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To cite this version:

Anne Bargès. The Urban African Environment and Disease : Anti-leprosy segregation and adaptative behaviour in Bamako (Mali) traduit du français. Ecologie Humaine, 1993. halshs-03106858

HAL Id: halshs-03106858

https://shs.hal.science/halshs-03106858

Submitted on 12 Jan 2021

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The Urban African Environment and Disease : Anti-leprosy segregation and adaptative behaviour in Bamako (Mali)

Anne Bargès

Thanks for their contributions are due to: the French Minister for Research and the Laboratory of Human Ecology and Anthopology, the French Association of Universited Women and the medical comity of French Raoul Follereau Association.

Leprosy is an ancient endemic disease. Well before the arrival of Europeans, it engendered representations and forms of social behaviour stigmatising for the person afflicted by it (Bargès, 1993).

At the beginning of the 20th century, the colonial health policy based on the segregation of those ill only lent credit to an exclusion of "lepers". But to that exclusion, which was essentially individual – apart from certain villages grouped around local caregivers – it brought a technical and collective dimension. Thus 1934 saw the construction at Bamako in French West Africa (colonial Government of France named A.O.F.) of the Central Institute of Leprosy (Institut Central de la Lèpre : ICL), an institute which in 1945 took the name Marchoux in honour of the great medical figure in the tradition of Pasteur.

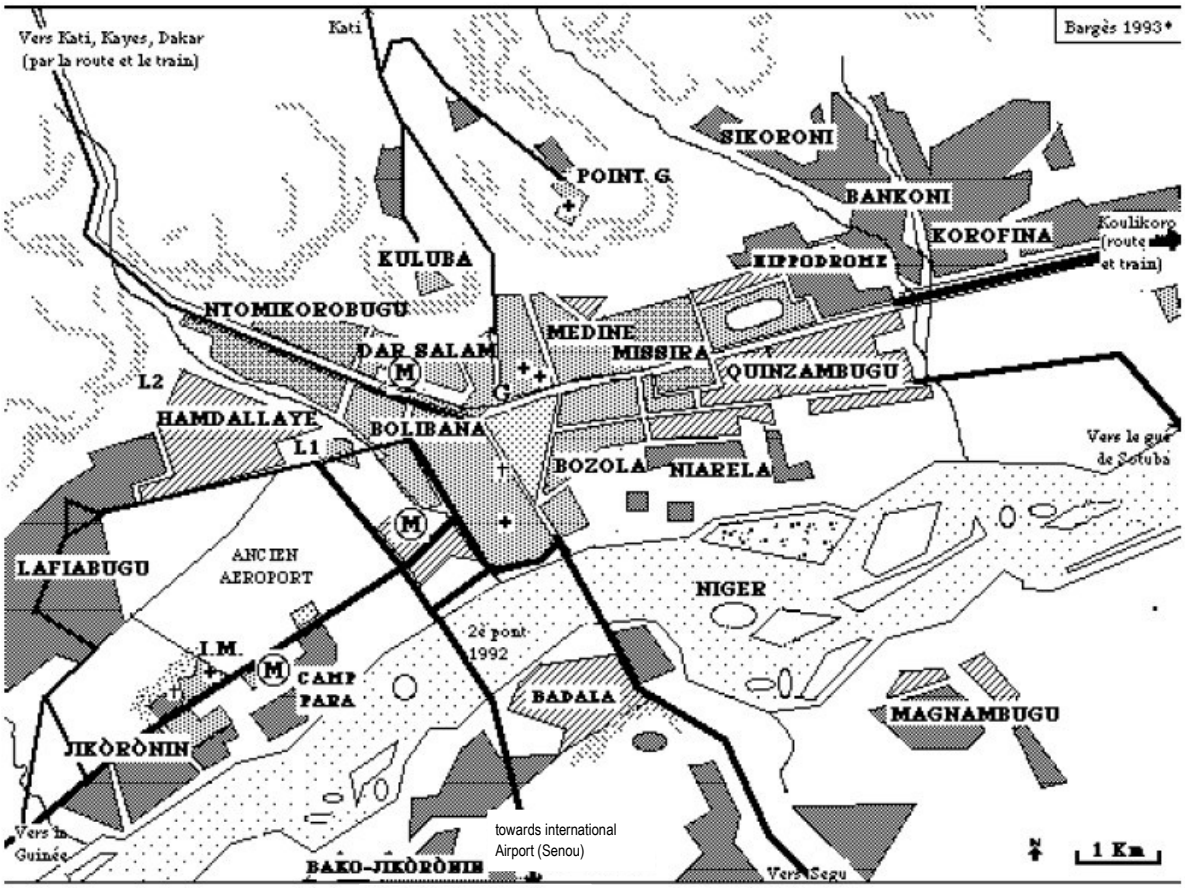
The history of anti-leprosy segregation is therefore intimately linked to that of the city. By way of the location of treatment structures, the history of the struggle against leprosy and other endemic maladies enables a better understanding of the construction of space in Bamako (Figure 1); conversely, diachronic analysis of the present urban milieu assists in understanding the particular evolutions in the "leprosy world", whose epicentre is *Jikòrònin* [Djikɔrɔni]. Through an examination of the history of this "lepers' quarter", constructed opposite the Marchoux Institute, we will analyse the way in which a minority has structured itself and managed its environment with a view to economic and social betterment

