THERAPY CHOICE, UTILISATION, AND SATISFACTION BY LOW BUDGET HEALTH-SEEKERS IN SUBURBAN AND RURAL BANTU AFRICA

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INTERLOCKING CHALLENGES

The annual UNDP human development report and the annual UNICEF state of the world's children speak of the state of poor health in many parts of suburban and rural bantu Africa. Other than general surveys regarding the health situation, up-to-date information is lacking. In addition, we can make inferences about the state of health in many African countries, from community or household studies and from data regarding health service providers (health stations, clinics and hospitals). Most African capitals or urban centres show a pluralism in medical practice of interregional and intercontinental cultural influences moving at different speeds and on different socio-economic levels. The suburban and densely populated rural areas (increasingly engaged in agricultural production of export crops on poor land) desperately struggle with problems of malnutrition, sanitation and health care infrastructure, alongside pervasive addictive drug abuse, sexually transmitted diseases and violence. All these problems are increasingly spinning out of control or being under-recognised by any kind of public institution.

1. Institutional challenges

Since the 1980s, the proportion of public resources budgeted for health (like those for education or the social sector in general) has been drastically reduced to less than 4 percent of the GNP in most African countries, mostly in favour of different kinds of nation-state building projects (including national elections, military expenditures) and so-called higher-return (that is, productivity- enhancing) activities. Yet we continue to see how, in many underprivileged areas, the externally-financed and established religious institutions (Christian, Muslim) and NGOs increasingly develop and/or co-ordinate privately-operated medical care

systems. A small number of well-stafed and well-stocked private clinics continue to serve the well-to-do minority and expatriate personnel in the down-town and affluent residential areas. In contrast, the squatter zones that have developed over the last decade have been completely neglected, while the older suburban townships have only a minimum of good primary care centres and a few efficient polyclinics at their disposal.

Most countries are faced with the difficult question as to how to guarantee both community health care services and a nationally-run curative health care system that remains affordable for the State and equitably accessible to the communities it serves. The much broader question is also raised as to the appropriate reforms necessary to improve nutrition, provide more accessible school education (in particular for girls, those who are mothers-to-be and thus responsible for the health of the coming generation), or furnish sanitation for the suburban zones of habitation.

Over the last decade the sanitary infrastructure as well as the biomedical preventive and community health care services in suburban and rural areas have severely declined in quantity and quality, due to deteriorating living conditions and the total collapse of state services. Generally speaking, the national health system is in any case incapable of coming to terms with a high rate of demographic growth (partly due to urban migration) and the poverty-linked diseases of infection and malnutrition. In the underprivileged areas, people no longer invest their precious cash in prophylactic measures against malaria, or spend it on firewood for cooking the often contaminated drinking water drawn from common wells. Here, malaria, tuberculosis and typhoid are endemic, air and soil pollution are high and ever increasing, and insalubrious housing and soil erosion are spreading rapidly.

Even security and peace in residential areas are increasingly being put in jeopardy in many regions because of ethno-political conflicts or changing land rights. The situation is steadily worsening in many African suburban and rural areas: there are now more than six million refugees in Africa (one third of the world's refugee population), and at least three times as many internally-displaced people.

1.1 Disconnected and competing health care systems are the most problematic aspect of the institutional health care situation in many parts

of suburban and rural areas as concerns the disparities and hostilities between the various health care systems or resources accessible to low-budget health-seekers. Numerous forms of folk healing are available from both initiated and self-made healers belonging to the Bantu-African therapeutic traditions (Janzen's expression: 1989). Charismatic faith healing is also offered by numerous Pentecostal congregations and hundreds of independent communities often designated as independent prophetic churches of the holy spirit; they surreptitiously integrate a logic of cult healing or ancestral references, albeit without mentioning these. Patients tend to circulate between at least three different health care settings, each one unfortunately possessing its own set of quacks in its margins: 1) the medical health care establishment and pharmacies, 2) folk healers (initiated cult healers, self-promoted healers, and herbalists), and 3) faith or spiritualist healers of the independent charismatic healing churches, in line with both Christian and ancestral traditions. These three settings form part of, and are embedded in, different cultural rationals, sociologies and psychologies; they operate according to different etiological, transactional and solidarity registers as well as according to different understandings of the human body and of the origins and sources of good health and disease, sickness, or illness.

In the minds of those who seek and provide such forms of healing, health and illness not only touch upon a state within one's own body but also concern relationships between members of the kinship group, as well as between these persons and the world of ancestral and cult spirits. From their perspective, health and illness have to do with fields of forces in and between persons and a type of socially-constituted, culture-and site-specific knowledge, dialogical discourse, practice and interaction. This type of contextual and culture specific aetiology is inaccessible to the biomedical paradigm, for it has no recourse to metaphor and a proper hermeneutics of embodiment of cultural meanings.

The knowledge, decisions and dynamics which inform strategies of consultation, and the habit of health-seekers to switch from one field of health care to another may well depend on the specific dimensions of an aetiology offered by family elders or significant others (for example, through divination or revelation in a healing church), and dealing with the social stigmatisation of particular health problems or injuries, as well as with the client's expectations, economic and family situation. Health

related decisions involve culture-bound values, interests, and perceptions of power. They entail, moreover, narratively and dialogically organised forms of knowledge, and embodied and practical forms of remembering (Antze and Lambek 1996). There is still a considerable gap in our knowledge concerning the daily health behaviour and health-seeking practices of suburban and rural people.

Of these three popularly recognised and utilised systems, only the biomedical services of a postcolonial heritage have been supported by the State and institutionalised in the form of a public health care system. In Lesotho, Nigeria and Zimbabwe, however, there is a search for a centrally-directed institutional co-operation, negotiation or joint effort between the biomedical services and those healing traditions stemming from African civilisations. A few medical faculties have begun to pay the attention due to these African civilisational traditions of healing: as in some other university faculties, a few colleagues in particular in psychiatry and public health have begun to raise the question of the endogenisation of knowledge in this domain as well. Yet in most biomedical settings, the health-related knowledge of patients and their various strategies and modes of health-seeking, as well as the expertise of healers and their specific contribution to public health, are as yet largely overlooked by governmental and private, mainly church-based, medical and sanitary programmes.

1.2. Prioritising the key problems

In many parts of Africa, the gap in the general consumption level (of cash goods, paid services) between rich and poor, have and have-nots is increasing. Particularly in the suburban and most densely populated rural regions, the poor face ever more profound severe problems of sheer survival. For this reason, the health problems of the very poor in numerous areas may perhaps not appear to render a true account of the health situation, on average.

In the poorer households, child mortality rates may reach 155 per thousand or more, a figure around three times that of the better-off.

A balanced allocation of infrastructure and expenditures between specialised hospital care and primary or community health care (PHC) still has a long way to go. International evidence shows that the benefits of

PHC far exceed those of hospitals; the cost of training for medical doctors is three to four times that for nurses whose output in primary health care, however, may be close to that of a doctor. Yet the decentralisation of health services is complicated politically, since senior hospital doctors in the capital and major centres are often political the most influential. This is not to question the importance of hospital medicine. Indeed, the proximity of a hospital, that is, the possibility of referral, makes a visit to a lower-tier health facility potentially more valuable. However, a hospital at the apex of the local health system should perhaps take up the roles of quality control, training and professional networking.

Does the answer lie in the privatisation of hospitals and of the provision of pharmaceuticals? The hospital system is well-suited to privatisation. The organisations are sufficiently large, and close to self-financing. The private hospitals tend to have higher doctor productivity and a better mix of staffing. The needed improvement in access for the poor can be achieved independently of whether hospitals operate in the public or the private sector. At present, some regions build private medical health care and pharmaceutical provisions into their health planning (WHO 1993).

The cost of treatment massively increases when pharmaceutical products are available only by medical prescription, thus implying the cost of a visit to the doctor.
Locally organised and voluntary health insurance schemes for hospital treatment are being set up by funeral societies, or by NGOs, in some regions (Ahrin 1995, Benoist 1993, Criel 1998, 1999, Demoulin and Kaddar 1993, Vuarin 1993).

1.3. Cost, availability, use and improvement of health facilities

1.Cost, availability and distance: Besides the recourse to home remedies in self-help, households seek outdoor treatment (biomedical or African medicine) in from 90 to less than 50 percent of the cases they recognise as illness, depending on the distance and availability of health facilities, but above, all on the cost of pharmaceuticals.

The variable of distance is strongly affected by the quality of the available clinics. Health facilities well equipped with reliable supplies of drugs, particularly antibiotics, attract more users. This also suggests the relative irrelevance of poorly equipped health stations and centres.

Physical and 'cultural' distance discourage the poor from availing themselves of health facilities when they are ill, until their illnesses become very serious.

Cost is by far the most important criterion in the explanation as to why people do not seek outdoor biomedical treatment. This fact gives cause for concern. At a time when many health policy-makers suggest user charges and other means of restructuring the financing of the primary health care system, I fear that an increasing number of poor people may be excluded from appropriate health care because of their poverty. They suffer longer illness episodes, seek less care (quantitatively) and end up with lower quality health care by buying medicines over the counter from relatively unqualified health workers. This situation also implies other disconcerting facts. Compared to the financing by the households, government at present is a minority funder (covering less than 40 percent) of health services. The government system is increasingly failing to assist the poor in the delivery of health care. And, given their very reduced financial means, the poor pay a disproportionately higher amount for health services.

The cost of pharmaceuticals to the general health budget (of both government and households) has increased enormously as a result of devaluation of national currency. Today, for most low-budget patients, medicines may absorb over 70 percent of total expenditure, with 20 percent extra going to fees for treatment and 10 percent extra to transport. Per illness episode, households tend to spend an amount double for adults above 20 years of age than per ill child or teenager. Proportionally, the poor show a slightly higher spending on medicines, while the wealthier spend more on treatment/service and transport.

2. Many of the policies which are likely to be effective in improving health are not directly health policies, but concern, rather
(1) raising the income of the poor, and

(2) bringing health services closer to the people .(in both a physical and cultural sense)

3. Donor support through projects has encountered severe difficulties. Donor-funded projects may remain underused. Broadly, given

the level of skills at lower-level tiers of regional government, there is great difficulty in meeting the requirements of either the central government or the donors.

Donors increasingly tend to fund recurrent non-staff expenditures, such as drugs and books. Donor drug programmes enhance very rapidly the effectiveness of the biomedical health care system.

2. INFORMAL LAY THERAPY MANAGEMENT

2.1.As with many other household responsibilities in a context of urban dislocation and poverty, health care, especially for the children, largely falls to mothers.

