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Lebensstörungen und Heilungen

Traditionelle Verfahren des In-Ordnung-Bringens
von Christus bis Mami Wata

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Inhalt

Shekhinah: An African Utopia

Jon P. Kirby

"Here There is Life!"

I sit with a group of my students under a vast mango tree at the entrance of the "Shekhinah free clinic" on the outskirts of Tamale, northern Ghana, waiting to see its charismatic founder, Dr. David Abdulai, or "Doctor" as the people call him. At 6.00 AM the temperature is already in the high 30s as a brilliant shaft of light streams across the long queue of patients at the gate.

They include snake-bite, hepatitis and tuberculosis cases, broken limbs and "convulsions," middle-aged men disabled by hernia and elders suffering from "river blindness" (Onchocerciasis), the lame resting on makeshift crutches, emaciated women with HIV and throngs suffering from the many scourges of tropical Africa—malaria, tropical ulcers, typhoid, guinea worm and a half dozen other poverty-related and water borne diseases. They have come by foot, "bush taxi," bicycle and strapped to the backs of motorcyclists. Some have waited most of the night for they know that the sick are admitted on a first-come, first-serve basis. By Western standards most are candidates for the emergency ward but the nurses will select the most critical and then admit the first sixty in line. The others will have to come back tomorrow.

Here and there in the line-up a pair of shoes betrays some schooling. For the benefit of the students I ask a shod person in English, "Why don't you go to Tamale Central Hospital? Don't you have National Health Insurance?" The answer is brief and to the point, "Yes, but I want Dr. Abdulai." Others are quick to add their responses:

"As for Doctor, he will not deceive you."

"He is not interested in money; only to help us."

"I trust him. I know he can help me."

"Doctor knows our difficulties. Some things, you cannot speak of when you go there [Central Hospital]. But he will listen. He understands us and we know him."

"He is one of us, a Dagomba. He will take care of us."

"I am not a Dagomba but I am not afraid. He loves us, won't he care for us too?"

"He is a man of God," says a man in Muslim dress, "and we are safe with him. As we Dagombas say, 'If God says you will not die then nobody can kill you'."

One sentiment resonates with everyone: "As for 'Doctor,' he is just good! We feel fine in this place. It is not like the Salaminga Hospiti (European's hospital, i.e., Central Hospital or Tamale Regional Hospital) where they send you to die. Here there is life."

Our first impression of this extraordinary clinic and the man who created it is a powerful one. But what lies behind this alternative place of healing? Why would they prefer this small, understaffed, makeshift clinic to Central Hospital? Who is this man they call the "Mad Doctor" and why is it they consider him "just good"? These questions, and how they relate to global concerns, are the subject of this paper.

The "Mad Doctor"

Dr. Abdulai first attracted my attention in 1989 when he made the radical decision to leave his job security and the respect of his colleagues at Central Hospital to follow a mandate that is boldly emblazoned on the wall of the clinic's OPD: "Services in this clinic are aimed primarily at the poor and the destitute purely for the love of God and neighbor and are ABSOLUTELY FREE. We depend unconditionally on God's providence."

In many ways he is an anomaly. Although highly trained in Western medicine both in Ghana and abroad, he uses herbal remedies and, in the words of his medical colleagues, "behaves like a bushman." His patients sleep on the floors of the clinic's mud and grass huts, as they do at home, and he encourages their family members to come and care for them. The people call him the "Mad Doctor" (dokota jirigu), for only a mad person would offer his services free of charge, provide shelter for lepers and HIV patients, and organize a food program for the more than 100 mad persons living on streets of Tamale.

But over the years this has become a term of endearment. His reputation for successful operations with a recovery rate that is much higher than Central Hospital is well known. Through films, talk shows, blogs, web and journal articles, his fame has spread throughout Ghana and beyond. In 1997 he received his country's highest honor, the Grand Medal of the Republic of Ghana, and he has received numerous other citations and awards. He is a recognized spokesperson for Ghana's poor. He has been called upon to intervene in Ghana's peacebuilding efforts, and he regularly receives prestigious visitors and dignitaries from all around Ghana, Europe and America.

