3. SOCIAL AND CULTURAL ANTHROPOLOGY IN MEDICINE

Colonial health care has developed over 75 years. The Central African population could meanwhile compare the advantages and disadvantages of Western medicine with their own traditional curative practices. Both systems were used to alleviate physical suffering and psychological distress. The basic differences lay in the fact that Western doctors employed more powerful means against serious life-threatening diseases and epidemics but, unlike the healers and diviners, they were not concerned to restore the well-being produced by the patient's reintegration within the family and community.

The local people as well as the auxiliary personnel wanted to test the doctor's skill and knowledge during his first months among them. They would confront him with the sort of diseases or lesions which they were familiar with but could not counteract. The young doctors were completely unaware of this subterfuge: confident of their own superiority, they could not imagine that their auxiliary personnel with only rudimentary training would be able to assess their response. Others discovered the trick, and even took advantage of the opportunity it offered to study the symptoms presented.

The result was a tacit, implicit balance between the two types of medicine, almost unnoticeable because the healers wished only to continue their traditional practice while the doctors saw the healers' limited skills as accentuating their own importance. Moreover, as traditional medical practice had been permitted from the very beginning of colonization, there were no legal obstacles to this type of African traditional health care.

The era of independence fueled a very understandable desire to revitalise African cultures. This recourse to authenticity put traditional medicine in a favourable position. Healers were encouraged to advertise, especially in the towns. The movement fostered the emergence of profiteers, skilled at finding their niche in this lucrative and uncontrolled market. The boom in the offers of authentic or counterfeit traditional medicine wiped out any demarcation between traditional medicine and its caricatural offshoots.

Traditional medicine, especially the plants used by healers, was studied by some researchers during the colonial period. This interest was linked to the age-old hope of finding a new miracle cure among these plants, quinine being the prime example. Efforts focused on ingredients supposedly effective against leprosy, various fevers and diarrhoeal diseases, were in vain. However, the research resulted in a catalogue of plants suitable for the local production of drugs described in the universal pharmacopoeia and, secondarily, for the discovery of new active ingredients.

By contrast, modern medicine in no way encouraged interest in the major rites of traditional healing. Anthropologists are currently striving to fill this gap. The rituals practiced in a large number of African regions are currently under study; and it is interesting to return to the sources of our own medical approaches by studying some of the leads contained in Africa's cultural heritage.
The relevance of this research has been demonstrated in the field of mental and psychosomatic diseases. These disorders are linked to a great extent to the sociocultural context – a territory which, like its uncertain boundaries, remains difficult to access. The most singular and least explicable manifestations of human well-being are found in this area. As there is only one mankind, some of the associations between modern and traditional medical methods must necessarily have a wider impact.

One phenomenon that has grown surprisingly in recent years is the proliferation of healing churches. They stem from the syncretistic movements which, under the colonial regime, were seen as anti-colonial and promoted traditional values. These messianic movements have become transitional havens for the growing numbers of urban and suburban refugees of all parts of society, offering them the possibility to recover physical and relational security; this constitutes a safe environment, from which their life-force can flow.

Social anthropology explores the peculiarities of African cultures and yet connects it with the transcultural values in mankind.

I. SOCIAL, CULTURAL AND MEDICAL ANTHROPOLOGY IN THE CONGO AND ZAIRE

When the term anthropology was forged it had a very general meaning that drew a distinction, in both English and French, between the science of the medical man and that of geography. As a result of this wide scope, countless specializations and different terminologies emerged.

While medical and cultural anthropology is currently in vogue, it is not new. It has roots even in the pre-anthropological sciences of otherness or alterity and the ancient Greek authors such as Herodotus, Xenophon (*Anabasis*), and Aristotle who, as Alexander's tutor, came in contact with the peoples of Asia Minor, the Middle East and India. Pliny the Elder, who wrote the first encyclopaedia of the natural sciences, may be the most interesting predecessor. The Byzantine era was followed by Arab authors such as Masʿudi, who described in his *Golden Plains* the Africans and Africa, and particularly the Berber Ibn Khaldun, from the Maghreb, who drew attention to a form of ecological determinism in his *History of the Berbers*. The Renaissance was marked by the discovery of new worlds and horizons. The searches for a passage to the Spice Islands led to the discovery of exotic places whose strange inhabitants fascinated the navigators. The accounts of the great explorers Houghton, Mungo Park, Horsmann, Cook, Bougainville and many others contain a wealth of anthropological information. Fast on their heels followed the notion of the noble savage; and the respective values of Western and non-Western civilizations were questioned.