Segregation

The principal treatment centres for endemic and/or contagious diseases have in common their out-of-the-way locations – isolated, situated in neglected areas. Thus the first centre for assembling those afflicted with leprosy was constructed in 1928 in *Bakò-Jikòrònin* [Bakɔ - Djikɔrɔni], "*Jikòrònin* beyond the river"; in the absence of a bridge over the river, access to it was extremely difficult – both, in one direction, for the local health-providers crossing the river in dugout canoes, as well as for the French medical teams with cars (13 km by ferry, 30 km by the Sotuba road – ANM 1930), and, in the other direction, for the patients, unwelcome in the city. The methods of peopling the village were arbitrary and depended on denunciations, as one old woman in *Jikòrònin* testified: "They brought us here by force; it is because of their strength that we are here […] I thought that they were going to throw us into the river". The wretched conditions in which the patients lived were such as to drive them to "flee" (National Archives of Mali, ANM 1930).

This system, imposed and unsuitable, would have needed to be "attractive" to the patient population in order to function. Under the auspices of the League of Nations (avril 1931), the government of French West Africa (A.O.F.) decided to implement a "more humane" health policy, but the logic of exclusion and concentration was perpetuated in the form of a treatment centre combined with an agricultural colony directly inspired by the leprosariums of the Christian Middle Ages: the I.C.L. (Institut Central de la Lèpre), which was supposed to serve as the centre of reference for leprosy research and treatment in West Africa.

From the map of Bamako in figure 1 one can understand the choice of location for the Institut. It was built in the hamlet of *Jikòrònin* [Djikɔrɔni], a small farming village situated on a somewhat wooded plain, formerly flooded at regular intervals, partly swampy and malarial, on a road poorly developed at that period (towards the Manding Mountains and Guinea, the river route being used more often) – a place close to military and merchant camps, *faliminkolen* ("watering hole for asses"), situated at the gate to the west of the city centre. To the social constraints of segregation were therefore added the physical limitations of the locale.



Extensions of the city observed in

1905	+	Hospitals and Medical Instituts
1947	I.M.	Institut Marchoux
1948	L	Lazaret
1960	†	Catholic Mission
1992	G	Station
	(M)	Military Camp

Bargès 1993 - Personal ethnographical observations have completed the topographical information taken from : Villien-Rossi 1966, Mougin 1948, IGN 1960.