The Quest

Although Dr. Abdulai accepts and freely helps all regardless of ethnicity or religious beliefs, he is proud of his Dagomba heritage. Dagombas are an Islamized people; the rulers of the kingdom of Dagbon, which in pre-colonial times controlled most of what is now the Northern Region, the largest region of Ghana. A spiritual journey has taken Doctor from the streets of Tamale (population about 500,000), where he was a destitute orphan, to Islam in secondary school, through Pentecostalism in university, to Catholicism in medical school. When speaking about his "conversions" he says:

"Yes, it was then that I was really 'converted.' But it was not to a religion or a Christian denomination, Catholicism, but rather to the idea that I had to serve God with all my strength and heart. And because it is through your fellow human beings that you show your love it was there that I got to know my true vocation was to be a doctor who served the poor."

Sr. Jane LeFrois, an American Catholic Sister whom he met while in medical school had a great influence on him. "Through her" he says, "I learned compassion for God's children. She taught me in her own special way that we are all 'children of God' and we must really see through all the rubbish to see God in everyone, but especially the poor." These sentiments stand out as marks of a strong Christian faith, true, but they also resonate with traditional African themes, like solidarity. David recognizes that the choices he made were integral to his Dagomba cultural identity: "Some do not go as far as others. They only want to do what is acceptable and will make others happy. They are not concerned about their own spiritual life. They don't recognize it even. But I have noticed that we Dagombas, when we come to believe, we put our heart and soul into it."

"The Mother Therese of Africa"

Here we arrive at an important juncture. Many regard him as a contemporary saint and some call him "the Mother Theresa of Africa." And while it is true that Dr. Abdulai's quest coincides in many ways with a Western notion of Christian sanctity, I wish to show that its roots also penetrate deeply into an African psyche and philosophy of life. For example, his spirituality is open-ended. He says, "I have found a true home in the Catholic Church. But I do not try to impose my beliefs on anyone. There are good things in every religion and people must follow their hearts and their conscience." At the clinic he has constructed a poustinia, a Russian house of prayer, for peoples of all religions. He embraces the meditative spirit and unity of creation found in Eastern religions, especially Buddhism, but he feels closest to God while playing his flute in the forest. He comes from a Muslim family and strongly

affirms Muslim prayer when he says: "There are many things that I love about Islam like putting God first and the way they pray, the open space in the mosque. It is more in tune with the way things are for us Dagombas. The churches have pews that separate us from each other. I want to be next to the one I'm praying with. I want to feel that I am one with him before God." Clearly, Doctor's Catholic faith builds on and expands traditional understandings.

Along these same lines, Doctor feels an intimate kinship with the Hebrew scriptures. The Star of David hangs over the clinic's entrance and its name, Shekhinah, which means the immanence or abiding presence of God in our midst as a cloud by day and pillar of fire by night (Ex 40:35), encapsulates all that he strives for. He says, "We express the feeling of the presence of God by loving one another, and by sharing with all the people around us especially those most in need." Doctor's "Shekhinah vision" might lead the casual observer to think that he is integrating God into Western medicine. But, given his rootedness in all things African, he is actually integrating aspects of Western medicine into an African worldview and philosophy of life. In order to understand this more fully a comparison with Central Hospital will be instructive.

Shekhinah = Life; Tamale Hospital = Death

Fifteen years ago in an article entitled "White, Red and Black" in Social Science and Medicine (Kirby 1997), I showed how Tamale Regional Hospital, the citadel of modern healthcare in northern Ghana, was quite ironically considered by the people as "a place to die." Today little has changed. Therapeutically and symbolically they still connect it with black, the color of death. Then as now, the hospital is underused and inadequate, not only because it is hopelessly underequipped, understaffed and falling apart, but more importantly because it is out of sync with the peoples' expectations. In their traditional healthcare management schema which involves three stages signified by the colors white, red and black, the people see what they call the "Saliminga hospiti" (lit. White man's hospital) as the final step, a place to go when all other means have failed. The first step, or the white stage, is a period of waiting and requires family assistance. As the situation worsens and becomes "hot" or "red," traditional specialists like diviners, clan elders, herbalists, and shrine custodians are called in. When all traditional means have been tried without success, the situation begins to look like a "bad fate" and moves into the black stage where the solution is pronounced "over to God." It is then that the villagers turn to the "Salaminga Hospiti." I suggested that this could be remedied by encouraging healthcare institutions to acknowledge and take charge of these traditional processes toward "life," and I offered Shekhinah clinic as an example. I will develop this theme below but first a look at how this fits into the process of globalization.

Many Globalizations

Development theorists in the 90s expected that the whole world would rapidly follow the tracks of the West and, despite the fact that it has not happened, this expectation persists. For example, even though our European interns at TICCS are required to learn key phrases in the local language before we place them in a local village, I am always amazed to hear them when they return to the center after a few nights saying, "Why didn't you tell us they don't speak English in the village?" One can only assume they are overwhelmed by strong presuppositions. Similarly, in the almost 20 years since my initial research on illness management one would expect things to have changed yet the three stage process described above persists.