In 19th-century Denmark the term ethnography referred to a simple description of the customs and religions of a population. Its meaning changed gradually to that of descriptive study. The risk at that point was to be carried away by exoticism and folklore, for the customs and traditions of peoples living in unfamiliar environments can easily lead observers to become collectors of differences as defined by their own cultural narcissism.

The term ethnology, as used in France, connected this science with the history of human groups (mainly non-literate, traditional societies) and linguistic changes. After a period dominated by philosophical discussions and a return to anthropology under Broca, attention focused on the need to produce a synthesis of the facts described for various cultural groups, notably their anatomical and physiological features and social and cultural traits.

Poorly-defined boundaries bolster terminological confusion and disputes over vocabulary. In the English-speaking world ethnography began by dissociating itself from anthropology, only to encompass social anthropology again at a later date.

It was up to ethnology to try to make some sense of the incomplete data resulting from the diversity of cultures and variability of human beings over time and space. The incorporation of such data in a well-structured system would take some time.

Ethnology has become a highly disparate assembly of diverse disciplines that can nevertheless be classified as either natural or social sciences, each with its own methodology to allow objective comparisons. Physical anthropology covers anatomy, physiology, heredity and genetics, anthropometry, and ethnopaleontology. Social and cultural anthropology in its narrow sense encompasses the study of social and cultural life of various communities including language, demography, economics of production and exchange, law system and jurisdiction, as well as the study of psychological reality, art, music and healing. Participant observation has been the distinctive attribute of the anthropologist.

In the Anglo-Saxon countries and in international publications the term socio-cultural anthropology has gained acceptance. In the work, we shall speak of social and cultural anthropology.

HISTORICAL BACKGROUND

1. The beginnings

Social anthropology or ethnology developed as such only during the late colonial period. However, this science is greatly indebted to the many expatriate administrators, magistrates, officers, missionaries and doctors, whose patient and selfless observations emphasized their real attachment to the populations they served. Many of these expatriates showed themselves capable, in the interests of objectivity, of superseding their own perceptions and attitudes in order to gather complete and unaltered facts about traditional behaviour. These assiduous observations, which continued for long periods, are of considerable value and differ greatly from those of tourists and of the exotic journalists.

These anthropological data cover a wide range of areas, such as customary law (land distribution, ownership); marriage customs (laws of exogamy, endogamy, polygamy); matrilineal and patrilineal systems and their combinations; births; the significance of twins; initiation rites; naming; mortuary rites (funerals, tombs); ontology; ancestor worship; sacrificial rites; myths and legends; magic; totems; taboos; pets; diet; hunting; fishing; the arts (sculptures, musical instruments, headdresses, tattoos); the types of housing and their internal arrangement... in fact, the whole range of human activities. Each investigator's interests and observations related to one or another of these themes.

It would be a mistake to underestimate this contribution on the pretext that it was collected for utilitarian reasons and under a colonial regime. For some analysts these data are above all signs of the colonial tensions and conflicts and are thus ambiguous. Actually, the observations were inspired by the Latin proverb *Homo sum: humani nil a me alienum puto*, "I am a human being, thus nothing human is foreign to me".

2. The achievements

Belgium has a long tradition of anthropology in Africa. The ethnographic data collected by the Central African Museum in Tervuren (near Brussels), for example, date back to 1897.