-The city of Bamako is characterized by : the intensity and rapidity of its development over the past twenty years (rural migration in the 1970s), sprawling neighbourhoods, spontaneous neighbourhoods, empty spaces within city (often cultivated), market gardens along the river.
-The Marchoux Institute (leprosy) and the Lazaret (yellow fever, cholera, meningitis) were constructed some distance from the city ; the Lazaret was pushed up against the rocky hillsides ; the Institute Marchoux has become incorporated

Figure 1
Bamako, Capital of Mali

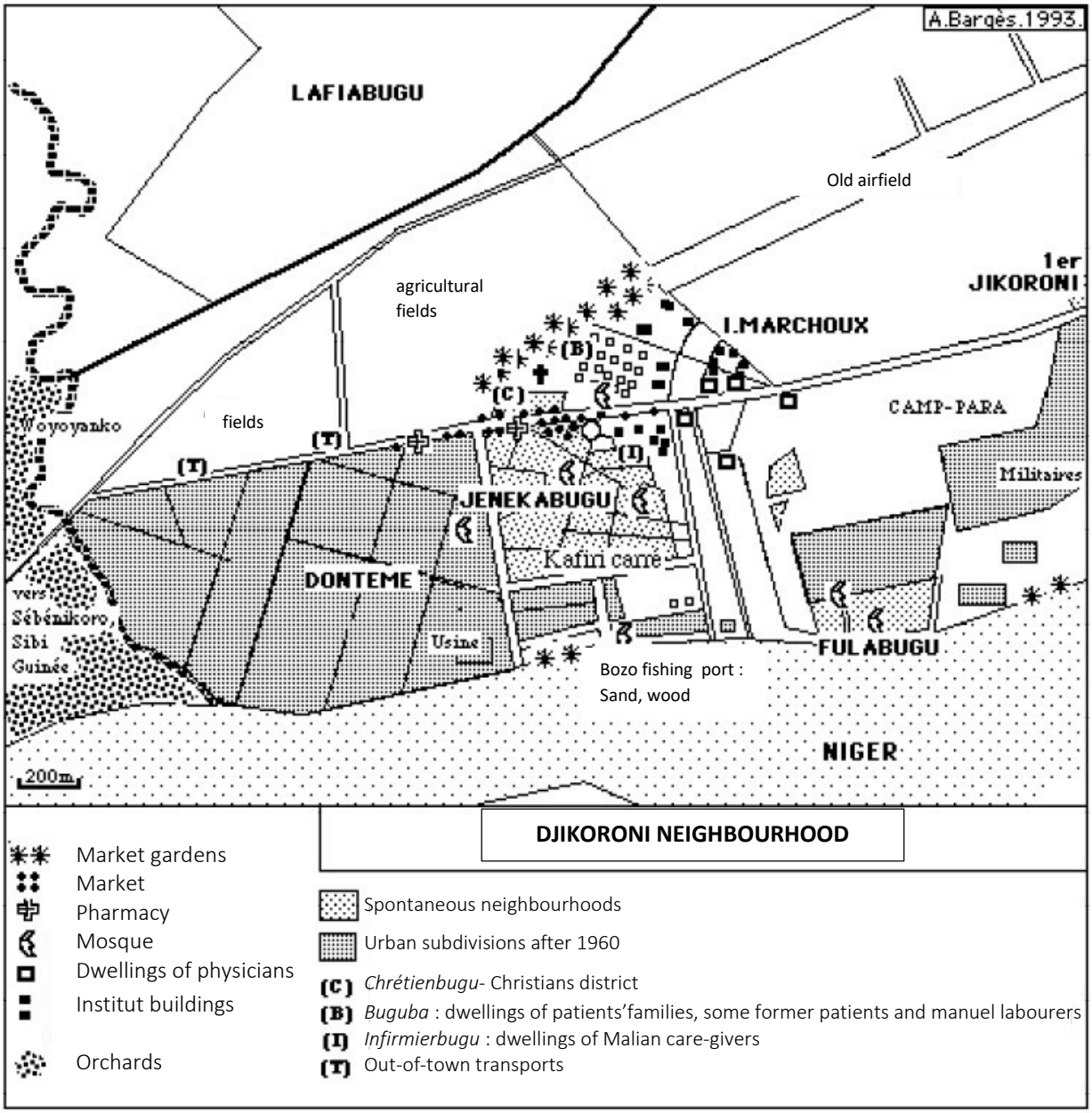

A.Bargès.1993.
LAFIABUGU
Old airfield
1er JIKORONI
agricultural fields
I.MARCHOUX
(B)
(C)
CAMP-PARA
Woyoyanko
fields
(T)
(T)
(I)
Militaires
JENEKABUGU
Kafiri carré
DONTEME
vers Sébénikoro, Sibi Guinée
Usine
FULABUGU
Bozo fishing port : Sand, wood
NIGER
200m
DJIKORONI NEIGHBOURHOOD
Market gardens
Market
Pharmacy
Mosque
Dwellings of physicians
Institut buildings
Orchards
Spontaneous neighbourhoods
Urban subdivisions after 1960
(C) Chrétienbugu- Christians district
(B) Buguba : dwellings of patients’families, some former patients and manuel labourers
(I) Infirmierbugu : dwellings of Malian care-givers
(T) Out-of-town transports

Figure 2

The "lepers' quarter*": Jikòrònin-Jenekabugu* [Djikɔrɔni -Djenekabougou] (Figure 2).

Isolation

At first a place of imposed segregation, the "lepers' quarter" soon became, for its inmates, a protected and beneficial locale. The treatment centre offered them numerous material advantages: food, clothing, accommodation. The families of the hospitalised patients and those "bleached" (expression from hygienic heritage meaning "cleansed" or "without risk of infection") were lodged in the agricultural village, comprised of four quarters (500 inhabitants). The ensemble constituted a veritable small city (nursery, school, workshops, church, mosque), and the cultivated fields extended over 180 hectares (Sorel, 1938). At present, the surface is limited to that of the health-care establishments (roughly fifty hectares), and nothing remains but a quarter known as *Buguba* (Bougou-ba, the great case in "banco"). Subsequently, the Catholic mission provided a great many gifts in kind and offered Christians