- Yet, the enrolment of girls in schools remains far lower than that of boys ...) In the shanty towns where the great majority of the men are under- or unemployed, the mothers have increasingly borne the brunt of child-rearing and contributing to social survival (Sheldon 1996). Many mothers belong to single-parent female centred households with adult sisters and their children. However, even where the household may be headed by the woman, she remains dependent on the father(s) of the children under her care for much of the financial decision-making regarding school education and critical health problems for example. Mothers seeking health care for themselves or their children nonetheless rely heavily on their support networks (Sugar, Kleinman and Heggenhougen 1994) or residence connections which, as we will argue, function as lay therapy management groups.
- Mothers having primary education are 50 percent more likely to take sick children to biomedical clinics, in case these are within reach'.
- In the poorer neighbourhoods, the heavy work load and new tasks bestowed on mothers often take them away from their home and new-borns who are then exposed to an increased risk of malnutrition and childhood diseases.

2.2. Within the context of the Bantu-African therapeutic traditions, healing is cult healing. It very often entails a kind of homeopathic self-healing. In other words, cult healing aids both the patient and support group to embody as well as to re-experience one's predisposition and embodied skills and habits (see Bourdieu 1980) that otherwise remain largely latent or unconscious. In line with cult traditions, it is in the healer's capacity to expand on the therapeutic scene the bodily ways of incorporating, hence

remembering, the complex and culture-specific premises and views regarding life, the human body, the person, the past, therapeutic and gift relations, good and evil, support and persecution or trauma, ancestors and descendants. It has become more and more clear to us that, in their circumambulation from one field of care to another, patients submit their various experiences of illness to several tests: besides seeking to restore their physical health, patients also seek to neutralise the evil causing the illness or misfortune in order to remove the social stigma associated with the ailment. As with kinship relations, healing practices are largely governed by a logic of the gift, of openness and flow, and they set the scene for a strong therapeutic relation, embedded in culture-specific symbols, with the healer. Whereas misfortune and sorcery entail closure or blockage of flow, gift exchange and ritual performance vitalise social relations making them visible and personalising them. In the therapeutic traditions of Central-Africa, the underlying metaphors of healing are those of tying, intertwining and of knotting or weaving the threads of life. (Bekaert 1997, De Boeck 1991, 1994; Devisch 1993:23ff., 255ff., Devisch and Brodeur 1996, 1999).

The way people and experts interprete the meaning of an illness entails a view of an invisible realm of life-bearing and life-harming forces at work in the social domain and in the life-world. To be in good health depends on the relations between people, or between the individual, the social group and the life-world. Good health results from the vital integration of elements, rules and processes (such as one's relations to named spirits; behavioural rules; rules of descent, filiation or hierarchy; space-time co-ordinates; humoral logic; double-sided processes of fate and anti-fate, good fortune and misfortune, destruction and regeneration; or deceiving and redeeming) which also determine the life-world and the physical and material well-being of both the individual and his or her family or residential group as a whole. Cult therapeutic interventions aim at reassuring the patient's being-in-the-world through the ritual creation of a new integrative order in which the physical and social bodies are once again attuned to one another and brought into line with the space-time and cosmological orders.

2.3.Translated into the urban context, and in analogy with folk notions of illness and health, we hypothesise that successful health care must involve an interconnection of, or some negotiation between the different

fields of therapy choice and resort in a manner that sustains the patient's basic search for healing, that is, for appropriating therapeutic good and restoring wholeness (healing as whole-making; etymologically, the two words whole and heal share the same roots in old German and old English). Consequently, neither cult/folk nor medical settings in health care would be capable of independently supplying a satisfactory and encompassing answer to disease, sickness and illness, the more so since sickness and illness have cultural and psycho-dynamic roots in two different socio-logics simultaneously affecting and operating on the patient. We would argue that a valid health care policy in the contemporary African urban context must not only offer the possibility of linking the basic support logic of the neighbourhoods in town with that more idiosyncratic or entrepreneurial and commodity logic of the city, it must also be capable of responding both to the individual crisis and the social crisis to which the former relates. There is a great need, it seems to us to create a space in which suburban communities could themselves explore the possibilities of improving the interconnection of community health programs with the social dynamics of the basic support groups, healing churches and cult healers, all of whom find themselves in a context typified by the process labelled, in Kinshasa since 1993, as the 'villagisation' of town; the term suggests people's 'home-coming' in what the colonial powers had created as non-customary townships (Devisch 1995, 1996, 1998a, b). That Kinois people increasingly bury their deceased family members only in town is crucial to this 'domestication' (literally, turning into a home, a family place of living) of townships.

3.QUESTIONS FOR HEALTH SYSTEMS RESEARCH AND POLICY

In view of identifying, organising and co-ordinating plural resort to otherwise disconnected healing services at community level, a health system's research could combine a medical-psychiatric, sociological and participatory anthropological approach. It could focus on the following elements or fields as constitutive of or determining health care: 1) the deteriorating socio-economic situation and the cultural context; 2) the diverse health care systems and facilities, namely biomedical, cult/folk healing, and faith healing; 3) the patient and his or her lay therapy management group and local community who jointly develop specific help-seeking strategies on the basis of culturally-informed attitudes, beliefs and explanatory models concerning health and illness; 4) a limited number of interrelated culture-bound idioms of distress and of common

health problems for which people seek help in the various care facilities. It is only by studying these various fields in their interaction that we can better understand actual health care practices.

In this perspective, two categories of important questions could be raised with regard to the development of human resources and health policy options. These questions, which may serve to guide the research, illustrate quite vividly the multiple aspects of the particular health problem dealt with in this paper. The data to be obtained concerning the urban and rural health care facilities, coupled with an increased understanding of the specific character of cult healing practices in relation to the prevalent culture bound conceptions of illnesses, should enable us to develop an approach in which the conditions for integrated and co-operative action might be fulfilled. It is clear that any resulting action would require a spirit of complementarily and understanding between community medical health care, on the one hand, and cult and faith healing practices, on the other.

1) First category of questions to be raised concern the relation between cult therapies and community health care policy. All too often, it seems, co-operation between healers and medicine creates the risk of deprofessionalization and degeneration of the very healers one is seeking to integrate (Dozon 1987, Fassin 1992, Hours 1986). This is mainly due to the high level of competition among healers as they seek to gain governmental or institutional recognition. On the other hand, there exist many healers, as well as representatives of the scientific and political communities, who wish to circumvent the dangers of opportunism within the sphere of community health and that of the relation between the nation and modern science. Community health-care policy planners have increasingly been forced to address a number of questions to the imported biomedical health care system, including the following:
- Is medical health care really capable of solving the country's health problems, or even of responding to the high levels of expectations it has evoked, given the absence of economic growth and a spectacular demographic expansion?

- What must be done about the concentration (in many cases, more than 80%) of hospitals, medical staff and curative health care institutions in the most urbanised centres of the country's cities, especially the capital, which

deprives poor suburban and rural populations of elementary health services and access to immunisation, potable water and proper sanitation?

- How can we come to terms with the uncontrolled sale of pharmaceutical products (at exhorbitant prices) and the fact that multinationals often use African countries to dump medicines which are no longer in circulation in the North?

- Can one continue to ignore the existence of plural health care, and the fact that most people (at least in chronic cases) systematically consult biomedical clinics, cult/folk healers or healing churches at the same time?

- From the scientific and medical standpoint, what is one to do with the widespread conception that a medicine derives its power and effect from the person who administers it (compare with the placebo effect)?

2) A second category of questions concerns a better understanding of the specific character of cult healing, and an evaluation of its scientific validity, practical efficacy, and the acceptability and legality of the healers' therapeutic practices:

- Does urbanisation promote secularisation, that is, an inherent shift in the explanation of misfortune, accidents, and illnesses from ethic, mythic, sacral (ancestors, spirits, deities, supernatural sanctions, sorcery) and social dimensions (seniority, group solidarity and sanctions) towards a more mechanistic and secularised image of the body, and more cognitive and subject-related dimensions of experience (fear, fatigue, stress, risk behaviour, malnutrition, infection)? In other words, does cult/folk healing, with its special attention to kinship and the intergenerational context, adapt to conditions of life in the city, with its monetary economy and pragmatism? Can healers adequately function outside the kinship network?

- Do these forms of medicinal knowledge, skills, ritual practices and objects, these therapeutic initiations and conceptions of illness, aetiology, ritual-medicinal preparations, steam or smoke bath massages, rinses and aspersion, form a coherent domain, an integrated and unified body of rules, knowledge, practices and specialisations?

- Do the healer's paranormal capacities of clairvoyance and healing not imply a capacity to harm and undermine the health of his or her client as well?

- When and why do people resort to cult/folk healing? If the suburbs were to have at their disposal a sufficient and financially accessible health care infrastructure, would the population still consult the cult/folk healer?

- Is biomedicine capable of replacing the African medical traditions completely? In which cases are they harmful or even dangerous?

- How must one concretely evaluate a healer when the latter is accused of incompetence or abuse, of charlatanism or sorcery?

4.THEORETICAL, SOCIAL SCIENCE, VIEWS

4.1. Endogenisation of community health care in a postcolonial era: health and the gift economy.

When engaging in developmental policies and health system (re)organisation, one has to understand how the recent years of political turmoil, economic crisis and rapid socio-cultural changes have affected numerous people in so many parts of the continent whose up-coming generations entered a post-colonial phase with political and cultural horizons no longer defined in reaction to the colonial ones up till the late 1980s. All this may have forced them to radically transform their social groups, institutions and spaces, and they may have succeeded in various ways in particular in their strategies of promoting plural health seeking in both biomedical and African civilisational traditions of healing.

It is surprising, even there where the medical health (co-ordinated and financed by established church institutions) may be efficiently organised, that today autonomous local networks of health care increasingly form the primary recourse for the majority of health-seekers in the poverty-stricken suburbs. In these areas, the average person, the man in the street, seems to increasingly consider the biomedical health care facilities as too alien. Moreover, health- seekers are tending to abandon the opportunist self-made type of healers and their often fraudulent, if not ignorant, curative techniques. Common people tend to spend their rare cash only in case of serious ailment; they then turn to the classical traditions and the reputed healers, those who have been fully initiated in the centuries-old

cults. Does this reliance on African medicine imply a search for endogenisation or cultural re-rooting of health care in people's own cultural soil? Unlike the biomedical staff, who very much operate in line with the patronising stance of the modern, hegemonic or globalising, civilisational project, healers entertain a local and culture-specific, yet often very implicit, epistemology and cosmology, which in turn determines their views on all aspects of human life: relations between man and woman, hierarchy, order, time, need, health, education, knowledge, word-craft, seniority, ethics, taxonomy, and so on... Moreover, these healers support a process of empowering the local community networks in which health care decisions are increasingly taken, evaluated, executed.