Considerable research was conducted by the Solvay Sociology Institute, particularly its Solvay-Congo unit; the Colonial Royal Institute (1928) which became ARSOM (Royal Academy of Overseas Sciences) in 1956; IRSAC (Institute for Scientific Research in Central Africa) and various Belgian university foundations (FOMULAC, CEMUBAC and FULREAC, Ganda-Congo, of Louvain, Brussels, Liege and Ghent universities respectively); and the Ghent University's seminar for African cultural history. A team of researchers and experts helped gather, analyze, and draw interesting conclusions from a wealth of invaluable information. Their activities have increased since the end of colonization and have earned an excellent international reputation.

Human geography or anthropogeography basically catalogues facts and displays them in map form. Such information was collected from traditional and pre-industrial societies during explorers' trips and surveys. These data reveal their true significance only when examined within their own geographic and biological context, in other words against the same background as that of the societies in question. Moreover people change their spacial environment through their dwellings and their various activities. The geographer's role is to determine the relationships between the natural background and the current lifestyle, to ask questions which will adequately establish the causes and motivations in order to formulate working hypotheses and to propose solutions. This broader notion corresponds to modern geography and is the basis of human geography. Such an approach necessarily increases the points of contact with other fields, notably sociology, economics, linguistics, history and major health problems.

Although this field of applied geography differs from ethnology and sociology, it maintains so many links with them that the demarcation is sometimes blurred.

MEDICINE AND CULTURE

This relatively new field of science is hard to define because it comprises the natural and social sciences indispensable to grasp the physical and cultural diversity of groups seen in relation to their cultural and ecological niche. Social and cultural anthropology must thus take into account many peripheral fields ranging from anatomy to sociology, psychology, linguistics and economics.

1. Medical anthropology

Each human group has developed a tradition of healing arts, by convention labelled *traditional or popular medicine*, which enjoys constant media coverage. *Cosmopolitan* or *scientific medicine* firmly opposes all so-called *popular* forms, including many aberrant practices. Medicine springs from the human instinct to treat and prevent diseases, and has evolved considerably over the centuries. The fundamental rules of medical practice arose from the rites and practices of archaic medicine. Throughout history, scientific medicine has been linked to the attitudes of its time. Only its hostile reaction towards earlier and non-scientific practices has remained constant.

1.1. *The culture shock for young Western doctors*

The colonial doctor was working at a time when medicine was driven by the enthusiasm which microbiology's early successes and the birth of chemotherapy engendered, seeming (as they did) to promise the

imminent discovery of an absolute weapon against infectious diseases; so it is hardly surprising that he turned away from traditional and archaic medicine. Moreover, the civilizing mission these doctors had assigned themselves required that they should westernize, and eradicate harmful customs and practices. It was fortunate – and striking – that the governors and legislators of the Belgian Congo had the wisdom to recognize the presence of traditional healers and to accept that they might continue their activities, subject only to the international rules of public order.

1.2. *Different types of health care*

A comparison of scientific medicine with traditional health care, or of biomedicine with holistic, traditional medicine, cannot ignore their common origin: man's distress when faced with disease and death. The first mainly and primarily deals with disease, the second with illness understood as the interpretation a patient or his group offers of the origin and significance of being unwell.

1.2.1. *The diversity of traditional health care*

Healers and bone-setters are common in all groups. Their presence makes up for the weaknesses (real or supposed) of scientific medical technology and lessens consequent dissatisfaction. Traditional medicine is practiced in the realm of traditional world views that emphasize the life-force and its dynamic power, the intervention of magnetic or cosmic waves, and other similar phenomena. These techniques belong to practitioners endowed with the charisma to apply them; and many are said to draw on a so-called natural medicine resting upon a doctrinal point of view that advocates a return to nature. This medicine parallels that of Hippocrates in its use of dieting, fasting, and abstinence to limit the presence of metabolic wastes in the body and to promote the elimination of such residues through sweating, purges and bleeding, the overall aim being to restore the body's equilibrium.

There are more than 100 different types of *popular and alternative medicine* and their number is growing. They emerge and re-emerge under increasingly attractive forms and names. Acupuncture, anthroposophy, astrology, gold therapy, chiropraxis, clairvoyance, the laying-on of hands, iridoscopy, etc. – the list is constantly increasing, especially in the industrialized countries.