housing lots in the area (*Chrétienbugu*), as well as lands for farming on the banks of the Niger at a distance of about ten kilometres. Thus these advantages, combined with the local agricultural possibilities, encouraged self-sufficiency and dispelled any illusion that the persons healed and their families would return to the bush. The living areas within the precincts of the institute became overpopulated, and, until recent years, a black-market in sub-letting developed there. Since the administration of the Institute did not authorise families to become established in that location, towards 1940-45 families began to assemble in front of it. Later on, the greater number of sick persons in care, the migrations of rural inhabitants to the city (the drought of 1973) and the large number of donations and humanitarian actions furnished by the international charitable associations accelerated the process of consolidation, with the result of forming the present "spontaneous" neighbourhood, without allotted divisions, of *Jenekabugu*. The specific features of the area were exploited, with the lands of the Institute and the mission serving for the growing of millet or maize, or the creation of orchards (mango trees…); commercial relations (river, highway) with the region of the Manding Mountains, Mande (Sibi, 40 km), and Guinea are now favoured – trading in traditional products (tissues, fruit, wood, sable, gold…) or modern articles (an illicit trade – see below). Currently (in 1991, the quarter specifically for "lepers", *Jenekabugu*, is

overpopulated: its population density may be estimated at nearly 15,000 inhabitants per km2; as for Bamako and *Jikòròninin*, their populations in 1987 were estimated at 646,163 and 36,115 inhabitants, respectively – figures which must now be revised upwards (République du Mali 1987: 59 and 67).

Bad reputation

Segregation thus provided people sharing the same experience, the same trials, with the opportunity of living with each other "in their own home" within a specific territory. This appropriation of a place, well defined as a locale and easily identifiable by the rest of the city's population, allowed them to realise their social existence in the eyes of the healthy.

