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"I'M SICK...I'M COMING": ILLNESS  
AMONG ZAIRIAN ELITE WOMEN

by

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Abstract: Among urban elite Zairian women, friendship networks substitute for the kin networks that socially construct the illness episode in rural Zaire. A participant observation study, conducted in two Zairian cities, shows that friends make important decisions concerning the illness and act as a therapy management group. The friendship networks are defined by mutual rights and obligations. By their activities in the illness episode, the friends satisfy previous obligations to the sick person and incur new obligations towards themselves. These new obligations further strengthen the ties among the members of the network.

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11

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This paper analyzes illness episodes of Zairian elite women in the context of urban life and the social networks that these women construct and in which they participate. I shall present three case studies of illness episodes in order to show the way in which illness influences the dynamics of the social support systems of the sick person by providing an occasion for solidarity to be affirmed and friendships strengthened.

In rural Zaire, the individual lives within a complex kinship network to which almost all activities, economic, productive, reproductive, spiritual and illness, are related (Vansina 1965). The interrelationship of kinship and illness has been well documented in studies among the Bakongo (Janzen 1978) and Cokwe (Yoder 1981) of Zaire as well as in other rural African settings, (Turner 1967; Evans-Pritchard 1937; Abasiokong 1981) in Polynesia (Parsons 1984), in China (Kleinman 1980), and in India (Nichter 1981). Little is known, however, of the interrelation of illness and friendship networks in urban Zaire. Because of the highly mobile and scarce job market in Zaire, many people who leave their rural villages to seek work must go far from their regions of origin to find a job. They then step out of the insulation of the kin or clan network as they leave all or most of their relatives behind. In their new homes, they are able to participate in only a segmented kin network or none at all. To substitute for the kin networks, people participate in and construct other networks such as colleague networks, neighbor networks, and political networks (Pons 1969; Kornfield 1974).

The women I studied constructed friendship networks to substitute for the kinship networks in which they no longer participate. Kinship networks are held together by sets of rights and obligations which are defined and transmitted from generation to generation. The new members are children, who, as they grow up, are socialized into the network by their relatives who teach them, directly and indirectly, the expectations of rights and obligations that the members have of one another. By the time of adulthood, these expectations are taken for granted and enacted with little self-consciousness. It is different for the women who live in the city. They construct their own friendship networks when they are already adults. As they do not have a "taken for granted" system of rights and obligations among themselves, the process of their interactions construct the definition of a new system of rights and obligations. In the episodes I studied, illness provided one occasion in this construction process for the clarification of the definition of the friendship relation.

In looking at illness in this way, I am taking a different standpoint from that of Janzen (1978) in his analysis of illness episodes among the rural Bakongo of Zaire. Janzen (1968) focuses on the ways in which social relations of kinship influence the definition and social construction of the

illness episode. I focus on the way the illness episode influences the construction of social networks of friendships. Janzen analyzed illness episodes whose causes were considered to be "by man," that is, diseases whose origins were attributed to "hostilities, tensions, or malefic intentions among kinsmen" (Janzen 1978:68). In these cases, the cure or healing process lay in some type of reorganization and/or renegotiation of family members to resolve the discord among them. With the resolution of the discord among the family members, in principle, would come the restoration of health. Janzen's focus on the social aspects of illness results in the analysis of the kin activities revolving around the source of illness and the renegotiations needed to restore health. He pays little attention to the social activities surrounding illness episodes that do not involve kinship renegotiation or to the various types of supporting activities carried out for the sick person during the illness episode.

In my analysis, I focus on these supporting activities, which are necessary for the sick person and the fulfillment of which is more difficult in the city where kin, who would normally be expected to carry out these functions or duties, are absent. In the city, the sick person has to depend on other people, friends, neighbors, and colleagues, to do these things for him/her. Such important and necessary support becomes problematic for the individual. For that reason, at the time of illness, the need for the friendship network becomes very great. If the illness is defined as involving kind discord, the support activity of friends may occur alongside the efforts of kin to renegotiate the rights and obligations defining their relationships in order to resolve the discord. On such occasions, the friends have a special obligation to the sick person to accompany her to her village and do whatever else is necessary.

The role of such friendship networks in urban illness episodes has not been analyzed in detail in the literature on Zaire. Jansen (1978:131) makes only casual references to friendship networks. Yoder (1981), in his case studies of Cokwe illness episodes, mentions the participation of friends but mainly describes the role of family members in the episode. Little work has been done on illness among urban, elite women. These women are particularly interesting because they are developing new, unique ways of dealing with situations which will form the basis for new traditions among the children who are growing up in the cities and will never experience life in integrated kinship communities.