Contrary to common belief, the executives, managerial staff, business merchants, traders and employees, make up the bulk of the clientele, rather than the manual workers and peasants.

Some categories of natural medicine – hydrotherapy, balneotherapy, the Kneipp system, and Moerman diets (a Flemish healer prescribing special diets) – are practised under the wing of orthodox medicine. It is often difficult to determine the degree of deviation in these practices. Hahneman's homeopathy tends to come the closest to biomedicine. Its foundations are somewhat weak, since they are built on erroneous theories, but it does contribute some important elements. For example the care given to examining the patient creates a climate of confidence, and becomes the complementary proof of the existence of a placebo effect observed during well-planned treatment trials in which 35-40% of the patients receiving inert substances responded favourably and 70-80% of the disorders were immediately cured.

One may wonder where Freudian and Jungian psychoanalysis should be classified. Part of the success of alternative medicine probably lies in the anti-culture, anti-science, and anti-technology tendencies. The search for alternative lifestyles falls in line with a healthy ecology and a general renewal that strives to combat the depersonalization affecting man in the megapolis or high-tech society.

WHO, whose role is universal, tries to standardise public health doctrines and techniques worldwide. However the extreme diversity of the situations, cultural attitudes, and budgetary means cause many obstacles in the implementation of its programme. Consequently it would be a mistake to lump African traditional medicine, Chinese medicine, Ayurvedic medicine, the *Unani Tibb*, and the archaic medicine of the Latin American *curanderos* all together under one name.

On the other hand, to consider that many Third World countries have no other alternative but to resort to traditional medicine is a sophism, for it amounts to legalising all healers. An approach that puts charlatans and professionals under the same heading can only benefit imposters and adventurers.

Rural communities had no need for others to identify for them ancestral medical practices and to distinguish these practices from sorcery. Yet the more recent proliferation of amulet sellers in semi-urban and intercultural contexts, whose market stalls offered a range of objects (plant detritus, feathers, broken bones, monkeys' skulls, insect carapaces, shards of pottery, powders, etc.) defying the imagination, was likely to offend a form of medicine with undeniable cultural roots.

1.2.2. *Traditional medicine on other continents*

Chinese medicine can refer to a long experience codified in the *Canons of Medicine* or *Nei-Ching* written

some 500 years before Jesus Christ, under the Yellow Emperor. Based on about 300 symptoms calling for very elaborate examinations, instructions for hygiene and techniques such as the moxas and acupuncture, this medicine is practised by more than 300,000 formally-trained practitioners working in more than 500 traditional hospitals and in allopathic hospitals with departments reserved for traditional medicine. These arrangements facilitate contact with biomedicine, which has led to some very useful discoveries such as that of the antimalarial properties of qinghaosu, whose active ingredients were isolated by modern pharmacological methods and assessed by scientific procedures.

Ayurvedic medicine has been part of life in India for close on 3,000 years, but written information about it is more recent, and appears in stanzas of the Charaka and Shushruna. One Upanishad contains the doctrine of Indian traditional medicine. Diagnoses, reached by a specific, thorough and careful examination, determine subdivisions into various branches or specialities: internal medicine, surgery, paediatrics, ophthalmology, ENT, psychology, geriatrics and toxicology. There are three types of practitioners: healers who have learned by traditional methods, practitioners who receive three to five years of extensive training in one of the country's 150 or so Ayurvedic medical schools, and conventional doctors who undergo complementary training in Ayurvedic medicine. The fact that these two types of medicine are practiced side by side offers mutual benefits. Of course there are also other types of traditional medicine on the Indian subcontinent, such as Siddha (an astrological medicine of Dravidian origin).

In the Islamic countries, especially Pakistan and Saudi Arabia, attempts to renew medical traditions are currently under way. The tradition of the *Unani Tibb* (Arab doctor) is rooted in the Arab medicine of the 11th to 13th centuries inherited from the Greeks. Its practitioners are trained in medical schools, the teachings of which derive from five volumes of Avicenna's *Canon* and the writings of Averrhoes and Maimonides. This is a reinterpretation of the theory of the four humours and four temperaments. Traditional healers, whose prescriptions begin with "*Hovash lafi*" (God is the healer) and who seek their inspiration in the surahs of the Koran, are always consulted.