In the 1960s and early 1970s, public health experts had expected the so-called traditional healing arts to die out in the face of African modernisation as biomedical services became more accessible to health-seekers. As a consequence, stress has been put on the formulation, realisation and implementation of primary and community health care programs and the managerial organisation of preventive campaigns to combat malaria, malnutrition, diarrhoeic infections, smallpox, leprosy, and sexually transmissible diseases. In the period beginning towards the end of the 1970s, however, there has been a movement on the international scene of rediscovery and revaluation of African civilisational traditions and specifically the healing arts. It was increasingly recognised that the African civilisational traditions of health care and healing constitute the heart of a people's culture and that much of the meaning of African healing practices escape biomedical understanding. In the 1980s, at the onset of the dramatic economic crisis, effective medical programmes and expenditures appeared far too expensive for a growing number of African countries owing to the costs of training personnel and of importing both infrastructure and pharmaceutic supplies. It is against this background that one has tried to re-evaluate the potential role of the different categories of healers who live and work in the rural or popular urban milieus of Africa.

World Health Organisation reports (Akerele 1990) testify that, since that time, a growing number of African governments have subscribed to the main options formulated by the African Committee at the 1976 Kampala meeting of the WHO; dealing with the theme of Traditional medicine and its role in the development of health services in Africa, this assembly

endorsed collaboration with traditional healers (WHO 1976). Despite the appearance of a series of enthusiastic governmental proposals and recommendations along these lines since the late 1970s, lasting state-organised co-operation with cult/folk healing has by and large been relatively neglected. Many an African country has founded centres for the promotion of genuine African medicine, yet many end up promoting a narrow definition of herbal medicine with the help of pharmaceutical firms from the North. Although medicine is the last-born of health systems, in the post-colonial state it, nevertheless, played the role of eldest brother, with the support of political and international institutions. Centres for African medicine tend to comply with their sponsors' wishes, in order not to lose an essential source of income, and therefore exclusively study chemical-therapeutic qualities in plant, animal and mineral products, neglecting or disregarding the broader psychological and socio-anthropological dimensions of traditional medicine or the clinical evaluation of the healer's total performance.

Due to a lack of means, many joint ventures between biomedical and African medicine have been prematurely called off and never reached the stage of implementation. Today, we still find ourselves positioned at the starting gate: healers are to date ignored by national health policy which continues to recognise only bio- and para-medical training and the use of patented pharmaceuticals. Past failures with regard to promoting cult/folk healing in the context of public and community health were often due to the fact that political decision-makers themselves had (and have) an inadequate knowledge of the specific nature of these civilisational traditions of health and healing. Today, decision-makers and community health-planners still fail to take into account people's daily health behaviour and practices of health-seeking in the rapidly growing (sub)urban milieus. Expert knowledge among decision makers with respect to the major healing cults and traditions has not greatly improved, although one is likely to encounter considerable tolerance towards African medicine.

Many a project envisaging a re-evaluation of cult healing fails when healers are invited to work in a hospital setting or under the supervision of medical doctors. From the start such a relationship between healer and medical doctor remains a one-sided and a-symmetrical one. In such situations, healers are not accorded an autonomous status in their own

right; they tend to feel that biomedicine may not be the only judge of their activities. An enforced biomedical context also tends to deprive healers and their therapies of their proper identity and meaning; in the eyes of their clients, healers no longer have control over the total therapeutic intervention in the hospital setting (Dozon 1987:16). The medical services offered by physicians, polyclinics, primary care centres and pharmacies are embedded in a commodity economy and stand as a social emblem or signifier for the bureaucratic realm of the city and the paternalistic yet bankrupt and alien state which favours the emulation of the modern, entrepreneurial individual. People therefore associate the medical services with the realm of state institutions and not with people's rights and privileges in the daily sphere of survival. In line with the commodity logic and the ethos of the capitalist entrepreneur, the individual's enfranchisement from his or her kinship group also implies an attitude of closure and non-sharing. Such dispositions, condemned by the traditional ethics of the kingroup, are deemed necessary to make profits and maximise capital. In subscribing to this entrepreneurial ethos, clinical or curative biomedicine is chiefly concerned with the physical disease rather than with illness and sickness: the diagnosis is believed to be objective and the disease is objectified. Because of this overbearing attention to the physical, sickness or illness is reduced to mere disease; this is a logical naturalisation based primarily upon the idea of a necessary or objective physical cause. Any reference to context, subjective and interpersonal understandings, and cultural meaning is left out of the picture. Disease is medically defined in terms of a predominantly instrumental or functional view of the body. In the clinical setting, the medical doctor fights the disorder allopathically. He or she approaches the patient as a distinct instance in a dyadic relation which is characterised by unequal competence and one-sided responsibility; to top things off, payment terminates the therapeutic relation.

Inasmuch as he or she works as a scientist, the doctor neither shares nor wishes to influence the patient's social network. Medical doctors and paramedical staff belong to a formal, bureaucratic medical organisation which operates by virtue of the written word and is characterised by its particular conceptions of authority and by its rational and clearly defined allocation of tasks, impersonal rules, a radical segregation of person and role, and a quantitative conception of linear or progressive time. In medicine, authority and dependence are generated and concentrated on

a scientific basis and in the name of therapeutic commitment and efficacy.

Seen from a sociological perspective, the functionalistic commodity relations based on monetary and formal transactions have formed a master metaphor for the rhetoric of modernisation in many an African country and have served as a central mechanism of social change in the urban contexts over the past decades. Due to a number of diverse factors, including an extremely high inflation rate throughout the 1990s, especially affecting the food commodities and health supply sectors, the market economy and the failing public services are partly being replaced by more personalised systems of gift exchange and innovative approaches. These trends are evocative of the most basic life-giving practices and relations of support among kinsfolk such as commensality and matrimonial exchange.

In order to understand and value these African civilisational traditions of healing in their own right, it is necessary to study the group ethics, religion and cosmology. It is only when the underlying representations and the logic or rationale of their symbolism with regard to solidarity and the resonance between body, group and cosmos (that is, between the physical, social and cosmic bodies) have been brought to the fore that those healing practices and representations no longer appear as merely irrational behaviours and beliefs. Then one can also begin to understand why and how the solidarity and reciprocity shared between healers or between healers and patients in cult groups forms part of and is informed by a more encompassing cosmic and cultural order. The healer works from a resonance-aetiology concerned with the illness in relation to the patient's body, group and life-world. Healing practices are condensed expressions of beliefs concerning, for example, the human body, humanity, life, good and evil, ancestors and descendants. Cult healing practices are governed by a logic of reciprocity, between persons and their life-world, and of inclusiveness that is expressed through symbols and orally transmitted representations. As such, healing cults often become strongholds against the usurpation of capitalism and bureaucracy in the new African nations.

4.2 Cultural idioms of distress

African civilisational traditions regarding healing and the interpretation of illness are a total phenomenon. It is important to understand the rationale

of these traditions from within, to lay bare the inner logic of these traditions, of their concepts of the body, etiologies, and world view. In line with this insight, gained through previous research, the independent variable of our research is the multi-layered cultural embeddedness, the meaningfulness, of practices; this element evokes a sense of: we, health care-seekers and providers, we do what we do because it seems meaningful, because it is the proper way to go about it.

Contrary to current medical notions that view health merely as an absence of organic dysfunction, cult-healing associations, self-help groups, and faith- healing communities in the Congolese cultures under study interpret health and individual well-being as resulting from a specific array of human relations set in a much broader context. To be in good health depends on proper relations between the individual, the (family) group and the life-world, and results from the dynamic integration of vital elements which also determine the fertility of the family group, the life-force of the elders, success at school or on the job, the moral and physical well-being of the family group, or success in the hunt or other highly valued masculine activities. As such, being in good health is being whole, that is, being interwoven or integrated in a meaningful way into the relational fields or multi-layered texture of body, (family) group and life-world.

The healer and/or diviner at least in the Koongo (Bockie 1993, Buakassa 1973, Jacobson-Widding 1979, Janzen 1978, MacGaffey 1986, Mbonyinkebe 1989, Van Wing 1958) and related cultures of Western Congo works from an etiology involving at least three fields of parallel investigation: his or her interpretation of the origin of the illness starts from the hypothesis that there exists a meaningful resonance between the three fields of the human body, the (family) group and the life-world. Symptoms and illness are read as signifiers of socio-moral lesions, as a disruption both within the sufferer and with respect to the embracing contexts of physical, social, moral and cosmological components.

Illness concerns the subjectively and culturally-informed experience of the ailing person and the way its meaning is given shape in the terms of that culture. Notions of illness and misfortune are related to this integrative notion of personhood and health. The meaning of illness can only be understood within the wider context of the forces at work in the social and

life-world. Like health, illness situates itself between people, or in the relation of the individual to the family group and the life-world.

In the popular representations and divinatory discourse of the Koongo and related cultures of Western Congo, two associated syndromes of illness are basically considered as a problem of boundaries and relations: illness alters the vital flow by way of contraction or enclosure yibiinda, biindama) or, in contrast by way of effusion (n-luta, phalu).

The healer envisages a neutralisation of the sickness, that is, of the conflictual relations of which the patient's complaint or behaviour is a symptom. In this perspective, the therapist tries to rehabilitate the patient in the group. At the same time, however, he is also concerned with the illness; in a holistic, symbolic and multifaceted way he tries to counter the origin of the illness and return it against itself. In Koongo and related cultures of Western Congo, for example, the healer or ritual specialist is referred to as the one who unties (biindulula) the patient from this negative bond, and who redefines the patient's position in terms of a more positive liaison in which personal health and well-being are essentially coextensive with social and natural/cosmological fields.

Therapeutic efficacy is generated in an innovative and transformative process which disentangles the disintegrative knots through ritual praxis and transforms them into a new vital whole. Medicinal preparations, the use of cupping horns, scarification, ointments and the regulation of cooking and food, all these elements are part of a more encompassing ritual drama that fashions corporeal processes by using their metaphorical equivalents. A woman suffering, for example, from amenorrhoea may be invited to administer luke-warm enemas, at sun-dawn, while crouching in the doorway between the sleeping chamber and the place for cooking, while the potion which is made from buds associates her with the transformative process of ripening. The healer's attention is not in the first place directed towards the disease or the somatic trouble. The ritual and therapeutic search for health and fertility aims at the integration in practice of body, social group and life-world. The basic transformative metaphors of hunting, fermentation, cooking and weaving provide the patient and healer with basic models of healing: therapy, for example, evokes the act of weaving, producing a total reorganisation of synergies, a renewed impulse of the vital flow from body to life-world and vice versa.

4.3. Conceptualisation - the pattern that interconnects- the body

The leading heuristic hypothesis regarding cultural determinants in community health care which orients the project's anthropological perspective draws on former work, studying culture as both a transmitted and inventive process by which a given group unveils and/or attributes meaning in daily life experience. Culture forms an intermediary space between the inner world and the world outside, between body and group, between self and other, man and woman, parent and child, dead and living, past and future.