The data for this study was collected by participant observation over an eight year period in Zaire, three years in Kisangani and five in Lubumbashi from 1968-1978. Kisangani is the largest city in the Upper Zaire Region, ranking third in the country, and is the seat of the regional government. It is situated on the Zaire River about thirty miles from the equator. The weather varies little with an average temperature of about 85° and rainfall year round. Fish from the river are plentiful and locally grown fruits and vegetables are always available because of the continual rainfall. The city houses the offices of the governor as well as other government administrative services. There are two hospitals, both

well equipped. The Free University of Zaire and a few industries, hotels, restaurants, shops and the government offices supply employment for the population. Most people live in mud and wattle houses surrounded by chickens, maybe a goat, and fruit trees such as banana, mango, avocado, and palmtut. Houses built of cinderblock with running water and electricity are occupied by the elite of the city who are employed by the government, university, or private business.

Lubumbashi is the second largest city in Zaire, the largest city in the Shaba region, and the seat of the regional government. It is in the southern part of the country in the area known as the Copper Belt. It was developed by the Belgian copper company that opened copper mines and built communities for workers from villages in the surrounding areas to live in. The climate has a six-month dry season and a six-month wet season. This means that, for six months of the year, locally grown food is abundant but, for the other six months, food is scarce. Sources of employment for the population are the copper companies, a few industries, the university, and government administrative offices. There are several shops, restaurants, and hotels that serve the elite population as well as three hospitals and several private medical clinics. Lubumbashi has a predominately urban atmosphere although one often sees chickens and goats wandering around. Social stratification is more rigid than in Kisangani because of the industrial development of the city.

During the time of the study, I was a university professor and researcher. Because Zaire was my home, I was also a member of friendship networks which included Zairian women who were the spouses of university faculty and administrators or administrators of private enterprises. I participated in the activities of the women and developed along with them the systems of rights and obligations that defined their friendship network. Along with marketing, social gathering at each others houses, celebrating holidays together, and sharing in general daily life, came frequent participation in illness episodes when they or a member of one of their families became ill. As a friend, I was able to participate in their illness experiences as they participated in mine. In that way, I learned what they expected of each other and the importance of these expectations for their friendship as well as their needs in the difficult moments of illness.

The women represented several ethnic groups. They had all been dislocated from their regions of origin when they followed their husbands to their university positions. What brought the women together was their status as wives of university people, their relatively high level of education (all had at least some secondary schooling), their common socioeconomic status derived from that of their husbands, and the proximity of their homes. They all spoke French, the only language they had in common. Their regional languages were Lingala, Swahili, Tshiluba, Kikongo, and several other languages representing smaller ethnic divisions.

To understand their illness episodes it is first necessary to understand the context in which they took place.

### The Medical Context

The general health status of the Zairian population is poor. The average life expectancy at birth for both men and women is 43.6 years. The infant mortality rate is 104 (World Almanac 1982; figures from 1975). Diseases endemic to the populations of both Kinsangani and Lubumbashi include malaria, parasitic and bacterial infections, smallpox, severe forms of measles, chronic diarrhea, chronic malnutrition, kwashiakor, sickle cell anemia, venereal diseases, and poliomyelitis. Medical services are concentrated in the cities. For the entire country there are two physicians per 100,000 population (World Almanac 1982).

In Kinsangani, from 1968 to 1971 medical facilities were scarce. The best hospital had no running water or properly functioning plumbing facilities. Pharmaceuticals were difficult or impossible to obtain. There was one small, expensive private clinic as well as the university infirmary. In Lubumbashi, from 1973-1978 medical facilities were better than they had been in Kinsangani. There were three hospitals. The private hospital which belonged to the mining company, had facilities similar to those expected in a modern European hospital. The University hospital lacked many important facilities but was better than the overcrowded public hospital.

The women in this study were in a privileged position. In Kinsangani, they had access to the best facilities and in Lubumbashi the second best (the university hospital) or, in some cases, the best (the hospital of the mining company). They and their children did not suffer from chronic malnutrition and the resulting diseases. But they did suffer from the other diseases endemic to the rest of the population. While the women, their spouses, and children had access to the best medical care available, they still witnessed the premature death of their children from sickle cell anemia as well as the deaths of friends and relatives from the inadequacy of the facilities or lack of access to them. Thus, illness for these women was always a serious occasion which could become a crisis situation.