From 8 schools in Pakistan 6,000 students have qualified, but this is a very small number among the 350,000 or so practitioners without degrees. Their knowledge of medicinal plants is remarkable.

1.2.3. *Traditional African health care*

Traditional African medicine takes us back to the roots of our own conventional medicine; it reveals basic human components in the practice of modern medicine, whose scientific concern with the order of facts tends to overlook its human aspects and man's subjectivity.

Conventionally trained doctors despised the so-called "bone-setters" now known as traditional healers. This contempt stemmed from the usual prejudices of all fraternities and cults, and also served as a pretext for stressing the risks inherent in the use of native remedies whose ingredients were secret, variable and unjustifiable. Moreover it served as an outlet for the frustration caused by the inevitable failures in treatment when serious cases appeared too late.

a) Medicinal plants and dramatic methods

The rare observations made of traditional medicine have focussed too much on the description of the exotic or even too exclusively to *medicinal plants* and their use.

A major motivation was the hope of discovering a new active ingredient in these plants, following the example of the drugs obtained from Latin America.

Another focus concerned various ingenious and *dramatic methods*, such as using ants' pincers to close wounds, applying unusual suction cups, scarring with raised tattoos, and the evacuation of pathological fluids using the clean inner stem of a blade of elephant grass that was bevelled and then inserted through a cutaneous incision made with the tip of an arrow or spearhead heated red-hot in a fire. Some Babira healers were past-masters in the art of evacuating pleural effusions in this way.

b) Psychosomatic background

The undoubted value of traditional medicine was demonstrated in the area of psychosomatic disorders. The competence of Western medicine in this area is roughly limited to disorders with an organic basis. Sleeping sickness is the main example. Psychosomatic disorders *per se*, however, are well beyond the scope of European psychiatrists, who have at best an incomplete or inaccurate knowledge of African mentalities and customs. The transaction between intrapsychic forces and group dynamics is a situation still difficult for the Western doctor to grasp and handle.

Traditional psychiatric healing was quickly recognized by Western opinion, not so much for its fundamental merits as for its spectacular results. The terms *amok*, *latah* and *koro* respond perfectly to the expectations of those possessed by the demon of exoticism.

Thorough analysis of specific cases reveals how Western observations stem from their own scientific perspectives and are far too limited, fragmentary and

external, leading inevitably to contradictory interpretations. It confirms the self-limitation of the Western approach to fully evaluate traditional health practice and healing. The healer-patient relationships, on the other hand, are rooted in the sociocultural context. This guarantees a holistic approach, which should be much in evidence where community life is intense and more in focus than the separate position and make-up of the individual.

Thus the fundamental problem arises of what is normal and/or abnormal in terms of general criteria for human behaviour. Maladjustments and deviations from the behaviour-pattern of a given community can lead to mental disorders, the subtlety and apparent irrationality of which baffle Western-trained psychiatrists. At this stage a deeper understanding of the fundamental problems is important, since the development of new drugs with a wider psychotropic action will never be more than an adjuvant factor.

c) Research into the cultural diversity

Ethnologists have recently striven to uncover the general bases of traditional medical systems, in order to acquire not an overall view but a better understanding of how they are interlinked with specific cultural principles. The substratum of this type of medicine is composite, encompassing the ailment and the means of treatment as perceived by the people as well as the role played by social and political customs and practices. The recent contributions regarding Zairean cultures and on the Ngbandi medicine of G. Bibeau (1982) and those of R. Devisch and S. Mbonyinkebe (1985) on Yaka medicine provide extremely useful keys to a better understanding of the cultural substratum of traditional medicine (see also pp. 52 to 61).

Among others, the concepts of cultural groups in Mali and Uganda also shed light on these cultural roots.

1) The *Bambara* of Mali use a cosmological or symbolic approach based on the equilibrium of the four elements, clearly stemming from the antique concept of Empedocles, inherited from Sumerian medicine; this concept influenced the ideas of Hippocrates and dominated Western medical thinking until the 19th century. Thus the Bambara associate the air with skin disorders and respiratory diseases.