This identification was all the easier in the case of leprosy because the disease carries a stigma. The bad reputation of the disease and of the leprosy sufferer so-called "leper" imparted notoriety to the area. Still isolated from the rest of the city prior to the 1980s, it was and remains a territory *mabò*, "apart". This negative image has attracted the establishment of illegal trading activity – in spare parts, drugs (cannabis…), medicines such as amphetamines, hypnotics and anti-leprosy treatments (DDS – Diamino-Diphényl Sulfone) – while the dealers are not pursued by the police within the neighbourhood; the humanitarian donations (clothing) have long been the object of resale in the local market; as for the proximity of the military camp, it has fostered and sustained what, in the French of Bamako is termed the "marché mondial" (world market) – that is, prostitution. One young girl sums up the situation well enough:

> "People say that *Jikòròninin* is a 'rotten' neighbourhood – everyone says so all the time, even some people who live there. It's true – we children of *Jikòròninin*, our names are spoiled (…). In *Jikòròninin*, who are the prostitutes, the 'drogueurs' (druggers – local French)? Most of those girls come from other parts of Bamako, but they've got parents, girlfriends and boyfriends here. The girls end up taking rooms in *Jikòròninin*; they pick up men at night along the 'goudron' (highway), and who is accused? – the girls of *Jikòròninin*. They're not educated in the same way as the boys. The boys from other neighbourhoods come and find girlfriends here because where they live, it's downtown, and they can't get

> away with certain things; so they come to *Jikòrònin* because it's an isolated area where you can hide easily (…). I'm not saying that the girls don't do prostitution, but most of the girls weren't born here" (Jenejabugu, 1992)

In the 1970s and 80s, there were increasing arrivals from rural areas, and the newcomers looked for accommodation in the poorest districts: *Jenekabugu* was one of these. Thus the wave of migrants from Guinea came to be installed in the southern part of *Jenekabugu*, in the area formerly subject to flooding on the bank of the river. Poorly regarded by the inhabitants of Bamako, this population added to the bad reputation of the area, because it was rumoured to be very active in the illicit businesses previously mentioned. This part of the neighbourhood, considered the most dangerous, was called the *kafiri carré*, the "carré" (subdivision) of the "cafres". "*Kafiri*", a term of Arab origin, is strongly pejorative and not to be used in public; to the Muslim sense of "infidel" (one who does not believe in the right God) are added that of "pagan", in connection with animism and fetishistic practices, and that of the European word "cafre", expressing contempt for Africans; these pejorative connotations had their origin in the power relationship established by the Arab and European slavery systems. This metaphor illustrates the mistrust and contempt in which the inhabitants of Bamako held those of *Jenekabugu*. In keeping with this "pagan" aspect, without faith or law, all along the highway are to be found a number of bars termed "fetishist", where *dòlò* (millet beer) and alcohol of all kinds can be consumed.

This neighbourhood is also, because of the concentration of former "lepers", the place where beggars assemble, who regularly, and by turns, go into the city. Before 1980, Bamako, a modern African city, was distinguished, like Dakar, by peremptory management of the disadvantaged categories of the population that found themselves on the street. In 1972, they were labelled "human encumbrances" by L. Senghor (Collignon 1984) and for a long time were the object of enterprises specialising in so-called "riddance". In the 1970s, the Bamako railway station was the theatre of veritable "leper deportations" to the frontier. Thanks to these forced migrations, or spontaneous ones due to beggary, the "leprous" beggars and their "blind" comrades (onchocerciasis sufferers) – for they are often indissociable – have learnt to develop veritable "professional" networks. These networks are also linked to all the illicit commercial enterprises

dealing in drugs and medicines – the diffusion of the latter from treatment centres being managed by patients in the course of treatment, but especially by the health-care workers.

Thus, the bad reputation of the place has been self-maintaining but has largely contributed to an economic and social dynamism.

Opening to the outside, a dynamism characteristic of the neighbourhood

From stigma to "leper milieu" – "leper world"

The stigma has therefore engendered an entire commercial system relying on an ensemble of ties created between the neighbourhood and the city centre, but also between the neighbourhood and foreign territory. This has contributed to breaking the social isolation in which the "leprosy world" was initially maintained and has fostered an internal and external dynamism belonging to it.