Peter Berger and Samuel Huntington in their book, Many Globalizations, challenge this expectation that as Europe and America go the rest of the world will soon follow. While not denying the power of globalization or "extended modernization" (Berger 2002:16), Berger recognizes great differences in the ability of cultures to adapt creatively to this "cultural earthquake" (2002:9). Thus, he speaks of "many globalizations" rather than one grand process. Apart from the world's cosmopolitan elites, where acceptance is whole and entire, he theorizes that the key to interpreting this process is a strong versus weak cultural identity. Places with a strong cultural identity, such as Japan and China have resisted accepting in totu Western cultural modes and have found their own blends of modernity. In Japan, for example, we find suit and tie at work but yukata and calligraphy at home (2002:12). Berger maintains that at the other extreme are those cultural complexes of weak identity, such as in Africa, where there is very little resistance to Western modes. But, weak or strong, he emphasizes the need, in any given culture, to find a balance, a middle path, between the old and the new, thereby evolving new "sub-globalizations."

Is Western Medicine Unchallengeable?

The common assumption that Africa is an instance of "weak cultural resistance," especially when it comes to healthcare and medicine, is understandable but mistaken. Western medicine, with its miracle drugs and scientific method with its locked-in technology would seem to offer an unchallengeable product to our modernizing world. Nevertheless, this assumption is profoundly challenged by the Shekhinah phenomenon, which is not simply the product of a living "saint" or idiosyncratic doctor, but may be better understood as a dynamic African response to globalization, an evolving African middle path, and an admission that African cultural complexes, especially those rooted in the African worldview, and are stronger than we think.

Foundations of the African Worldview

In Africa today, beneath a thin Western façade there lies an African view of the world resting on four principles involving concepts of life, destiny, unity, solidarity, interdependence, moral order and ethical action—all of which affect healthcare. These are: (1) All being exists in two dimensions: the seen and unseen. (2) The seen and unseen are one, interconnected and interdependent. (3) Everything is ordered according to a hierarchy based on the principle of life. (4) And all things follow a dynamic moral imperative to acquire greater life.

The Unseen and Seen World

The unseen world—that of God, deities, spirits of the earth and ancestors—is the source of life and creative energy. The seen includes all visible things, animate and inanimate. Separating the dimensions can help us to understand this complex, but they are a unit and we cannot speak of one without the other. From this perspective, the Western, purely material world suffers from a paucity of meaning, for it recognizes only half of what is there.

All Being is One and Interdependent

Based on their unity, the seen and unseen are also interdependent. From this, the African communal identity with its notions of solidarity and interdependence are derived. Consequently, where Western healthcare institutions presume and impart a secular individualism focused on personal, physical well-being, African healthcare expectations insist on an interconnected and interdependent social nexus focusing on holistic well-being or "life." They relate to the whole person and community in a unified, seen and unseen, world. Many of Doctor's sayings like "We are all God's children" and "All paths lead to God" flow directly from this view.

Relations with the Unseen

Doctor's emphasis on God's providence is a strong traditional theme and an integral part of the African worldview. Dagombas often say, "Nawuni!" (God!) which is the equivalent of "God will provide," or "Everything depends on God." Ties in the unseen world also extend to the deities and ancestors who are more immediate and accessible sources of life. And maintaining these relations is essential for a holistic healthcare process. Thus, when Doctor attends daily mass, and prays with his volunteers before work and meals, he is not only practicing his Catholic faith but is

simultaneously responding to a very traditional worldview. Understanding this traditional base sheds considerable light on Doctor's unique approach to some problematic situations, e.g., why, in spite of enormous criticism by White nuns and priests, he felt compelled to divorce his wife after she accused his mother of witchcraft.

Relations with the Seen

There are many Christian hospitals in Ghana but none are free. Shekhinah is "free," not simply because of Doctor's Christian faith per se, but at a deeper level, because of a traditional economy of interdependence and solidarity. This affects everything about Shekhinah—especially the way things are shared and distributed on the basis of need. For example, Doctor follows the cultural rules of solidarity to elicit support.

He pressured local chiefs into giving him the land for Shekhinah and he organized the villages around Tamale to build its recovery rooms and care for the patients: "The villagers built these huts. They repair them and keep them up. This is a big help. They don't have the money but they can do something with their hands. It is way of sharing. We encourage them to share. Sometimes the villagers come here for food in the rainy season when there is no food. We share what we have. Nobody here sleeps hungry. We reach out to those who cannot help themselves."