2) The *Baganda* medical system (in Uganda) relates diseases to certain parts of the body and classifies them according to three criteria, namely whether they develop spontaneously or are sent by the spirits, are harmless or serious, and are of foreign or *kiganda* origin. In contrast, the Shona of Zimbabwe name the disease on the basis of the symptoms that develop.

This option, called the biocultural option, selects the names of diseases within a multidimensional framework on the basis of six elements: the *site* of the complaint (for example the skin); an *appearance* resembling elements of the plant or animal world (fish scales, pig skin); a dependent *relationship* between the *symptoms and signs* (itching, lack of feeling, leprosy); a *causal relationship* (sweating, bathing, punishment sent by the spirits); a correlation with *the type of treatment* (stiff neck and a spear); and the *failure to observe a general rule* (for example the resumption of sexual relations too soon after childbirth); see also p. 56.

This system, which attempts to establish the cause of the disorder, is not devoid of interest, for in seeking the cause of the complaint it draws a distinction between the *how* and the *why*. The former concentrates on everything within the realm of the five senses, the latter on the role played by sociocultural factors and magic thought.

3) The *Ngbandi* system of medicine (in Northern Zaire) draws a surprising but unequivocal distinction between diseases and commonplace complaints. The latter fall exclusively in the sphere of family medicine and, as such, their treatment relates to universal practices. Diseases, on the other hand, transcend purely physical disorders, to enter a realm comprising sociocultural influences, politics, and beliefs. This complex situation covers four levels, closely connected: nosology, causality, knowledge of the individual, and therapeutic practices.

The perception of the basic cognitive principles must be sought in linguistic or ethnosemantic data and behaviour-patterns. This information immediately reveals that Western medicine has no equivalents for the Ngbandi notions of disease, medication, care, and cure or recovery. In the Ngbandi scheme, a disease involves not just the body but daily life as well. Curing a disease means restoring order. The healer purifies and heals. The therapeutic substances may be medicinal plants, products of animal origin, inorganic matter, and even protective objects (such as amulets) belonging to ritual practices.

The Ngbandi give each disease a name combining biomedical and psychosociocultural elements. A nosology based on such a wide variety of elements is disconcertingly rich. When the terminology and classification of diseases are based on an association of symptoms and causes rather than on the aetiology, a great disparity of names for one and the same disease is inevitable. Thus the Ngbandi language contains more than 1,000 names of diseases.

It is worth examining the process leading to this great diversity in the Ngbandi's aetiological approach.

The chain of speculation starts with an initial cause that may be a faulty action by the patient himself (breaking a taboo, violating custom, insubordination within the family or tribe, theft, refusal to share, jealousy, anger). These various faults trigger a search for the main causal agent: a supernatural being (see II, 4 the Ngbandi on p. 55) or spirits who activate the more or less visible causal agent; and such interrelationships give rise to an *aetiological axis*.

The process starts on a socio-psychological level, evolves towards a biomedical aetiology and draws attention to meta-empirical factors, such as spirits and magic allowing the patient to transfer an internal conflict to an external agent. This is of great help to many on the road to recovery.

The causal agent can intervene in many ways. The natural spirits engender anxiety, the supernatural spirits a feeling of guilt; spells cause aggressiveness, sorcery, envy and jealousy. Magic can involve practices that override all other methods, but they may sometimes boomerang.

4) These aetiological patterns are found in the philosophy of the *Yaka*. Disorders concerning the senses have no particular aetiology and are solved by treating the symptoms. However wounds, hunting accidents, and so on may be interpreted as bad-luck diseases, connected to evil influences (the *evil eye*). Consequently such an illness will concern the family group, which in turn will rely on divination and oracles. The various types of diagnosis based on divination have been studied extensively by R. Devisch (see pp. 55 to 57).