In our view, the body, it appears in the healing cults and practices in Western Congo, is seen as an intermediate space (Devisch 1993 chapter 4, 1999 chapter 1). It is the locus and agents of a complex interweave: the skin, the body's orifices (mouth, nose, ears, eyes, genitals, rectum, fontanelle, breasts, navel), the sensory and communicative functions (feeling, hearing, touch, speaking, smell, sight) provide opportunities to meet with and mediate between man and woman, mother and child, self and other, body, group and environment or life-world.

Healing cults, for example, develop a multi-layered and totalling interweave between the flow of affects, motivational forces and bodily states as well as the various group processes. These processes are interwoven with the lived, partly shared and encompassing worlds of images, meanings, values and strategies in which the participants are immersed. The healing ritual projects the body experience and life history of the patient onto the space-time stage formed by the seclusion house and the intervention of healer and family. Expressed in general terms, the patient moves from a state of being tied in, closed up or emptied out, towards being gradually reinserted in the complex interweave of body, group and world. The therapeutic drama offers a space-time stage upon which metaphoric correspondents of organs, affects, energies, and bodily functions are constituted and manipulated. The cult spirits that are invoked are associated with basically ambivalent, potentially life-threatening and life-giving forces. In the ritual, the patient's body merges with the significance of the ritual house, itself a metaphor of macrocosmic life-bearing processes. Moreover, the various members of the therapy management group, the multiple roles connected with life-transmission as organised by kin and alliance, and the various positions one might claim in

society all offer a projective space for the patient who is thereby invited to recover his or her identity in relation to one or another of these roles and positions.

5. AN EXAMPLE: LOCAL KNOWLEDGE SYSTEMS AND MODERNITY IN CONTEMPORARY CONGO

In the following we describe a more specific aspect of the socio-cultural context of today's Congo in an effort to get at the heart of a fundamental difficulty in the evaluation of the plural health care setting. In order to better understand the major difficulty, it is necessary to describe in greater detail how the contemporary mindset in urban Congo, affecting both the educated and uneducated, is dominated by rationalistic and universalising conceptions propagated by formal education and Christianity and mass-media.

5.1 Shattered mirrors

To understand health resource allocation in Kinshasa as well as the factors that have modified health-seeking patterns in the urban context, we should acknowledge the influence of modernist or reformist views on health and medical care introduced to the Congo by bio-medicine and in particular by the colonial and post-colonial health actions and models. Already from the 1950s, in the late colonial period (the Congo attained political independence in 1960), the new models offered as mirrors to the (urban) people for evaluating their health were founded on optimistic developmental theories in demography and epidemiology, related to social reform, or inspired by western-borne evolutionary visions regarding legal-rational authority and good government, social well-being and the political economy of modern health for the new nation. Let us take a brief look at these mirrors and views of history according to the stages in which the urban Congolese in the last decades have first assimilated new ideals of health and health care and later partly rejected them. We maintain that the populace, through the wide-spread pillaging of the so-called modern institutions and enterprises (in a kind of Luddite uprising) that took place in the early 1990s, has broken down the mirroring process and false hopes stemming from the (post)colonial legacy which remained ensconced in the new social and state institutions (Devisch 1995, 1998a, b). The mirrors of progress and modernisation in fact helped the state to conceal the overall lawlessness in the public domain and prevented the cultural, social, and behavioural determinants of dysfunction and anarchy from being laid bare.

Beginning with the 1950s, a new call for modernisation disseminated by the State, school, church, and mass media defined rural people and the village domain as the inverse of the new era, the white universe of modern civilisation. The village and its practices were represented as a negative space to be converted or abandoned; its paganism, polygyny, healing practices, and sorcery, like the oppressive conservatism of the elderly, were to be eradicated. In the eyes of the city-dweller, the ancestor or the parent in the village represented avidity and persecution rather than a source of knowledge, filiation and identity. The modernist position, meanwhile, continued to affirm that the educated and far-sighted citizen could indeed liberate him or herself from the debilitating yoke of retrograde credulity and clan solidarity, just as it could free the individual from the endemic diseases and recurrent epidemics encountered in the village. From the 1960s on, development rhetoric, echoing colonial voices in support of the civilizing mission, stigmatised village life due to conditions of inadequate food, unclean water, poor hygiene and inferior shelter which left villagers defenseless vis-à-vis natural disaster, perils and infectious disease. In this modernisation discourse, mortality, fertility and vaccination statistics were nearly always the first items mentioned in colonial administrative reports as if hygienic, obstetric and medical action were adding new regions to rational modernity's emporium of progress. In this modernist and privative vision of reality, the world of the village was reduced to a realm of untamed and unsafe nature. Life in the bush, as colonial discourse defined it, was considered to have practically no social or cultural existence, insofar as it represented exclusion of the purest form, namely from the civilising function of the school, written word, hospital, administrative post, capitalist enterprise, market or church.

Kinshasa, with a population of about five million at present, is one of the largest urban centres of tropical Africa. Numbering less than half-a-million in 1960, the city has expanded rapidly at a rate of approximately 10 percent annually in the 1970s and 1980s. Massive immigration and high childbirth rates among a young population, for whom having many children constitutes a mark of wealth and a social security strategy, has deepened the division originally drawn by the Belgian colonialists between the European sections of the city, called la Ville, and the ever-expanding African settlements which surround it, called *la Cité*. The former includes the downtown area with its places of employment, stores, and neatly-

planned neighbourhoods where the privileged minority reside. The latter covers more than three quarters of the total area of the capital. Most Kinois live here, either in older, somewhat planned districts or in newer, poorer zones or shanty towns where successive waves of immigration have inscribed themselves onto the urban terrain. Many of the shanty towns that comprise the expansion zone are inhabited by members of the same ethnocultural community or group and share a common language, making Kinshasa a microcosm of Congo. In the last fifteen years, there has been such stress on every aspect of the city's infrastructure, along with a lack of maintenance and mismanagement, that public schools, medical and administrative services, transport, roads, and telephone communications have deteriorated considerably, if not broken down altogether.

Many of the *Cités* are inhabited by members of the same ethnocultural community or groups who share a common language; this makes of Kinshasa a microcosm of Congo. A history of successive waves of immigration has inscribed itself into the urban terrain with a continuous expansion zoned- construction and squatting on the periphery, extending from west to east over a stretch of some 70 by 25 kilometres, parallel to the Congo river. In the last fifteen years there has been such stress on every aspect of the city's infrastructure, along with a lack of maintenance and mismanagement that public schools, medical and administrative services, transport, roads, and telephone communications have deteriorated considerably if not broken down altogether.

There are no updated administrative records for the older zones, and none for the shanty towns. Besides the general demographic data offered by Jean La Fontaine (1970), on le Saint Moulin (1969, 1977, 1996) and Joseph Houyoux (1973), Marc Pain's assessment (1984) of the demography and the material conditions of life in Kinshasa is one of the most recent of its sort. He estimated 60 percent of the predominantly male populace of Kinshasa to be under twenty years old in 1976. Of an annual growth rate of 20 percent, two-thirds were due to immigration; this influx, however, seems to have considerably diminished since 1990 when life in the capital became noticeably more difficult. For 1973 (at the end of his demographic research for the Mission Française d'Urbanisme de Kinshasa), René de Maximy (1984:208ff.) estimated total formal employment in the city at some 218,000, which means that only 18.23

percent of the population in the study said they held a salaried job. In research carried out three years later for the same institution, Marc Pain (1984:105ff.) gave an employment figure of 345,000, extrapolating on indirect data and polls carried out by others around 1967. Half of these jobs were lost because of the looting and destruction which took place in September 1991 and January 1993 (Devisch 1995). While the cost of living continues to rise, the labor market shrinks and, since 1990, the average daily salary for a civil servant covers less than one-fifth of a family's basic daily necessities. Today, it is estimated that more than 90 percent of Kinois do not draw a regular salary. For Kinshasa, besides the problems of extramarital mores and the survival tactics of numerous women by selling sex often for just a small income and at the risk of venereal disease and AIDS which have been the subject of study (Schoepf 1993, 1996), other significant problems such as widespread substance abuse (notably of hemp and locally-brewed alcohol), rampant violence and social anomy remain as undocumented as do issues of nutrition and life expectancy, infectious and nutritional health problems, or the patterns and composition of mortality and illness and deteriorating health circumstances. In Congo, the large majority of physicians settle in the centres of the country's major cities. According to broadly-defined UNDP estimates, the economically underdeveloped country of Congo also scores poorly with regard to human development.

In the spatial hierarchy of the modern city-in-the-making, the peripheral shanty towns, the areas of the capital furthest removed from the city centre and/or the least urbanised were assumed to reflect and maintain the old ways of village life. In other words, the capital city has developed into a dual society. Kinshasa has a very small opulent-rich minority housed in the most luxurious residential areas largely and drawing on the resources of the State, whereas income for the majority is unpredictable and barely at survival level. Kinshasa's masses, if they have any gainful occupation, are most often involved in petty trade and services- what has been called the informal sector (de Villers 1996). In this sphere, perhaps 90 percent or more of the economic responsibility falls on the women who have an extremely heavy workload and a long working day due to the combination of their productive or income-generating activities and essential household duties such as child care, food preparation and collecting firewood at ever further distances. Infant mortality is close to 10 percent. During the day, at least under the former Zairian government,

functionaries continued to man their posts even when they were no longer or barely paid or when the services were clearly not operative. Any particular expense related to housing, medical care, school education, or funerals forces the suburban family to rely on the solidarity of the extended family, the support networks including the workplace, the village of origin, and/or the church community. Hence, in the popular suburbs and slums, street vending of small quantities of food and snacks (bread, cassava flour, vegetables, peanuts, fish, sugar, milk, fruits, cola nuts) and firewood or charcoal, as well as the communitarian economy of barter (nails, pieces of board, grass for mattresses, mats, and the like, for food), have become necessary elements in the survival strategy of an increasing number of city-dwellers.

From the late 1960s on, under President Mobutu, a Eurocentric rhetoric of modernisation has been integrated into the party-state's nationalist cause and presented under the guise of a Return to Authenticity politics. This rhetoric has fuelled the desire of many immigrants to Kinshasa to break with their dark origins and whiten their collective memory through actively participating in the enlightened project and promises of modernisation, formal instruction, conversion to Christianity and the benefits of biomedical services. Most immigrants adopted the new lingua franca of Kinshasa, lingala; particularly striking is the fact that men rarely spoke their mother-tongue even at home. Many youth left the villages in order to settle in the city, saying this was necessary in order to break with the backward mentality of the parents who incessantly demand help and sharing, if necessary through sorcerous threats. A fairly high number of immigrants applied themselves to assimilating the French language and the manners associated with Western education and consumerism. They felt pressured to adopt any available marks of antinomy with regard to their ethnic and familial origins. These marks were supposed, in some phantasmal way, to facilitate their integration into the space of modernity, namely the West which to them appeared as the domain of ultimate power and pleasure. The call of the city, the imagery of modernisation and the religious language of conversion incessantly opposed school to tradition, biomedical personnel to presumably quack witch doctors, pharmaceutical medicines to fetishes, knowing to believing, intellectual to manual labor, good to evil, Christ to sataani, science to magic or illiterate credulity, or modern development in the hands of the modern man in a white-collar job against the morbid backwardness of the illiterate mother

and her domestic duties in the village or suburban home.