For cash Shekhinah relies on donations. Although Ghanaians also help, the largest receipts are from abroad. Patients offer whatever they have—food, labor, or small sums money. His 35 Ghanaian workers also hold to the principle of solidarity. In the words of one: "I am always happy even though I do not have a salary. Whatever I need I will somehow get it by the grace of God. Doctor helps us whenever we need it. Whatever we get we divide it up and it is usually enough for us." Volunteers from abroad also learn to follow these implicit rules of give and take. Doctor says of them, "normally we have a number of volunteers working with us. Some are in various stages of medical training. We supervise their training and we hope that they will also learn about the power of love as they learn about the power of medicine."

Doctor sees the contributions not as charity but as a social duty engendered by solidarity. He says we cannot do otherwise: "I just want to be happy. But I cannot be happy just being there like that. Even in going to medical school I did not go just to be a doctor but to serve the poor." Doctor shows that he understands God, as the source of "life," to be at the heart of this solidarity package when he says things like the following: "At the beginning of the season corn is 450 new cedis a bag. It is not cheap. Still I have been able to provide food for them. It is God's blessing. Always!

Up until now we always have enough. But if it comes to a time when there is nothing, then it is over to God."

A Home for All in Need

"Feeling at home" is very important at Shekinah. The round thatched huts with sleeping mats on the floors, the bathing areas and cooking places, the compounds and the shade trees are all very familiar sights to the patients. Here they quickly recover from treatment, for they are not alone, or disconnected from their world as they would be at Central Hospital. Doctor says:

"This is a family hospital in the full sense of the word. The entire extended family is welcome and encouraged to come and do their part in caring for their sick relative. This is the way it would be in the village if they were cared for in the traditional way. Members of the family would all be called upon to play their part—some cooking, some cleaning, sweeping, washing, and gathering firewood. Children too play their part."

The patients' family members are not embarrassed or chased away, as they would be at Central Hospital, and the patients can quite literally eat the "healing food from home," while the staff make sure that the medical regimen is followed.

Those who are rejected by society are especially welcome for, in an interdependent world, what affects one affects all. Doctor says, "I wanted to help the mad people and the absolute destitute, the ones that nobody helps. We have built a place for them here. We have 35 destitute with us at the moment."

In 2001 he started another clinic at Wamale on the eastern outskirts of Tamale but he extends this same hospitality beyond the confines of these clinics. A truck goes out each day to feed the mad people waiting at their spots around the city. He has discovered a neglected village of 250 lepers near Nkanchina, 150 miles from Tamale. Once a month he offers them medical treatment, food, and clothing. And every Saturday he offers food and medical attention to 70 old women, mostly widows, who have been rejected by their families and are destitute. "Old lady," he says, "in our language is a euphemism for witch." He affectionately calls them his "friendly witches."

Identity and Destiny

The third pillar of African worldview is the principle of "abundant life." Everything is ordered to this principle (see Magesa 1997). God is the source of this life and the entire unseen and seen world participates in this vitality by degrees moving toward

greater or lesser life. This leads to the fourth principle which concerns life's dynamism. From childhood to old age we advance through stages of ever-increasing life until we attain fullness of life as an ancestor. As humans we are swept up in a moral imperative to pursue life and, given our solidarity, a loss of this vitality is a threat not only to the individual's identity and destiny but to that of society as a whole.

According to Dagomba belief, a person's destiny is set by what his or her guardian spirit announces to God just before birth. Life is a quest to discover and fulfill this destiny which marks one's true identity. A moral order spurs us on to life-accruing action aimed at achieving this destiny. This internal structure is evident, among other things, in Doctor's commitment to the poor and helpless when he says, "Our duty is to give lovingly and that is what we do here. I will do it every day for as long as I live. If I die then it is over to God." We become what we are by continually responding to the gradual unveiling of this destiny. He says: "My life has been in stages but when I look back through all the different paths I can see the print of the Spirit urging me on. As a child of the streets in Tamale God let me realize that he had something special in mind for me otherwise God would just have let me die like all my brothers and sisters."