2. Aetiology and forms of divination

The diviner is selected according to a very strict criteria and undergoes a well-codified initiation. The choice of an acceptable replacement for a deceased diviner depends on the candidate's ability to go into a trance or be possessed and to make contact with his ancestors in his sleep.

Predispositions to epileptic attacks are favourable signs. The candidate undergoes nine months of initiation under the guidance of a master diviner checked by anonymous patients; these have to ensure that the candidate is genuinely clairvoyant and that no fraud is involved. In the final test the candidate must also be able to identify a *mediating object* that has been placed in contact with the body of the absent client and detect the basic elements of the consultation. He must then be able to apply an aetiological grid to messages received in dreams (oneiric messages). To interpret this information he will be plunged into the ethos of the lineage, involving the delicate patrilineal relationships with their statuses and social privileges, as well as matrilineal kinship over the past three generations.

The oracle may return to the past to reveal criminal acts, misdeeds, and curses perpetrated or uttered in the past, and to pronounce judgment on the different stages of life. He can decide the terms of compensation to be paid to the family on the matrilineal side, especially to those governed by the avuncular system in which the first uncle presides.

3. Group therapy and restoration of social order

The aim of this treatment is to rearrange the various natural and supernatural elements in order to restore the traditional social patterns.

The cause of the disorder has multiple facets, and Western medicine has no equivalent for the way in which a disease is related to its origin. The cause is social and cosmological, stemming from an activity forbidden by custom or from the weakening or termination of the life-force. A biomedical aetiology, when accepted, still remains subordinate to the initial sociopsychological cause.

The cause is detected by divination and rites. The diviner listens to the patient as a physical, mental and emotional whole, within the context of his social relationships and subject to cosmological influences; and to this end uses incantations, dances, smoke, trances, and other rites.

Treatment has several phases. The procedure is set in motion by the maternal uncle, who settles all debt problems, releases the patient from the onus of ritual errors and the breaking of taboos, and lifts any existing curses. Then it is the turn of the therapist, usually someone who has previously been cured of the disease in question. Thus he can reproduce its symptoms by going into a trance, can establish a formal link with the patient, and can apply the curative methods which he himself received.

Even without further detail, it seems at the very least unlikely that a Western doctor could fit into a process with such constrictive Black African norms.

The diviner is considered competent to solve a wide range of problems. Thus he is consulted for persistent, malignant and supposedly lethal diseases, reproductive problems, sterility, skin diseases, and noticeable and rapid weight loss; also to dispel bad luck in hunting or finding a job, or in cases of a fire, theft etc. The return to normal involves the judicious implementation of exchanges, in other words compensation in the form of a gift.

4. Coexistence with scientific medicine

While the foregoing provides only a glimpse of the problems of medical anthropology, it shows that medical practice in general, and not just ethnopsychiatry, could benefit from knowledge of these ancestral practices. Indeed the ability to project human problems onto complaints is never superfluous; but a great many investigations must still be conducted in various societies in order to discover the general rules of this medicine. In addition, modern medical thinking, as it developed over the course of history, must be confronted with this information, and attempts should be made to adapt Third World medical practices accordingly.

4.1. *WHO policy*

WHO (the World Health Organization) is of the opinion that the developing world needs a combination of traditional and modern medicine. This synthesis is occurring in various forms of Eastern medicine that rely on training institutes teaching the canons of each form of traditional medicine. The substratum that would allow such a synthesis with African traditional medicine unfortunately does not exist.

The renewed interest advocated by WHO in traditional remedies, especially medicinal plants, is thus feeding the hope of discovering one or more *miracle drugs*. This appeals to Western pharmacologists, ever on the look-out for new molecules. Serpasil is just one example. Another is the traditional Chinese antimalarial, qinghaosu, from which other artemisine derivatives have been developed. The Mexican practice of applying spider webs to the umbilical cord continues to raise eyebrows, although the strands of silk allegedly have antibiotic properties.

WHO also hopes to incorporate traditional practitioners in primary health care systems, and plans to retrain healers to this end. There are two prerequisites: to specify the type of healer sought, and to obtain his/her consent.

