* (Paris: Editions de la Réunion, 1992); J. Mercier, *Arts that Heals: The Image as Medicine in Ethiopia* (New York: Prestel, 1997).
23. For instance Enoch 15:8; Jubilees 10: 8–9.
24. Mercier, *Arts that Heals, op. cit.* (note 22), 46.
25. Cacciapuoti, *op. cit.* (note 21), 323–29.
26. *Ibid.*
27. Pollera, *op. cit.* (note 18), 315.
28. Ayele Tekle-Haymanot, 'Le Antiche Gerarchie dell'Impero Etiopico', *Sestante*, ii, 1 (1965), 61–7; B. Tafla, 'Titles, Ranks and Offices of the Ethiopian Orthodox Tawahdo Church: A Preliminary Survey', *Internationale Kirchliche Zeitschrift*, lxxvi, 4 (1986), 293–306.
29. S. Strelcyn, *Prieres Magiques Éthiopiennes pour Délier les Charmes* (Warszawa: Panstwowe wydwnictwo naukowe, [Rocznik Orientalistyczny, T. XVIII], 1955).
30. Mercier, *op. cit.* (note 21), 12–13.
31. S. Strelcyn, *Médecine et Plantes d'Ethiopie: Les Traités Médicaux Ethiopiens* (Warszawa: Panstwowe wydawnictwo naukowe, 1968), 22.

32. H. Lambert, 'The Cultural Logic of Indian Medicine: Prognosis and Etiology in Rajasthani Popular Therapeutics', *Social Science and Medicine*, xxxiv, 10 (1992), 1069–76. I am particularly grateful to David Hardiman for bringing to my attention this extremely interesting article.
33. A stimulating discussion of the relationship between the written and oral tradition in the Abyssinian region in D. Crummey, S. Sishagne, and D. Ayana, 'Oral Tradition in a Literate Culture: The Case of Christian Ethiopia', Paper presented to the International Symposium on *Unwritten Testimonies of the African Past*, University of Warsaw, 7–8 November 1989; and J. McCann, 'Literacy, Orality, and Property: Church Documents in Ethiopia', *Journal of Interdisciplinary History*, xxxii, 1 (2001), 81–8.
34. G. Tresca and S. Fameli, 'Appunti di Etnomedicina Eritrea', *Annali di Medicina Navale*, serie I, xxi (1965), 1–40.
35. *Ibid.*
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45. W. Munzinger, *Studi sull'Africa Orientale* (Roma: Ministero Affari Esteri, 1890), 94–6, 114–27, 140–2.
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115. C. da Chaux de Fonds, *Padre Angelico da None* (Torino: Vice-Postulazione, 1970), 64. More biographic details in C. da Chaux de Fonds, *Abba 'Ngelico* (Torino: Tip. Scaravaglio, 1962).
116. The title *käntiba*, originally designated the chief of districts and later was used to indicate the major of a town. In Eritrea *käntiba* became common also as purely honorific title except than among the Habab and Mensa people where it was used to indicate the chief of a village or community: A. Tekle-Haymanot, *op. cit.* (note 28), 61–7; C. Conti Rossini, *L'Abissinia* (Roma: Cremonese, 1929), 165.
117. da Chaux de Fonds, *Padre Angelico da None, op. cit.* (note 115), 85. Author's translation. It is interesting and also revealing the fact that the Capuchin father is basically represented as a 'Catholic' *sheikh*.
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10

The Social Dimensions of Christian Leprosy Work among Muslims: American Missionaries and Young Patients in Colonial Northern Nigeria, 1920–40

Shobana Shankar

Here the role of mission medicine in the British campaign to control leprosy is considered. The case of the emirates of colonial Northern Nigeria draws attention to the social relations of medical work, not only between European and African, Christian and Muslim, but also within colonial circles and indigenous communities. The campaign exposed the different interests of administrators and missionaries, who were North American and somewhat removed from colonial government. For their part, patients were largely migratory young men. This chapter argues that although local social dynamics were often misread in mission sources, they influenced the direction that medical care took in this region of Africa.

Introduction

Leprosy stands alone in the history of medical missions for several reasons. Given the importance of the disease in the Bible, it is little wonder that Christian missionaries saw work among leprosy sufferers as a special calling. By the twentieth century, Christian organisations led the worldwide leprosy relief campaign, bringing together missions, the medical community, voluntary societies, colonial government, and local authorities in Africa and Asia. This collaboration brought attention to sufferers among colonised peoples and made leprosy no longer solely a Christian concern but a critical matter of colonial-era public health.[1] As Megan Vaughan rightly notes, 'No other disease called forth the resources required for institutionalization on a large scale.'[2]

Though scholars have explored the significance of leprosy missions in blurring lines between medical and religious healing and between imperial mandate and Christian evangelism, research on the cultural and social dynamics of the campaign is just beginning. The perspectives of sufferers