Curers and healers of various ethnicities practiced their professions in both cities. The women often had access to curers from their own ethnic groups, and they might consult healers from other groups when their therapeutic skills seemed particularly appropriate.

### The Social Context

The women in this study lived in single-family dwellings with their husbands, their children, and sometimes children of their kin, younger brothers or sisters, or other relatives. Sometimes a mother, father, or other adult kin lived with them temporarily. These women lived relatively comfortably. They resided in houses with modern plumbing facilities, electricity, stoves, and refrigerators. They had the responsibility for the running of the household and for child care but benefited from their

husbands relatively high salaries to be able to afford house servants. The servant did housecleaning, some child care, cooking, and marketing for them. As a result, the women had leisure time for visiting each other, spending mornings doing social marketing and afternoons plaiting each others' hair, and carrying on petty commerce. They even had enough leisure time to sit home alone and become bored. This meant they had time for each others' illnesses. Visiting friends in hospitals to celebrate childbirth or give emotional comfort in time of sickness was a regular part of their daily lives.

### Case Studies of Illness Episodes

I have selected from my case studies three types of illness situations. The first was a mild illness of one of the women. The second was an epileptic attack of one of the children. The third was a serious intestinal condition of one of the women which required hospitalization. I participated in these episodes, and those activities that occurred when I was absent were recounted in detail many times to myself and other concerned friends.

#### I. Mild Illness Episode

Feza woke up one morning feeling feverish and dizzy. She prepared the usual breakfast of tea and bread for her husband and children, who, after eating, left for work and school, respectively. After giving instructions to her servant for the noon meal and to look after the smallest child, she went back to bed. When she awoke later in the morning, she still felt feverish and weak and had no desire to eat. She called her servant and asked him to go to her friend Mado's house to report that she was not feeling well.

Upon being given the news of Feza's illness, Mado gave instructions to her own servant to complete the task she was doing and went to Feza's house. On her way, she stopped at Marie's to tell her where she was going. Marie responded that she would visit Feza a bit later in the day when she had finished some household chores.

When Mado arrived at Feza's house, she joined Feza in her bedroom. They discussed Feza's symptoms and decided she was having a malaria attack. Marie arrived and the three women decided it would be best for Feza to take some "nivikin," a commonly used malaria suppressant. If she did not feel better later in the day, then she would go to the university clinic for tests. Mado got the "nivikin" from the drawer and gave Feza a glass of water. Feza took the standard dose of two tablets. The two friends remained and chatted while Feza alternately dozed and spoke. When the toddler came into the room, one of the women played with him.

When I came home from teaching at noon, my servant told me of Feza's illness. Her servant had been told to leave the message for me. Later that afternoon, I visited Feza and found other friends there as well. As she was

feeling somewhat better, everyone agreed she was only having a mild malaria attack and would be fine in a day or two. The following day, Mado and I checked on Feza's health and sent messages, via children and servants, to the others that Feza was still improving.

## II. Epileptic Attack

Mado's youngest child, Hubert, a four-year-old boy, had an attack of convulsions, trembling and fever. Mado was very frightened. She immediately sent her oldest daughter to get Feza because she knew that Feza's daughter had had some kind of convulsions also. Brigitte ran to Feza who immediately dropped what she was doing and hurriedly went with Brigitte to her home. Before leaving, Feza told her servant to go tell Geraldine about Mado's child.

By the time Feza arrived at Mado's, Hubert's convulsions had ceased a bit, but he lay trembling, rigid, and feverish. Feza had brought with her some herbs with which she made a warm infusion to wash Hubert. She had received the herbs from a healer to whom she had gone when her own child had had convulsions of similar appearance. Hubert fell asleep in Mado's arms and the two women sat together watching the child. Little by little other friends, who had been notified by servants, children and Geraldine, arrived. They watched over the child and shared experiences they each had had with similar cases of convulsions. They gave the illness the name in Lingala, "maladi ya ndege," which means literally "sickness of the bird," but which they translated into French as epilepsy.

They shared stories of the unsuccessful efforts of biomedically trained physicians to cure the illness and agreed that those doctors really did not know how to treat it. Feza told about the healer who had been treating her child who suffered from "maladi ya ndege" since she was an infant. She recounted that the number of attacks had diminished as the child got older and felt certain it was a result of the treatment of the healer. Mado was skeptical but interested. The women also debated the effectiveness of the physicians at the university clinic. Together they decided that when Mado's husband returned from work that evening, Mado would tell him all the information she had from the women and together they could decide what treatment to follow. Then the women would help Mado carry out the decision Mado had made with her husband.