"Bad Fate" and "Bad Death"

All illnesses are potential threats to "life." In the African context, the blind, the lame and lepers are barred from chieftaincy because high office must foster life, not death. Moribund cases like leprosy and HIV, and anti-social third-columnists like the insane, and potential "witches" like widows and old women are, therefore, all identified with "bad fate" which leads to "bad death"—the reversal of abundant life or a kind of "anti-life." People with such conditions reverse the moral order and their life-diminishing contagion must be contained. Asocial deaths, dying in childbirth, away from one's family, or by suicide, are the very essence of "bad death." Given these understandings, the middle path for African healthcare needs to involve a holistic, communal "about face" toward life.

This is not a concern in Western healthcare institutions but it is a major concern for Doctor. For example, the USAID helped Doctor build a modern HIV unit on the condition that he used it for only the very worst cases with a short time to live. But when he did this the people stopped coming for fear that it would confirm a "bad fate." "They were all scared," he says, "that if they would come they would quickly deteriorate and die. Now we mix them and it is much better, much healthier. They do not think they are coming to die. One was even recently diagnosed as negative and she went back home."

In the same vein, cemeteries are not normally associated with healthcare facilities but Shekhinah has a cemetery. According to Magesa (1997) we only acquire life's total abundance in the afterlife as ancestors. Only then are we fully human, and mortuary rites are the final gateway to abundant life. Without them life is incomplete, one's destiny is cut short. Doctor's life-giving role, therefore, does not end when patients die, and he makes sure that the dying attain abundant life through these last rites.

An Ecology of Life—An African Utopia

Shekhinah, then, is much more than a clinic; it is an African celebration of life. This is confirmed in dozens of otherwise anomalous and incoherent activities. For example, every year at Christmas, more than 3000 blind, lame, mad and destitute people of Tamale are brought together to celebrate life. He says his aim is to love them, to show that they are somebody and that they belong. This alone has a healthy life-giving effect on them. But more than what he does, Doctor's very presence has a life-giving effect on his people. For example, while standing on the grounds of the clinic as he recounts stories of incredible changes that have been wrought by extending such life-giving love, a madman passes by greeting him in French. Doctor returns the greeting and explains, "He is from Togo. He was standing along the roadside on the outskirts of Kumasi and he looked in very bad shape. I stopped the car to offer him some bread. Then the mad man wanted to join me. So he climbed in the car and joined me to Tamale. He has been with us now for four years."

Abundant life extends to all of creation. Although Tamale is in a semi-arid zone, Shekhinah is a verdant paradise of gardens medicinal herbs, flowers, trees and irrigated farms. In the words of the Doctor, "It is a place where God is all around. I fill the compound with plants. They are so important for life. We try to be self-sufficient with food. We have a fish pond and we produce our own firewood, maize, fruit, vegetables, bananas and plantains." The result is a total ecology of life, an African utopia.

Finding a Middle Path in African Healthcare

Berger says that the greatest challenge in our age of globalization is for cultures to find their own middle ground, a balance between the old and the new. Without it they are doomed either to "endless relativization" or "reactive fanaticism" (2002:16). In this paper I have tried to show how Shekhinah moves toward this balance by resituating modern African healthcare on the four basic principles of the African

worldview. It is a true African response to the globalizing process, for, while it confidently blends the best of both worlds, it uses African modalities as the base or matrix for integration.

Toward an African Middle Path

Is this an anomalous experiment or the harbinger of a more widespread movement in African healthcare? Up until now the unhealthy spaces of Central Hospital can still be contrasted with the life-enhancing spaces of Shekhinah where a blending of Western medical technology and traditional holistic expectations about life have been combined. The good news is that the doctors at Central are now more open to Doctor's experiment. Doctor says: "After I left Central Hospital they did not respect what I was doing and wanted nothing to do with me. I think that they too thought that I was mad. Now we have better relations. They have weekly meetings to share their work and try to resolve some of the problems of the hospital. Now they invite me to join them and I go."

There are also signs that the idea is spreading across Africa and beyond. Doctor tells of a woman in Wa who has started working with the destitute and someone in Burkina Faso who saw what was being done at Shekhinah and is now running a food program for the mentally ill in Ouagadougou. Another Shekhinah has been started across the Atlantic in Canada by a volunteer who spent some time with Doctor.

"Flows" such as these are helping Africa to recognize and affirm its valuable cultural heritage which emphasizes a holistic environment for life. And experiments like Shekhinah give evidence that a change is occurring. Rather than obsessively modeling its healthcare system on the West leading to unlivable places to die, Africa is slowly finding its own middle path. The success of this venture is needed not only for Africa but, especially now in our global age, for the health of our Western healthcare institutions and, indeed, for the good of all of humanity.

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