We have seen how the population had made the most of the physical environment by means of cultivation for food production. The banks of the river are presently less exposed to flooding (the flow of the Niger is partly regulated by the dam at Sélingué, situated on one of its tributaries); they can be exploited and built on. Since 1983, the marshlands development projects of the principal charitable association (the French R. Follereau Association and its Malian representative) have proven to be one of the economic motors of the community. Located between the Institute and the former airfield, they have considerably expanded in recent years. Thanks to this farming, but also to the legitimate as well as illicit commercial activities previously mentioned, the market of *Jenekabugu* is reputed for the price of its products and for its growth.

In the city, apart from the beggars, we can observe other pursuits specific to the "lepers". Their activities as merchants are those neglected by the rest of the population because considered degrading: they are resellers of spare parts for cars or motorcycles, chicken merchants. Others, by contrast, are linked to the mysterious, secret, unregulated – hence potent – aspect of the disease and those afflicted with it: the main commodity is treatments (sale of traditional

remedies or allopathic medicines, therapeutic and/or magic practices), which are the affair more of the individual "leper" than of the group. Here is the testimony of a nurse:

> "In *Jikòròninin*, there were people who said they could make you rich or do you harm (…). In the year [19]82, there was an old [leper]. That man, every time he was on the trail [i.e., every time one met him], people said that he was very knowledgeable, that he had made a fortune. He fell into a coma; before his death they [people] didn't dare approach him, for they said he was a great practitioner of fetishism; even his corpse was capable of doing harm (Missira, Bamako district, 1992)

Economic dynamism implies social dynamism. There exist in *Jenekabugu*, as in the rest of the city, numerous relational networks. The stranger will not identify this particular structural property of the society, which has adapted to the modern phenomena of migrations and urban expansion, as well as to administrative and political structures. From the group of friends, the "grin", to officially registered associations, there exist various ways of forming alliances between people. These are more or less ancient, "traditional", modernised or modern: "tons" for the men, "tontines" for the women during festive occasions; associations of young people according to age; regional associations (persons who come from the same place: city or village); "clan" associations (ethnic: Bozo fishermen, Soninké merchants; castes: blacksmiths, "griots" poet-musicians, hunters…); religious, union or political associations.

Two kinds of networks are peculiar to leprosy: one linked to the health system and the other linked to charities; one may cite the most important as follows: the group of manual labourers and former patients of the Institute; the association and agricultural cooperative of the area's former patients; the association of women afflicted with leprosy; the association of Christian women of *Jenekabugu* and *Chrétienbugu*; the association of beggars. … But in general these different networks intertwine and in their informal aspects constitute extremely influential forms of power.

Despite the persistence of stigmatisation, economic dynamism and social dynamism have finally permitted "lepers" to acquire a position as a "group" and hence a certain value within the population.

A "leper" identity

Favoured by an identical experience and vision of the world, this community has developed its own sociability networks. By structuring the "individual lepers" as a "community", this interior identity has caused them to be recognised with an "identity" from the exterior as well. In a culture where the values of the individual blend with those of the group, what were initially constraints have been transformed into advantages. On the same principle as certain castes – such as the griots (*jèliw*) – by turns disdained and valorised, one may speak of a "leprosy sub-culture" with its centre at *Jikòrònin*. Although initiated at first by the social stigma, even as this decreases, these identity-related phenomena tend to persist through the micro-society of the area. They depend on the group's will to exist as such – a means of controlling its physical and social environment – a will that can only be expressed because the "lepers" have acquired an economic and social place within the society of Bamako.

In the face of changes

The urban environment, however, is subjecting this neighbourhood to spatial transformations and multiple social changes more or less rapid and important. Since 1935, the population of *Jikòrònin* has known how to face up to them; but during the last twenty years, the process has accelerated.