4.2. *The importance of thorough studies*

The major advantage of a thorough and objective knowledge of traditional medicine is without doubt the possibilities it offers for retracing the very source of man's attitude to disease and death. The feasibility of collaboration in the sphere of psychiatric medicine has been determined; but a realistic basis for cooperation in other fields has not even been planned. Meanwhile, the notion of *disease* and the principles of *causality* could provide general pathology with new concepts.

The rich ancestral experience rightly attracts the attention of medical anthropology. Observations by medical anthropologists have shown the fundamental factor in traditional culture to be that illness is linked inveterately to a cause. In such systems, illness includes various alterations of an individual's state of health, such as systemic involvement, localized complaints, and mild discomfort or indisposition. It is not an isolated concept corresponding to a precise, limited aetiology, but a familial and social health-change. Traditional medicine deals with serious, often chronic, illnesses. Identifying and describing the disease precedes the search for its cause.

Efforts to recognize healers' activities and to induce doctors in tropical regions to practice them have produced results. The doctor working in traditional communities knows very well that, apart from emergencies or cases of coercion, no patient consults him for a serious or chronic ailment without having first obtained the blessing of the local diviner. Traditional practitioners are mainly concerned with chronic disorders, against which modern Western medicine rarely possesses the effective procedures it applies to acute disorders; or else the local healers deal with illnesses for which conventional doctors show no interest. This proves that the community can be given the care it desires without the one side trespassing on the other.

4.3. *Cooperation between traditional and modern medicine*

a) A point where traditional and modern medicine can constructively meet is in those mental illnesses whose sociocultural implications the conventional doctors in tropical regions feel unable to interpret correctly. The criteria and boundaries for this collaboration have been easy to establish, and the move from the hospital to the healer's village is smoothly accomplished. No other field of medicine in which such collaboration would be useful and desirable has so far come to light.

The synthesis advocated by WHO cannot be implied immediately, assuming that it is realistic.

b) Healers benefit from traditional legitimacy in their society. Recognition of their abilities by the relevant authorities gives them only formal satisfaction, and they are well aware that secrecy offers financial rewards.

It is impossible to predict to what extent qualified healers will agree to work within the primary health care system, an arrangement that would first of all attract adventurers and quacks.

c) Some phytotherapists (see the chapter Herbal medicines) have proved appreciative of Western health systems, and have provided the ingredients of their concoctions with instructions for their use in exchange for payment. Aware of the benefit they could find in a more correct dosage for their powders, brews, and purgatives, they hope to avoid errors by obtaining more precise information about the amounts to use. They may well realize also that, if one or another of their medicinal plants turns out to contain some compound of interest to the pharmaceutical industry, demand for the plant may open up a profitable market.

d) The bone-setters, who reduce fractures and dislocations, puncture the pleura, extract Guinea worms and sometimes chiggers or fly larvae, and dress wounds, will certainly not object to the use of internal and external disinfectants to improve their results. However, their role in primary health care is not a priority.

e) Village midwives realized long ago that the Unicef midwifery kit and similar aids gave them considerable advantages in assisting deliveries and competing with midwives from the state health services. Improving hygiene through the use of a washable plasticized sheet, scissors, ligatures for the umbilical cord, disinfectant and soap raised their status, and ensured a more lucrative practice. Moreover it is obvious that their help can be enlisted in administering tetanus vaccinations, as shown by the example of Sierra Leone.

5. Folk medicine within primary health care

The inclusion of traditional practitioners in primary health care services requires first that WHO should specify the type or types of healers to be chosen as collaborators in Central Africa.

Chinese acupuncture, which is taught in many medical schools in the United States and Europe, or Great Britain's itinerant Ayurvedic healers do not seem to be very acceptable examples. More recent WHO technical reports will undoubtedly define the limits of and the needs for this inclusion.

Meanwhile, the number of institutes for research into traditional medicine is growing. They are collecting data and therapeutic substances, but staff turnover is too rapid to ensure continuity. What is important is that such bodies exist and will inevitably be better utilized in the future. The most pressing need is to increase the number of investigations as discussed in the following contribution by René Devisch and Mbonyinkebe Sebahire.

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