The following day, Feza and Geradine went to Mado's early in the morning to find out what Mado and her husband had decided and to keep Mado company as she watched over the child. He was weak, but eating and playing quietly. The decision was that first Mado would take the child to the university clinic for tests and any necessary medication.

Then, if the convulsions persisted, she would consider taking Hubert to the healer. That afternoon the women accompanied Mado and the child to the University clinic. The results of the tests indicated intestinal parasites and malaria. The physician gave Mado prescriptions for each disease. Hubert was given the medication, regained his strength and seemed to be back to normal.

A few weeks later, he had another attack of convulsions. Again Mado was extremely frightened as were her friends. A similar process of mobilization of the women took place again. Some came immediately. Others waited for a more convenient time. The discussion centered around the agreement that European trained physicians do not really know how to treat "maladi ya ndege" but that the Zairian healer does.

At the noon meal, Mado and her husband decided that Hubert should be taken to the healer. They summoned Feza who said she could arrange for a meeting. I was summoned to provide transportation. Mado's husband returned to work. I drove to the healer with Mado, the sick child, and Feza who came with us to give directions and make the contact with the healer. She explained the situation to him, and the healer invited us all into his house. He administered the treatment and gave more herbs to Feza. He told her to continue the treatment as she had previously done and to return with the child in a few weeks or sooner if he had another convulsion before then.

We returned to Mado's house. She followed the instructions of the healer and continued going to the university clinic for further tests. The European trained physician explained that there was nothing to be done about the convulsions. He said that they might become less frequent as Hubert grew older. The healer, on the other hand, explained that he would cure Hubert of "maladi ya ndege." Hubert continued with the healer's treatment administered by either Feza or the healer himself. As he got older, the attacks became less and less frequent. By the time he was seven years old he no longer had them.

### III. Hospitalization

Mado had been suffering from severe heartburn and constipation for several months. She frequently had stomach cramps and could not eat comfortably. Her friends spent much time with her discussing her symptoms, relating stories of people with similar ones and explaining what they did for treatment. The friends suggested home remedies, which Mado tried but they did not help. She also consulted several physicians that the women recommended and underwent several types of treatment. She followed a special diet for ulcers, took medication for intestinal parasites, and used other medication for constipation. None of the treatments brought about results.

After further tests and X-rays, she and her husband decided to follow the advice of the last physician, who had suggested surgery. Mado felt especially confident in him. He came from a village near hers and they could speak the same first language so she could easily understand him. She explained that the doctor told her that the X-ray showed that her intestine was too long and, as a result, was tangled causing a blockage. This blockage caused the symptoms. If he cut out the tangled part of the intestine, the blockage would be opened and she would no longer suffer because her food could once again be properly digested. Since none of the previous treatments had worked, she explained, and the symptoms had become

so severe that she was spending much time in bed, was losing weight from not eating, and was not able to carry out her daily tasks properly, she consented to the operation.

This illness occurred while Mado, her husband, and her children were living in Lubumbashi which was far from their region of origin. Sometimes people living in the city, a long distance from their home, "adopt" kin from their own region even if they are not from the same ethnic group. When this occurs, the adopted kin would assume some of the rights and obligations that kin have toward each other but not necessarily the decision-making power real kin have. The rights and obligations include giving all the help they can during an illness. An "adopted" kinsman or kinswomen expects to receive this support without asking and expects to give it without being asked.

Mado had a few of these adopted kin as well as her friends who came from various regions and ethnic groups in Zaire. When she announced the decision to undergo surgery, her adopted kin and close friends immediately began taking responsibility for the preparation for surgery as well as for the domestic tasks she would not be able to carry out during hospitalization. The domestic tasks included meal preparation for her husband and children, care for the youngest child while the older ones were in school, and instructing and overseeing the servant. Preparation for the operation included accompanying Mado to the hospital for all the preoperative tests and helping her husband obtain the necessary pharmaceuticals, such as medication, intravenous infusion set, and sucrose serum, and the quantity of blood required for the surgery. Someone had to find people who would be willing to go to the hospital for blood tests and, if their blood type was compatible with that of Mado, make arrangements for the donation. The blood had to be obtained before the operation could take place, and getting it took several days. Mado's husband, the adopted kin, and the close friends obtained the blood by donating it themselves and by asking their friends and colleagues to do the same.