The spectacular extension of the outlying quarters of Bamako (such as Lafiabugu and other sub-districts of *Jikòrònin*: Dontémé and Camp-para), the improvement of the highway network leading to the downtown and the opening of the second bridge in 1992 have contributed to making the neighbourhood less of an enclave and reducing its distinctive features. To this are further added the exchanges and social links with the exterior previously described.

Violent and sudden social events may pose a challenge to such cultural sub-groups or permit them to reveal hidden social conditions. This was the case with the fall of the authoritarian regime of the 2nd Republic in March 1991. The political instability and deficiencies of the public authorities have contributed to: the collapse of the authority of the state and of public and private institutions; the development of the informal sector; the creation of numerous

associative groups; and a whole series of riots and popular movements making demands (students, unemployed young degree-holders…) (Champaud 1992).

Participating in these social events, the former patients and their families living in *Jenekabugu* also demonstrated against the institutional powers of the area, namely the Institute and the charitable association, as well as against their representatives (care-givers, administrators). Considering what had been offered them for 50 years as their due, they found in these political changes the opportunity publicly to denounce previous abuses and to demand further advantages (change in the organisation of treatment, more free medicines, redistribution of humanitarian donations). Thus the "Association des Malades Lépreux du Mali" (leprosy sufferers' Association of Mali) was created in October 1991; it is composed of sub-committees present within all of Bamako's CSC (Centres de Santé de Commune : Communal health Centers), which are accountable to the central headquarters situated at *Buguba* (*Jenekabugu* district). Their existence permits newly isolated patients to be supported in what they do and so furnishes them with a community of reference. By allowing former patients to be present in the treatment areas, this association makes them participants in the treatment and provides them with a certain right to oversee the organisation.

At *Jenekabugu*, as the first occupants of the area, the families of the former patients consider that they have ownership rights. Nevertheless, urban renewal projects begun in the 1980s propose to sub-divide this disadvantaged neighbourhood and envisage the displacement of part of its population; these have still not been realised and are being revised on a smaller scale, because the inhabitants have succeeded in applying pressure.

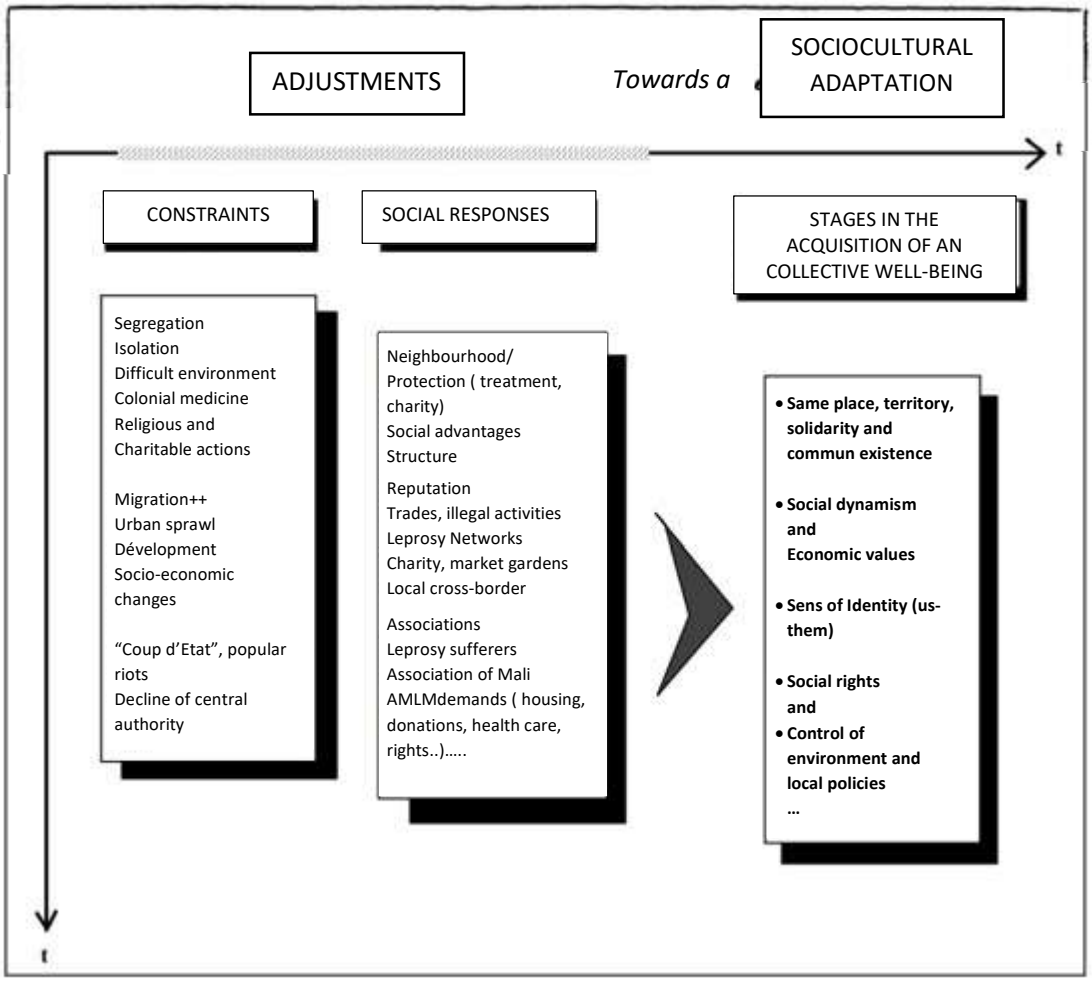
Thus, by opposing the politico-administrative structures and health-care institutions, the population is defending and demanding the territorial and social rights that it has appropriated.