Congolese have now begun to discover how much they have become foreigners to their original culture, family group, mode of life, education, and communalism rooted in their local traditions. With the Return to the Authenticity movement of the party-state under President Mobutu in the 1970s, itself a product of a European urban and late reformist vision, the underprivileged immigrant to the city was defined as a citoyen (a citizen), namely a typical member of the new nation. This identity was happily and positively contrasted with the colonial and ambivalent label of "*volu*" or acculturated, which would rather suggest a hybrid identity (rendered by the colloquial term: black white). The new characterisation, however, continued to be seen in contrast to that of the villageois (villager), a term substituting for the indigène (the indigenous person), one who was still devoted to subsistence farming and the traditional world view. The process of acculturation to the urban context was seen as a passage towards civilisation, as an upward movement within the social scene and providing access to new territories of citizenship, instruction, information and professional corporations. The "acculturated" Kinois had advanced from the village context to the urban, from tradition to modernity, from insalubrious life conditions to a new space under the dominion of so-called modern hygiene and biomedicine, or from local connections with a tribal culture having its own distinctive characteristics to more globalising and diversified scenes of foreign meanings, multiple norms and hybrid ideals. Similarly, moving from suburban to urban space (from *la cité* to *la ville*) was understood to be a vertical progression: the more a person's life involved going up to the city (monter en ville) to an elite school, business office, central hospital or to church, the higher he or she had ascended on the social and world civilisational scale. Being uprooted from the rural locale in order to attend school, be converted to Christianity, consult a medical specialist, or engage in an urban profession was a precondition for social climbing in terms of initiation and access to the higher social space of the city. Many Kinois would not have admitted to going down to the village (descendre au village) except for business or the funeral of close kin. How often one heard or read from Congolese "volu" that as long as the emigrant families believe in all these outmoded things, they will be incapable of assuming their proper role in modern society; better that they had remained in the village. A lack of adaptation to the new nationalist scene orchestrated by the Return to Authenticity movement was

considered a fault or a mark of the nonadaptive villager still bound to the traditional space of ancestral law. The individual who persisted in not fitting into modern urban life, remaining out of step or even rebelling against its lifestyle was soon marginalised and ostracised as a villager. Until late in the 1980s, the city-dweller spoke disdainfully about rural modes of life and especially its initiatory practices (such as circumcision rites), divination, the ancestral cult, and the world of sorcery), which traditionally link a person with an ancestral lineage tradition and a space and source of ethnocultural belonging and identity.

Alongside the regular influx of foodstuffs, in particular cassava, from villages at distances of three to eight hundred kilometers away (Goossens 1996, Goosens, Minten and Tollens 1994), the informal economic sector is playing an increasingly important role in terms of local supply and earnings in all the popular suburbs and shanty towns of Kinshasa (de Herdt and Marysse 1997). Many Kinois today find themselves in the thick of the struggle for survival, human dignity and decent housing. The misery and incoherence of life in the suburbs; the collapse of public transport, State-run educational and public health services; the breakdown of electricity and sewage systems; the serious degradation of the city's infrastructure and the sheer abuse of power by self-serving functionaries have shattered the party-state's mirrors of identity and models of progress. In this decade of hyperinflation and facing the impossible task of raising children, many women try to eke out an existence on the slim profit margins of street vending: many of them are quickly brought to ruin due to the rampant inflation. Kinois believe that the state of affairs has become totally unforeseeable and feel themselves as never before in an overall state of lack.

Since the 1980s, a predatory economy of the street has become an informal and increasingly widespread means of survival for a growing number of people in the shanty towns. Survival in most of the *Cités* is now more than ever defined by the infamous Article 15, as people have nicknamed the fictitious legal code that regulates the life of the deprived who have added it to the Articles of the Constitution, which they believe benefits only the wealthy minority. Article 15 refers to the predatory economy of the street, which we suggest is an urban version of the rural economy of hunting or collecting. This is a crafty, even malicious, sort of predatory behaviour, but not a violent one. For the oppressed, petty

thievery acquires the status of a common mode of survival; it is their version of power, under the sign of Article 15. Men and boys refer to Article 15 with both self-conscious laughter and pride when in the presence of a stranger, for it at least brings them virile honor, if not at times providing more benefits than regular employment. Article 15 evokes the semantic and social space of the petty thievery, crafty sorts of minor aggression, and resourceful perdition on others and the State.

5.2 The villagisation of town and lay therapy management

Matricentred households and female-centred networks operating at the core of suburban society sustain the process that Kinois people have called "villagisation" of town. Since 1993, neighbourhoods, religious and residential associations have engaged in communal support activities as improving neighbourhood security or providing basic amenities as pipe-borne water, sanitation, and electricity. Their leaders, including matrons, elders, and charismatic leaders in healing churches increasingly inspire the re-evaluation of their residence connections or networks of communal belonging and support. Economically destitute, the populace today increasingly mobilises its social capital as well as the will to temper the power of the State by exorcising grassroots democracy and civic culture. These civic networks now counter the tendency of the masses to submit passively to the bureaucratic State and have succeeded in gradually arousing sentiments of communal empowerment. This new communal dynamic, which to a large extent is the outcome of women's daily struggle to assure the nutrition, health, and education of their children, and bear the burden of many other domestic chores, involves no less than a rehabilitation of one's base or belonging in the urban tissue.

A new sense of solidarity and communitarian ethical duty has thus developed at the neighbourhood and township level. Although the villagisation of town does not actually entail a physical return to rural village life, city dwellers growing sense of rootedness in their residence networks draws on the collective and largely unconscious predispositions or *habitus* which somehow echo the socio-logic of village family structure and its communitarian economy of exchange or gift. When facing misfortune and bereavement, Kinois of the suburbs tend to reinforce the ethics and communal practices of matricentred solidarity among kinsfolk in line with seniority and descent rules. They thereby tie in with dispositions at the core of age-old etiologies, communal healing and ritual

enactments of life-changes. In Kinshasa, the major healing rites are performed in the language and style of the culture of origin and are thus adapted to the kinship allegiances and cosmology of the given group. Clients can easily cross cultural boundaries because the cults possess a common cultural substratum, especially with regard to the treatment strategies, metaphors related to the human body, and other preverbal symbols at play in the therapeutic setting: dances, mimes, body decorations, ritual objects, massage, fumigation, medicinal substances, and, above all, trance-possession.

Since the 1990s, many Kinois increasingly consider themselves the victims of an enormous hoax. Under the influence state has emerged as a cleptocratic state and promoted the *commodification* of urban livelihood as well as the unpredictability of income. The resultant despair and suffering in the absence of institutional justice and the abdication of responsibility by public institution are the main reasons for this process of villagisation and the recent re-evaluation of kingroup support networks in the suburbs. These networks find themselves dealing with matters of life and of suffering. This means that social institutions and culture are transmitted not only in ways of life but also in ways of suffering and death.

When it comes to health care, it appears that these networks play an increasingly important role. With the help of kinship, residence or church networks, patients seek out and test itineraries in the fragmented supply-side of the health care market. Informants could describe only idiosyncratic pathways via friends of friends, as the expression has it in the search for care, yet never general patterns of institutionally-planned or guided medical decision-making procedures. In practice, most patients, inasmuch as they rely on their own limited individual experience or that of their networks, only know that portion of the care-providing institution they are consulting; even key informants (such as doctors, medical centre personnel or healers) have little awareness of either the individual patient's various health strategies and opportunities or of parallel health care fields. In the pluralistic sector of health care, most decision-makers and care-providers seem to work very much on their own, promoting their own strategies or health resources, underestimating people's views (medical or non-medical, depending on the setting) on health and illness, and ignoring patients' own pathways of health-related knowledge and action. Almost half of cult/folk healers and faith healers state that they

may at times send a patient to a fellow-specialist or to a polyclinic for diagnosis or specific medical care. For their part, faith healers distrust cult or folk healers, whom they consider to be associates of the devil (sataani). Referring patients to some cult/folk health care or to faith- healing is a perspective that many of the older personnel in the medical sector still consider to be the very abandonment of their scientific ethos and medical responsibility. Our contacts suggest that perhaps one in ten Kinois students in medicine, public health or nursing and who themselves may have been affected by extensive abuse at the hands of the public health system are increasingly intrigued by the art of healers. A small portion of the medical staff are even members of one or another healing church.

Our focus on lay therapy management considers the health seeker's social situation and his or her strategies of therapy choice and resolution of illness as part of complex social strategies of a sort that do not often respond to short-term solutions. To date, the concept of lay therapy management by significant others surrounding the patient has been applied mainly in reference to rural health care settings in Africa (Janzen 1978, 1987, De Boeck 1991).

Since the 1990s, many Kinois increasingly consider themselves the victims of an enormous hoax. Under the influence of the hundreds of independent prophetic or charismatic faith-healing churches that have developed on the ruins of the millenaristic party-state, the popular imaginary register has ironically come to associate the notion of modernist utopia with sataani (Devisch 1996). Having lost out on the rewards of a modern emancipation promised them by parents, school, party-state and the established church, people's current reaction is to distrust any official discourse, pledge, or project put before them. With the wane of public ethics and collective ideals of modernisation, the collective imagery resorts to a dual world view where the anguish for evil, on the one hand, and the utopian dream, on the other, constitute two sides of the same coin: the fears of the night domesticate the disillusioned diurnal dreams of whitened progress. The significant increase in the consumption of locally-brewed alcohol and hemp, as well as the growing anomy in the major suburbs of Kinshasa today, very much derive from the unpredictability of the future due to hyper-inflation and the total collapse of state institutions in the early 1990s, the increasing sense of insecurity at the hands of poorly-paid military and police personnel, and the lack of any collective unifying project.

Kinois remain convinced that the current crisis will last for a long time. At the moment, they are unprepared to put their faith in the State's capacity to develop a new era of prosperity and greater justice. The populace has become increasingly aware that, in all matters of survival, health, security of the family or school education, individuals can count only on themselves and the solidarity of brothers and sisters in one's church or residence network. For the masses, participation both in the moral re-evaluation of collective issues at the household or residence level in communal prayer and sharing in the economy of divine grace and spiritual knowledge offered by the healing churches is as much a source of social respectability as one's status by birth or professional achievement. For this reason, critics now state that, in the long term, community health care should tie in with this revitalised social capital and new moral fabric, and become less dependent on governmental agendas and external agencies or funding.