Mado's husband drove her and the children to the university hospital the night before the operation was to take place. A few friends also accompanied them. They all stayed with Mado until she was ready to go to sleep. The following morning, her husband, who had taken the day off work, and a few friends went to the hospital. Two "adopted" kin women stayed at Mado's home to take care of the young child, prepare food for the noon meal for the older children, and make sure there would be food for Mado's husband whenever he got home that day.

I went to the hospital directly after morning classes expecting to find Mado either still in surgery or in the recovery room. Instead, she was walking about nervously. The operation had been postponed because the physician discovered that not all the blood collected was compatible with Mado's and, therefore, the amount was insufficient. Mado told me this and I asked her husband if he knew whether the public hospital had a blood bank. We both inquired of the nurse who told us there might be some blood there

and, if it were the right type, we might be able to exchange the blood we had for that blood. Since Mado's husband was also very nervous, jittery, and shaky by this time, I offered to drive him to the other hospital to exchange the blood. We did so and were able to obtain compatible blood.

The operation was rescheduled for the following morning. Friends arrived to accompany Mado to the operating room to await the operation with her husband. Some remained at the hospital all day. Others came and left as it fit into their work or domestic responsibilities.

During that week it was necessary to have 24-hour surveillance for Mado as the nursing staff was insufficient to provide the proper care. The friends arranged among themselves a schedule to ensure that one person would spend each night and be relieved by others in the morning. Others brought food for Mado. The adopted kin continued to run the household. Every afternoon and evening the hospital room was filled with visitors. The Zairian physician actually expressed concern that there were too many visitors and that the commotion was disturbing and could retard recovery. The visitors reluctantly awaited their turns to enter the room. All expressed the opinion that their presence would help Mado recover. She dozed, attached to intravenous feeding tubes and tubes draining fluids from her stomach or intestines.

By the end of the first week, the drain tubes and intravenous feeding apparatus were removed and she began to eat. Although she did not need the constant surveillance anymore, her friends still felt someone should spend the night with her so they continued the schedule. Visitors continued to come, bring food, chat and cheer her up. If Mado slept, they talked among themselves. When she wished, she participated in the conversation but no one expected her to do so. Her children came to the hospital after school. Her husband picked them up on his way home from work. Sometimes they all spent the evening and ate dinner brought by friends or went home and ate food prepared by the adopted kin.

During the third week, Mado regained enough strength and normal bodily functions to be released from the hospital. Her husband took that afternoon off from work to bring her home. During her convalescence, the close friends checked in on her daily to see if she needed anything and did necessary tasks for her, including taking her to the hospital for further doctor's appointments. Friends continued to visit at their convenience and focused their social activities at her house until she could go out on her own. Little by little she resumed her domestic responsibilities, began visiting others and participated in her normally expected activities.

### Analysis

The illness episodes were socially constructed by the sick person and her network of friends and family. There were four parts to the process of social construction (see Berger and Luckman 1966 for discussion of the social construction of reality; also cf. Suchman 1965). The first part was

the onset of the symptoms and the notification of the friends by the sick person. The next three parts were the specific points during the episode when the friends participated directly in its construction. I will call them consecutively first, second, and third meeting; the four parts of the episode are diagrammed in Figure 1.

At the first meeting the friends did three things. 1) They offered sympathy and emotional support by going to the sick person's home at her summons. 2) They defined the illness. The friends witnessed the symptoms and, through exchanges of experiences and knowledge with the sick person, they contributed vital information needed to arrive at a definition of the illness. They either named it, or recognized uncertainty and evaluated the severity. They ascertained the cause, which they assumed to be of natural and, therefore, curable by chemical or herbal medication. They turned to the consideration of other causes of the illness only if none of the biomedical cures worked. 3) They proposed a treatment plan based on their initial definition. If the illness were considered mild, the decision for the plan was made by the sick woman and her friends alone. If it were defined as serious, the final decision was made by the woman and her husband.

The second meeting consisted of the steps to carry out the treatment plan and, if the results were not satisfactory, the modification of the initial plan was made. This was the actual process of therapy management, which included medical consultations and the administration of medication or other types of treatment.

The third meeting consisted of the confinement period, if necessary, and recovery. During this time, the friends carried out all the responsibilities that the sick person was unable to undertake. They continued these activities, as well as the provision of moral and emotional support, until the sick person resumed normal daily activity and ceased sending for her friends.