Towards better social well-being (Figure 3).

The massive segregation imposed by the Europeans constituted a brutal change for the individual afflicted with leprosy; in the face of this, the adaptive response was collective. In fact, the acquisition of individual betterment can be conceived of in Africa only by way of a place

and/or group of reference. Nevertheless, to speak of the socio-cultural adaptation (rather than adjustment) of this population to its environment, I have chosen to place myself on a certain space-time level: I consider the neighbourhood within the physical and social space of Bamako, and not from the limited angle of an isolated micro-society, and I situate myself in the long term. This notion of long term (60 years from the beginning of the European segregation) is, of course, relative and must be resituated in the context of the modern African city, where human beings are generating changes that are continual, rapid, multiple and complex.

Within these mutations, constraints are presented which are, by turns, negative and positive (segregation, isolation, difficult physical environment, colonial health organization, religious and charitable actions, migrations and urban expansion, economic and political changes, etc.), and, in the face of these, the inhabitants of the neighbourhood -as social group- have been capable of responding with well-ordered choices. It is these different passages between such "responses" and "constraints" which I term "socio-cultural adjustments" – the responses being able to become constraints in their turn. These adjustments determine the successive phases of the acquisition of social betterment by the **community** and the individual "leper" (appropriation of a **territory**, of a social existence; acquisition of socio-economic dynamism and social valorisation; emergence of a sense of **identity**, of a defence of, and demand for, certain rights) – the stages of a socio-cultural adaptation in active evolution (Figure 3).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CONSTRAINTS
SOCIAL RESPONSES
STAGES IN THE ACQUISITION OF AN COLLECTIVE WELL-BEING
Segregation
Isolation
Difficult environment
Colonial medicine
Religious and Charitable actions
Migration++
Urban sprawl
Dévelopment
Socio-economic changes
"Coup d'Etat", popular riots
Decline of central authority
Neighbourhood/ Protection (treatment, charity)
Social advantages
Structure
Reputation
Trades, illegal activities
Leprosy Networks
Charity, market gardens
Local cross-border
Associations
Leprosy sufferers
Association of Mali
AMLMdemands (housing, donations, health care, rights..)…..
• Same place, territory, solidarity and commun existence
• Social dynamism and Economic values
• Sens of Identity (us-them)
• Social rights and
• Control of environment and local policies
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Figure 3

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