More and more people are seizing opportunities to contest, transform and overcome the self-victimising behaviour that has had such a negative impact on so-called traditional selfhood and 'village lifestyles'. This depreciation was one consequence of the colonial medical and Christian discourses on disease and epidemics which stigmatised the sick as sinners, for they had somehow failed to respect the modern and urban disciplines of hygiene, vaccination, proper diet and rest, information and enlightened self-control. To put the matter in terms proposed by Veena Das (1994:163-164), although she writes in relation to the plight of the victims of the chemical poisoning at Bhopal, India, in turning to healing churches, healers, and local 'health centres', the powerless seem to be discarding paternalistic notions by which health is handed down to the poor through a paternalistic and bureaucratically defined rationality. Omnis, the NGO co-ordinating health care action throughout Kinshasa, has become alarmed by the fact that, since 1995, health-seekers at otherwise well-functioning dispensaries have prematurely and unexpectedly been abandoning their prescribed medical treatment or follow-up. This recent and overall decrease in medical consultations is puzzling especially as it has occurred even where medical treatment is cheap and affordable. Five observations are to be made here. (1) By mid-1995, dispensaries and maternities in the townships had witnessed a significant decline in consultations while the overall health situation in the urban areas had deteriorated significantly due to epidemics and

malnutrition. The financial factor does not explain people's current withdrawal from, or dissatisfaction with, biomedical help since usually only token payments are required for treatment at most clinics. Instead, many patients complained of the low socio-moral satisfaction gained from biomedical consultation and treatment. (2) Random sample information suggests a recent increase of birth-rate in the suburbs; people say the impoverished no longer frequent taverns and many healing churches have turned childbearing, whether within a marriage relation or not, into God's blessing for the community of believers. (3) An externally sponsored tuberculosis vaccination programme, carried out in early 1996 and intended to reach the entire populace of the Capital has experienced a turnout of only 70 percent in some zones. Parents and neighbourhood elders explained that they have deliberately boycotted the campaign in an attempt to defame the State for, in so doing, it deliberately sought to infect their children. (4) Since 1996, a very grim and pervasive discourse accusing children even the youngest of practising harmful sorcery has set the scene for selective child neglect and ill-treatment. The discourse may be applied to sick children in a family whose ever-dwindling resources cannot assure the survival of all; or, facing a change of partner, a parent may accuse and abandon a disapproving child as an unbearable burden in the disastrous economic context of the suburbs. (5) Widespread rumors have led to an attitude of deep suspicion toward (para)medical personnel because many have turned their services into private business (it is common for medical staff only to treat patients after they have received something in the way of a personal payment, called "beans for the children"). These rumors increasingly associate clinics and primary care centres with the discredited cleptocratic state establishment, which people now wish to avoid altogether.

Under the present circumstances, health-seekers increasingly access ethnoculturally more familiar networks of health care in their own neighbourhoods for their minor ailments. Here they find an expanding informal sector of small and non-subsidised, often religiously-inspired, health centres run by paramedics or even quacks of some sort. Clients acknowledge that the service offered by these persons or centres may be of low medical quality, yet they find it largely reassuring and positive insofar as it helps them to look after themselves. Pharmaceutical shops, often kept by untrained personnel, can be found in every street and self-medication (especially with Ampicillin, Cibalgine or Indocid, among other

medications) for minor ailments is widespread. People often claim that, in view of the high rates of inflation, buying a pill from time to time remains a cheap substitute for the more costly daily bread.

At first, Kinois health seeking practices and attitudes towards medical practice seem to entail a series of contradictions. They may be understood, however as strategies to come to terms with unsettling and conflicting social, cultural, and economic realities. In the current processes of villagization and endogenization (or cultural re-rooting of health care in people's own cultural soil), neighbourhood networks seem to domesticate (literally, bring home or turn into a family place or network) culturally alien institutions, such as biomedical views on health, disease, and cure. These ongoing processes remobilize the kin and/or solidarity relations which underpin people's health-seeking behaviour and cult or faith-healing practices. In the coming decades, neither the State nor NGOs will have the material resources or moral capital to co-ordinate community health care. People's growing resourcefulness with respect to self-medication will draw increasingly on folk healing traditions than on biomedicine.

The current general state of dysphoria, the struggle for survival, and educational and health care opportunities, as well as the interminable political debates and manoeuvring, in the suburbs of Kinshasa certainly have had a direct influence on the present action-research programme. On the one hand, collaborators themselves often felt distressed by material, funeral or health problems. As researchers in the field, they met with doctors or healers and their patients in the thick of economic and institutional hardships and, like them, suffered the same vagaries of life in the post-colony. For their part, informants often lacked the motivation necessary to carry out interviews, or were tempted to turn them into opportunities for personal gain. Since October 1996, the severe political unrest in Kinshasa has slowed or hampered research in the field and has disrupted the programme of seminar meetings scheduled with public health planners and doctors. On the other hand, Kinois colleagues and collaborators have confirmed time and again how much their partnership with European researchers, even if short-term, provided them with essential and critical support. It enabled them to foster an attitude of lucid self-criticism in their work with patients who, in their contact with representatives of the medical or university institutions, habitually glossed over or suppressed the cultural rationale in their experience of illness, and

felt unable to express their symbolic means of coping with the sheer brutality of the struggle for survival.

The researchers are convinced that the project's involvement with local urban networks of lay therapy management is indeed significant, all the more since the action-research takes local health needs, strategies, and social distress or anomie as its point of departure. Moreover, the project aims to strengthen the communities' available resources, in terms of persons, relationships, responsibilities, or goods, while fostering people's culture-specific agency and views---elements which otherwise tend to be ignored in community health programmes. On the other hand, the culture-specific character of people's agencies and views in health-seeking has confronted the researchers with their own culture-specific mind-set, thus laying bare an epistemological paradox that the action-research has not fully been able to solve and which we will now examine.

6. COMPETING HEALTH SYSTEMS, COMPETING DISCOURSES

Among the problems encountered when attempting to institutionally associate cult/folk healing with biomedicine are included issues of quality, abuse, economic viability and legal status. Since these sorts of issues are internally characteristic of any institution, they equally pertain to formal medicine as well and this must be kept in mind. Other problems such as esotericism, craft-related or technical knowledge and different underpinning ideologies or world views of course affect all systems and stand in the way of mutual understanding, recognition and co-operation. This class of more epistemological difficulties bears consequences not only for relations between cult/folk, faith healing and biomedicine, but equally determines the behaviour of and relations between project researchers, participants and target groups. In order to better grasp this point, it has been necessary to examine the context, aims and activities of such a project from the perspective of the sociology of knowledge. From this standpoint one quickly perceives in the parallel health systems a struggle between a universalising, positivist and modernising knowledge, traditional, local and pluralistic attitudes and practices. In sum, contrasting historical and socio-cultural contexts have led not only to competing systems but also to competing discourses in the field of health.

6.1 Counter-effects of formally associating African medicine and biomedicine

Let us first look at some of the internal challenges posed when attempting to associate informal health care systems within a formal, national grid. Gordon Chavunduka and Murray Last rightly conclude their important study of these problems as follows:

> "The most obvious difficulty lies in the formal training and certification of healers in the future, and in particular what the content of that training will be. ...there is an inherent danger that traditional medical knowledge will be defined simply in terms of its technical herbal expertise, that this experience will in turn be recognised only for its empirical pharmacognosy, without reference to the symbolic and ritual matrix within which it is used still less, the social matrix in which those rituals and symbols have meaning at any particular time or place. ...Traditional medical knowledge, however, is much broader and more subtle than technical herbal expertise. Indeed, the very nature of this knowledge may militate against its formal structuring in the way professionalisation might seemingly require with its objective examinations and tests of efficacy. (Last and Chavunduka 1986:267-268)"

Local community elders and a spirit of co-operation among healers and in the cult groups seem to guarantee the healers' professional ethics (Oyebola 1981).

One could argue that by offering basic forms of technical medical training to informal health providers and by exposing medics-in-training to socio-cultural approaches to health and local knowledge systems, one might help to bring the African medicine and biomedicine closer together. And yet it appears that the converse approach the medical training of healers or a transfer to them of medical technology may in fact lead to the latter's deprofessionalisation. This is mainly due to the high level of competition among fellow-healers who seek to gain governmental or institutional recognition. Oyebola's observations from Nigeria apply to many other contexts as well:

> In order to counteract the criticism of lack of uniform standards among their members, some traditional healers' associations now issue certificates to their members. ... The traditional healers have also started putting some of their medicines in bottles that are well labeled. ... Many of the healers' associations have tried to meet the legal provisions of the Companies Act by engaging lawyers who help them

> in drafting constitutions. ... A few healers have set up traditional medicine hospitals where girls with little education are given uniforms and function as nurses. Instances of traditional healers owning and using stethoscopes have been reported in a national daily. (Oyebola 1986:232)

By defining themselves as herbalists, many healers have tried, particularly in the 1970s, to escape the negative image regarding healers, an inheritance of colonialism and Christianisation which had identified traditional healers with the realm of magic and the occult, with pre-scientific, inefficient, primitive, or even satanic practices. Traditionally, however, the use of herbs is embedded in a much more encompassing order, in a cosmology and in ritual performance, implying that one's life-world or cosmic order (including the medicinal plant), group and body resonate in a meaningful way. It depends on the etiology of the disorder to be treated whether the aim of the medicinal preparation and its administration is of a homeopathic or allopathic nature.

It has been observed in other African countries (see Fassin 1992) that those healers who are most eager to co-operate with the medical health care establishment on an institutional level are also those who are most in need of public legitimisation, primarily because it is precisely these persons who lack any form of tradition-oriented authority. A very real danger now exists that this relatively new quest for legitimation may lead to an exclusion of the more authentic cult/folk healer.

6.2 Epistemological difficulties: a sociology of knowledge approach

Differing conceptions of the body and the person reveal the as-yet-unbridgeable gulf between biomedicine and African therapies. Cultural idioms of distress and the intrinsically group therapeutic approach characteristic of African healing point to the fact that illness is above all a socio-cultural phenomenon. Here one might speak of a fundamentally relational etiology. As we have implied in the description of our hypotheses above, the biomedical approach situates disease primarily inside the human body. Cult/folk healing, which builds on a pre-given cultural perception, sees the person rather as a network or junction of relations and forces; illness is then an indication of a rupture or anomaly in those relations. At this point one understands the essentially physicalist approach taken by biomedicine, whereas African medicine intrinsically

refers to immaterial aspects of life. This point bears repeating in order to understand and stress two facets of a profound, secondary epistemological gap, intimated in the above, which this project has also encountered.