From the time the sick person notified her friends of the symptoms and they arrived at her house until she had recovered, the friends established an interdependence among themselves. This interdependence was defined by the expectations of the sick person and the members of her friendship network. The sick person expected the friends to give moral and material support as well as needed information during the illness episode (Schaefer et al. 1981 also cites these functions of social support). The friends expected the sick person to include them in the activities. Since the women were not living among their kin, who would otherwise have fulfilled emotional needs for security, stability and a feeling of belongingness as well as material needs when necessary (see LaFountain 1970), the women wanted to have these friends so that they would not feel alone and insecure in the city. The women needed to participate in the illness episodes of their friends so that they would be able to experience a sense of belonging in an environment that otherwise would have been strange to them. The sick person needed the friends to get through her illness.

The response of the friends to the illness defined the structure of the network and the sick person's position in it (see Mitchell 1969:27). Those women who responded to the first notification of illness by going immediately to the household and by taking initiative in the various activities formed the inner circle of the network. Other women defined the outer circle by waiting for a convenient time to visit and by participating in only some of the events (cf. Boissevain 1974:26 on network and "zones"; Kapferer 1973:87 on "circle"). The sick person controlled some of the movement from inner to outer circle by notifying some women first or by requesting help of some women and excluding others.

Each woman either strengthened or weakened her bonds to the sick person depending on how much she did for her during the illness episode. The more she did for the sick person, the more obligations to herself she incurred from the patient. These obligations would be carried out at any future date when needed. As long as the friend owes obligations to the other, the friendship will remain strong. If the friend does little for the sick person, then few obligations are incurred and the friendship bond is weakened. If the friend does not participate at all, she cuts off the relationship because she incurs no future obligations (Kornfield 1974).

In this way, these illness situations provided the occasion for the arrangement of the social network and the definition of friendship ties. This compares with the illness situations described by Jansen (1978) which provided the occasion for rearranging kinship relations. In Janzen's examples, however, discordant social relations were thought to be the cause of the illness and their rearrangement the resolution of it. In my examples, the social relations were rearranged during the construction of the illness episode, not to cure the patient, but to assure friendship alliances that were highly desired and necessary for survival in urban life.

In conclusion, this study indicates not only the significance of illness episodes for consolidating the friendship networks necessary for survival in the city, but also suggests new trends in the ways Zairian elites deal with illness.

1. The women consulted traditional healers from ethnic groups other than their own. These healers were mainly herbalists. This suggests that the urban women may have the same attitude toward healers who cure with herbs as they do towards biomedical physicians who cure with chemical medications. Evidence for this may be indicated by the herbal pharmacies that exist in Kinshasa along with the biomedical pharmacies.

2. The final decision for treatment for serious illness was made by the husband and wife only without the participation of other relatives. In less serious illnesses, the friends (from various ethnic groups) played a major role in decision making, and the husband of the sick woman participated only peripherally. If more kin had been present, they would have dominated the decision-making process. Janzen (1978:130) made a similar observation among city dwellers in Kinshasa except that women had

little say in therapy management in their husband's illnesses. Studies of illness in the African rural milieu show great participation by many relatives other than the spouse in all decisions concerning therapy management (Janzen 1978; Yoder 1981; Turner 1967; Abasiokong 1981).

3. The adult sick woman was an active participant in the episodes and contributed to the decision-making process herself. This contrasts with Janzen's (1978:130) findings which indicated that sick women had little or no say in therapy management. Those sufferers who did were usually male adults who could pay for their own care and still walk or travel. In Yoder's (1981) cases, the sufferer who participated in decision making himself was a male university student in the small town of Kikwit near his own clan village. These findings suggest a shift in the responsibility for therapy management in rural to urban situations. In the rural areas, only men participate in the decisions about their own illnesses whereas in urban areas educated, economically well-off women may also do so.

FIGURE 1  
PARTICIPATION OF FRIENDS IN ILLNESS EPISODES

ONSET OF SYMPTOMS

Notification of Friends  
Friends Arrive at Home

FIRST MEETING

Reaction to symptoms  
Give sympathy  
Define illness  
Initial treatment plan

↙  
If mild, only  
women friends

↘  
If serious,  
husband & wife

SECOND MEETING

Carry out treatment plan  
Obtain medication  
Administer medication  
Accompany person to consultation  
Provide transportation

THIRD MEETING

Confinement & convalescence  
(1) take over domestic  
duties of sick woman  
(2) daily visits for  
moral support

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