Healers accommodating to the mindset of the researchers

The first inkling of a secondary problematic area is the vehemence and persistence of many healers in proclaiming that they work solely on the basis of the medical properties of the plants they use. Similar affirmations, more understandably, are even more common among the faith healers. Though only a few faith healers use plants in therapy, they all of course attribute their powers of healing to the Holy Spirit. Many of the cult healers use the same spiritual language: alongside their plants, they will claim that it is their prayers and the power of God which ultimately heals. To the casual researcher, it might then appear, on the basis of the testimony of the healers themselves, that their therapies have nothing to do with ancestors, the spirit world, symbolism, group or ritual. One can easily comprehend that; if this discourse is accepted, any reference to the psychic, social or cultural spheres is effectively voided.

Echoing the testimonies of many of her colleagues, for example, one faith healer (Prophetess Ngadi, Ndjili-Kinshasa May 8th 1998; speaking in the vernacular lingala) informed us: "Tata azalaki kosala na makambo yo kala ya bakoko. Ngai nazali kosalela na tino ya Biblia, ya priere. Tobongola makambo ya bakoko tokoma na Biblia, na losambo. Ngai nayebi Nzambe nasalisaka naboyi nzete na kombo ya Nzambe. Bukoko ya kala tobwaka". (My father worked according to the old customs of the elders. I am working through the Bible and through prayer. We changed (kobongola: transform, modify but also disfigure) the customs of the elders and we arrived at the Bible and at prayer. I know God and work with him, and I refuse plants (nzete, that is, healing with plants in the way the elders did) in the name of God. We have thrown away the old ways of the elders.) This type of response poses both methodological and theoretical problems even for the dedicated, and forewarned researcher. Methodologically, cult/folk healing is intrinsically esoteric, not because witchcraft and sorcery figure at its horizon, but because it draws on the same psychic and cultural force fields which escape public observation, at least outside of the cult-therapy traditions which are forcibly communal in nature. The anthropologist familiar with African medicine can safely

assume, for example, that the vegetal substances for a particular treatment have probably been revealed in dreams to the cult or faith healer, collected in a particular, ritually-determined place and manner including the offering of prayers to the spirits, and prepared according to specific procedures determined by the healing tradition. When a healer denies that this is the case, the researcher is hardly in a position to contradict the informant or attempt to demonstrate an inconsistency. On the theoretical level as well, the observer-researcher has no right to contest the explanation of the healers themselves where they deny that their capacity to heal has anything to do with *non-empirical*, non-organic, properties or forces.

We have undoubtedly encountered here a limitation of the social sciences, as well as psychiatric and group-psychotherapeutic approaches in dealing with health perceptions and behaviours. Looking at the phenomenon more closely, we discover two levels at which scientific investigation encounters resistance. The first is a sociological phenomenon of auto-censure. This means that the only healers who are ultimately willing to co-operate with the initiative are those who are prepared to adopt a quasi-medical and christianised discourse: in the presence of researcher or biomedicine, they all affirm working strictly with medicinal plants, while at the same time some attribute their healing capacities to God or the holy spirit; a number of them may even pray together at the opening of their formal meetings. One might surmise that, at least for this group, this form of discourse does not reflect their actual practice, and indeed in most cases it does not. Does the researcher then assume that the healers are inconsistent, dishonest? And here we reach another, more subtle, form of limitation to social science and psychiatric research, what we shall call a matter of competing discourses. Verbally at least, these cult/folk healers would seem to be reducing their therapies to phytosanitary principles (they themselves are fond of speaking of the "principe actif" residing in the plant substance) just as the faith healers relegate any therapeutic efficacy to the work of the holy spirit. According to our socio-cultural perspective on informal therapies, however, patients would find little satisfaction in healing practices which do not take account of an essentially relational and group etiology.

It is worthwhile here to look again at how issues of cultural etiologies and therapies, on the one hand, and epistemologies, on the other, relate.

There can be no one-sided thrusting of scientific (medical) criteria (originating from a written culture with a visual logic) upon the cult/folk healers to evaluate their fundamentally oral and even gestural ways of gaining and transmitting therapeutic knowledge in the healing cults and folk practices. Each cult plays on the emotions, and engages the totality of sensorial corporeality, cosmology or life-world (that is, beliefs and horizons of meaning) and relevant kinship relations (social body) in the process of healing. The patient's symbolic death and rebirth takes place within a group drama and on the basis of complex symbolic processes. Each cult offers its own chain of metaphors and metonyms in order to remodel the specific syndrome into a vital consonance between body, group and life-world. A sphere of initiatory secrecy and sacralisation underpins the therapeutic relationship between healer and patient or neophyte. Of course, the ways in which such multilayered and predominantly non-verbal semantic drama leads to physical, affective and cognitive changes that not only heal but also give a new identity to the patient, escape a more positivist medical understanding. By definition, folk/cult healing cannot be evaluated by means of criteria commonly used for positivist scientific knowledge or applied by governments as standards for medical and therapeutic professionalism. The healers' therapeutic success with the patient equally functions as a test of their authenticity.

There remains a question to which we alluded earlier regarding the logical consistency of an apparently haphazard appeal to presumably contradictory explanatory theories where a cult/folk healer may shift from one discourse to another depending on his audience or the context. Indeed, the use of local language is telling: one speaks lingala or French to the researcher or in a community meeting, but once down to the serious business of healing, the only effective speech whether spoken or paradigmatic is the healer's mother tongue. The urban healer has been forced to carry his skills beyond ethnocultural boundaries and is thus necessarily faced with a problem of translation, at least where legitimation of the practice is at stake. To a certain extent, recourse to an otherwise foreign discourse is only a form of extension of one's professional sphere. But that is not all. Healers very well grasp the efficacy of modern drugs and surgery just as they recognise the validity of medicinal plants. Yet this acknowledgement in no way cancels or diminishes their knowledge and ability to manipulate other forms of power. In this, in their acceptance of epistemological categories and logic which surpass the primitive and

exclusive distinction between the material and the immaterial, they are indeed pluralistic, and intellectually honest. We can only raise the question as to whether the appeal at different times and in different contexts to equally valid discourses actually constitutes self-contradiction? What does it mean when one discourse (modernist, objective, drawing on the authority of science and the Medical Order) claims to be exclusive while the other (experiential, relational, drawing on the authority of Cult Traditions) does not?

For the healers, then, adopting a scientific, and christian discourse (for indeed, there is no contradiction evident here between the two) is simply one natural step or strategy in the effort to organise and improve both the quality and quantity of their services, and thus to legitimate their practices. In this way, they can only be said to be responding perfectly to the aims and objectives of the researchers who have sought their collaboration. The phenomenon of externally-initiated social projects and their agents raising expectations, paralleled by the soliciting (conscious or unconscious) of particular behaviours, among the target group is well-known; this project was no exception to the rule. In this sense, requiring that healers practice in a building belonging to the centre (something which some healers themselves decided upon, ostensibly to improve hygiene, presumably because of the added status) raises fundamental questions with regard to the integrity of cult therapy practice; we have not yet been able to adequately assess the consequences of this development. Again, it is important here to recall the weight posed by the State, the school and the mission to the urban society through the rationalising and modernising project which has been felt and absorbed, to varying degrees, by all levels and classes of the population---a point described at length in the previous section.

The mindset of the researchers

Our reflections cannot be addressed solely to the healers, for the researchers themselves are subject to the same sociological forces and epistemological conditions. It was our experience that, despite our vocation as social scientists and psychiatrists, most of the researchers were either unable to, or experienced great difficulties in, piercing the veil of the universalising and rationalistic knowledge purveyed by the western education we all shared. This made it nearly impossible to uncover precisely the culturally particular elements of illness and healing among

the suburban populations of south-western Congo. There are most certainly aspects of therapy dynamics which are shared by many cultures across the world, and discovering these was in fact part of the challenge of observing health behaviour among a mixed ethnocultural population. But comparative and generalising theories are clearly inadequate to explain the deepest, to a large extent unconscious, levels of local conceptions and practices related to illness and healing.

The fact that a dialogue between healers and researchers was at all possible is in part due to a mutual recognition of the other's vocation. Acceptance by others of our roles as researchers was determined by our negotiation of trust in order to overcome the biases of gender, ethnocultural identity, educational and middle-class status, or to avoid being perceived as a member of a state institution, for example. But trust and the possibility of dialogue is not a sufficient condition for mutual comprehension. As we have already shown, the adopted (we do not wish to imply 'affected') modernising discourse and behaviour of the healers, particularly in the presence of the researchers, constitutes an added obstacle which only the researcher who is familiar with the healer's mother tongue, local culture of origin and age-old hermeneutics proper to the healing cults, is able with any credibility to circumvent.

Serious limitations to research are encountered already on the linguistic level, for example. If the researcher does not possess a thorough grasp of the healer's mother tongue, it is all but impossible to carry on a serious dialogue on therapeutic practice with him or her, much less explore the culture-bound etiologies underlying the practice at hand. It is one thing if researchers simply have not had the opportunity to develop the necessary linguistic skills to deal with a particular informant and resort to translation. It is yet another when systematically, in the course of interviews, questionnaires and organisational meetings, the default language is never a mother tongue but the lingua franca (lingala) or that of formal schooling (French). This is in part a consequence of working in the urban context where ethnocultural groups mix, but this aspect does not impact directly on the culturally determined health seeking behaviours and therapeutic practices. The limitations and dangers of translation are well-known. But we do not mean to imply that the culturally determined aspects of etiology and therapy are exclusively verbalised or communicated through language; we would argue that the non-verbal and gestural level, which

may be even more culturally conditioned, is in fact predominant. This alone would explain the marked capacity of cult and faith healers to work in an interethnic context, although we are dealing with Bantu populations who share many cultural characteristics.

Rather, we observe that the use of a non-ethnic language (French or the vernacular lingala) is often either the unconscious choice of the researcher, who no longer masters the subject's mother tongue, or the conscious choice of the researcher who feels the necessity of communicating a certain status, education and distance from what the (post)colonial discourse commonly designated as indigène (indigenous), meaning backward, ignorant and typical of village life. The informant or counterpart is equally willing to attempt at least to speak in the modern language in order to affirm his or her own modernity. We have already spoken of the phenomenon of raised expectations and conformity to the expectations of project leaders or funders. This is no less applicable to researchers than to target groups.

Unlike the less well-educated, the researcher familiar with secularistic western science will today of course not be anxious to appeal to christianity as some of the cult/folk healers seem to do in order to sustain the image of having acquired the status of university researcher. Rather, for the sake of research, he or she is quite capable of fully participating in a healing service for which, according to the criteria imposed on participants by the faith healers themselves, one must have faith, be pure, and so on. Yet Christianity is omnipresent in the capital and south-western Congo, and everyone is familiar with its language; thus it is no surprise that anyone can easily resort to Christian discourse without necessarily being a practising believer. The problem resides more in the fact that Christianity has been in the forefront of the civilising mission, particularly where local religious beliefs and practices were concerned, for they were considered, a priori, pagan or pertaining to magic and fetishism (depending on whether the dominant discourse is religious or scientific). Even the modern educated Congolese is then anxious to avoid too close association with those local cultural spheres which smack of backwardness and ignorance, for fear that their affirmation or mere contiguity will make him or her appear equally backward and ignorant.

It is not that the researcher has abandoned the right to a plural discourse

except to the extent that his or her education and urban life have caused him or her to forget his or her culture of origin, but that he or she is all too often anxious to impose that discourse which confirms his or her modern status, power and education, at least in contexts where such behaviour is socially indicated. This means that the researcher is often less motivated to revalorise a local knowledge or practice, which he or she has forsaken, than to affirm the superior status of his or her university-learned rationalistic and universalising language. Without passing judgement on the researcher's personal motivations and conscious intentions (indeed a western problem), we can understand that the weight of the civilising mission is such that dealing seriously with indigenous culture requires not only significant effort (in terms of studies focused on indigenous knowledge and practices) but also a break with prevalent attitudes.

7. CONCLUSION

The way in which healers are capable of dealing with the dictates posed by city life, medicine and the market economy, and creatively transform and metabolise these conditions and influences, or the way in which they succeed in critically voicing the aspirations of the people amid the current institutional crises, or in critically validating the medical knowledge and know-how of the people and the African civilisational traditions of healing, is of vital importance for their reproduction. At the same time it is one of the key problems in our applied research. Our contribution must lie in the mediation between the world of healers and formal health care institutions as on the level of acquiring critical insight and knowledge. Among other things, this means that researchers must constantly be aware of the sociological and cultural factors impacting on their epistemological practice in order to minimise the limitations and maximise the potentialities of the social sciences, psychiatry and group psychotherapy they mobilise.

Acknowledgements

Following my training in philosophy and in anthropology in Kinshasa, I participated from January 1971 until October 1974 and in April-May and September 1991, in the daily life of Yaka people in a settlement of villages in northern Kwaango along the Angolan border (in the Bandundu province of Southwest Congo, some 450 km from Kinshasa). Since 1986, for approximately two to six weeks a year, I have been working among the Yaka and with Yaka diviners and healers in Kinshasa, in the poverty-

stricken suburbs of the capital Kinshasa, as well as with Koongo healing churches.

I have carried out or supervised research, albeit briefly, in Cairo, northern Ghana, southern Ethiopia, northern Israel (Druze communities), Southwest Kenya, Northwest Namibia, southern Nigeria, central and Northwest Tanzania, as well as in Tunis. All this research was, or is being, carried out in the Africa Research Centre, Department of Anthropology, Catholic University of Leuven (Louvain), Belgium. My research has been supported by the Fund for Scientific Research Flanders, the European Commission Directorate-General XII (B4 Sector Health STD2 0202B and STD TS3 CT94 0326; Coordinator and contractor, Prof. R. Devisch; Subcontractors, Prof. Lapika Dimomfu and Dr. J. Le Roy see Le Roy 1994, 1996), and the Harry-Frank Guggenheim Foundation, New York. I moreover acknowledge the valuable cooperation, in Kinshasa, of the IMNC (Institute of the National Museums of Congo), as well as CERDAS (Centre for the Co-ordination of Research and Documentation in Social Science for Sub-Saharan Africa, under the supervision of Prof. Lapika Dimomfu, which co-ordinated the sociological investigation carried out by Mr. Kiyulu N'yanga Nzo, Mr. Mulopo Kisweko and Mr. Matula Atul Entur, regarding the utilisation of the various health centres in the health zone of Mont Amba-Kinshasa). Bumbakini Ekwalama, Pascaline Creten, Jaak Le Roy, Matula Atul Entur, Muyika Musungu and Espérance Niku have joined parts of the research in the healing churches in Kinshasa. I thank Peter Crossman for his editorial help; he did mainly contribute, namely as first penholder, to the present paper's final sections on "Healers accommodating the mindset of the researchers" and "The mindset of the researchers". For the E.C.-funded research, I gratefully acknowledge the contribution to the research proposal by my colleague Filip De Boeck in theorising the dialectics between gift logic and monetary commodity exchange in view of understanding the new sociologics involved in health-seeking in Kinshasa. The hypotheses he has helped to put forward in that regard are in line with De Boeck (1996). In 1996, Walter Six made some initial contributions to the empirical research in Kinshasa. In Peter Crossman was the first author of the present paper's final section Competing health systems, competing discourses). The struggle, questions, itineraries, multiple voices of these many men and women throughout Africa, who have refigured my identities, are somehow rendered in my dialogical bifocality, my at times passionate writing and my

lasting commitment to an anthropology of empowering their voices, among others by overturning conventional representation and refiguring the relationship between science and local knowledge systems.

NOTES

1.See Bantje 1988, Bibeau 1981b, Bassett and Mhloyi 1991, Bledsoe and Cohen 1993, Caldwell and Caldwell 1990, Chabot 1995, Cole 1992, Dodge 1990, Faloloa and Ityavyar 1990, Fassin 1994, Feachem and Jamison 1991, Feierman and Janzen 1992, Fontaine 1995, Ferguson 1986, Fosu 1989, Gordon 1991, Headrick 1994, Hours 1986, Howson 1996, Falola and Ityavyar 1992; Janssens, Kivits and Vuylsteke 1997; Kloos 1987, Lado 1992, Mahongo 1986, M'Bokolo 1984, Ogba 1989, Okelo 1997, Raikes 1989, Rutabanzibwa Ngaiza 1985, Schoepf 1987, Schipton 1990, Schulsinger and Jablensky 1991, Singleton 1991, Turshen 1991, Van Balen 1997, Van Ginneken and Muller 1984, Van Lerberghe 1993, 1994, Vaughan 1991, Whyte and Karirki 1991.

2. Due to lack of available data, I am not in a position to discuss the input of Asian and other non African healing traditions in African cities. I venture to say that, except for charismatic healing, they are generally not affordable to low-budget health-seekers.

3. The perspective of endogenisation of both the research perspective and university training in the knowledge systems of African healing arts seems to offer a hard-won way out from the negative attitude towards the local. A revaluation of the endogenous entailed the recent shift in the scientific discourse from a universalising/globalising stance to an openness for plural, culture specific knowledge systems: Crossman 1998, Devisch 1997, Feldman and Welsh 1995, Hountondji 1994, 1995, Inayatullah 1991, Johannes 1989, Kloppenburg 1998, Long and Van der Ploeg 1994, Nader 1996, Waast 1996, Wallerstein 1996, Warren, Slikkerveer and Brokensha 1995.

4. Very relevant health systems policy and research in sub-Sahara Africa have been outlined or reported on by Alihonu 1993, Buschkens 1990, Chambers 1992, Tipping and Segall 1993, Varkevisser 1993.

5. Our colleague, Filip De Boeck, did field research, September 1996 and 1997, regarding the relationship between culture and trauma in the aftermath of the Ebola epidemics that occurred in 1995 in Kikwit (W. Congo), casting the specter of contamination and distrust on any form of biomedical health care.

6. The revaluation of African medicine and the complementarity between biomedicine and African civilisational traditions of healing have been advocated by WHO (1976, 1978, 1990), UNESCO, OAU, international colloquia and many publications: Ademuwagun 1979, Akerele 1990, Alexander 1985, Anderson 1991, Anyinam 1987, Aryee 1983, AttiasDonfut and Rosenmayr 1994, Bannerman 1983, Benoist 1996, Bibeau 1979, 1981a, 1982, 1984; Boddy 1989, Brink 1982, BrunetJailly 1993, 1997, Buckley 1985, Chavunduka 1994, de Rosny 1985, Devisch 1993, Devisch and Brodeur 1996, 1999, Devisch and Mbonyinkebe 1997, Dozon 1987, Fassin D. and E. Fassin 1988, Fassin E. and D. Fassin 1988,

Feierman E. 1981, Feierman S. 1981, 1985, Feiermman and Janzen 1992, Fosu 1981, Frankenberg and Lesson 1974, 1976, 1977, Gelfand 1985, Green 1988, Good 1987, Gordon 1991, Green 1988, Heggenhougen 1991, Heggenhougen and Sesia Lewis 1988, Imperato 1977, Janzen 1978, Janzen and Prins 1979, Jules Rosette 1979, Ingstad and Reynolds Whyte 1995, Kinani 1980, 1981, 1983, Lambo 1963, Lapika 1983, 1984, Kroeger 1983, Lasker 1981, Last and Chavunduka 1986, Lutz Fuchs 1994, Lapika 1980, Mbonyinkebe 1987, 1989, Mesmin 1997, Mullings 1984, Nyanwaya 1987, Oyebola 1981, 1986, Pearce 1982, Peltzer and Ebigbo 1989, Pillsbury 1982, Pool 1994, Reis 1996, Reynolds 1996, Sargent 1982, Sofuluwe and Bennett 1985, Taylor 1992, Twumasi 1988, Van der Geest and Reynolds Whyte 1988, Van Wolputte 1997, Varela 1985, Vaughan 1991, Ventevogel 1996, Wall 1988. Points on the African healing arts with regard to insanity and psychosomatic disorder were brought to the attention by the Dakar school of psychopathology, the Nouvelle revue d'ethnopsychiatrie (Grenoble), Bibeau 1981b, Coppo and Keita 1990, Corin and Bibeau 1975, 1981, Corin and Murphy 1979, Egdell 1983, Field 1960, Kisekka 1990, Lambo 1963, Mullings 1984, Schurmans 1994, WHO 1990.

7. We refer here to the work by members of CERDAS at the University of Kinshasa (Lapika 1983, 1984) and the Africa Research Centre at the University of Leuven (Bekaert 1998, Creten 1996, De Boeck 1991, 1994, 1996, 1998; Devisch 1993, 1995, 1996, Devisch and Brodeur 1996, Van Wolputte 1997).

8. Gordon Chavunduka, anthropologist and Vice Chancellor of the University of Zimbabwe, is the President of the Zimbabwe National Traditional Healers Association (ZINATHA) and Chairman of the Zimbabwe Government Traditional Medical Council.

9. One thinks of the faith healer who receives a patient from a desk decorated with a pot of flowers. He takes out pen and notebook in which an assistant notes name, address and personal data of the client on a blank left page. The healer, in semi-trance, then scribbles out a diagnosis on the right-hand page. When finished, he instructs the assistant to write down the prescription in the remaining space on the leftside. The case studies are replete with this sort of data demonstrating a give and take between systems, most notably the parody of the formal by the informal (Devisch 1996).

10. Having organised themselves, the healers felt their fees should be increased and assumed that the researchers should subsidise their activities, paying for equipment, costs for medicinal plant collection and so on.

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