Marketplace conversations in Cameroon: How and why popular medical knowledge comes into being

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MARKETPLACE CONVERSATIONS IN CAMEROON: HOW AND WHY POPULAR MEDICAL KNOWLEDGE COMES INTO BEING

ABSTRACT. The author argues that buyers and sellers of Western pharmaceuticals at a local marketplace in Cameroon construct their ideas about illness and medicines in reaction to two kinds of situations in which they find themselves. The *market situation* induces people to adjust their medical beliefs to the economic transaction. Sellers are likely to inflate the efficacy of medicines and customers adjust their medical concepts to fit their limited financial means. In that way they rationalise their inability to buy all the drugs they would have liked to buy. The *interview situation* leads informants to produce rather specific and assured answers on topics about which they may know very little. Reasons include the inequality between interviewer and informant and the latter's wish to avoid making an ignorant impression on the interviewer. Three conversations held during fieldwork in 1983 are discussed.

INTRODUCTION

All human knowledge belongs to culture. The statement "I know" is only one phase of a social and cultural process. Indeed, 'knowledge' is not only culture-bound, it is situation-bound as well. What is presented as knowledge depends on who the speaker is and who the listener, what the question was, etc. It may even matter, so to speak, whether the sun is shining or it is raining.

If knowledge is culturally produced, anthropological knowledge will be no exception. Philosophers and farmers, mineworkers and medical scientists, all develop elegant theories to explain their experiences. Anthropologists, too, construct plausible and coherent bodies of knowledge which we should regard as culture- and situation-bound artifacts. Obviously this line of argument also applies to this very text. It would not be so difficult to trace the process of its making and to place it in the story of my life and in the context of anthropological conventions. That is not the purpose of this paper, however. Suffice it to say that my role as ethnographer is rather like that of the old Cameroonian vendor of medicines who, as we shall see, struggled to verbalise coherently what was probably an utterly confused picture in his head.

Interest in how knowledge is produced is consistent with a growing awareness among anthropologists that nothing they 'find' simply exists 'out there'. What people make, do, say, and think depends on the setting in which they find themselves, since "We are never not in a situation" (Fish 1979:257). By studying the context in which informants, and then in turn ethnographers, tell

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what they know, we enhance our understanding of such knowledge.

The issue of the circumstantiality of knowledge is of particular relevance to medical anthropology. For a long time medical knowledge has been regarded as a more or less firm foundation for the selection of indicated medical interventions, a charter for preventive and curative actions. By knowing the charter, it was believed, one could see the rationality of medical actions. A very sophisticated example of this view is Evans-Prichard's classic on Azande witchcraft.

Recent research and reflection in medical anthropology, however, have called this somewhat static and too mechanical picture of medical knowledge into question. Last (1981) has pointed out that indigenous healers among the Hausa in Northern Nigeria command no systematic body of medical knowledge. One of the most conspicuous characteristics of their practice is not-knowing. Both healers and patients share a certain disinterest in medicine. When trying to construct a Hausa medical dictionary, Last found that "a large proportion of medical words (but especially terms for illnesses) have no standard meaning" (p. 390). He refers to Hausa indigenous medicine as a non-system.

Tedlock, who did fieldwork among the Maya in the highlands of Guatemala, also challenges the over-systematic bias of most medical anthropologists. She refers to the hot-cold dichotomy ascribed to Latin American indigenous medicine, as 'native etics', i.e., *anthropological* claims about what the *natives* think. The hot-cold concept, she writes, is "blown up out of proportion in the process of answering anthropological questions" (Tedlock 1987:1080). 'Native emics' (what the natives really think...) are far more complex and inconsistent. She illustrates her contentions with fragments from interviews in which people contradict themselves continuously and prove extremely opportunistic in what they say they think and how then act. When a young Maya was asked why a hot poultice was used to treat a hot illness, he answered: "Well, it's because it works! You only think about the hot-cold when you're not sure what to do" (Tedlock 1987:1075).

Young (1981), who carried out fieldwork in Ethiopia, discusses epistemological problems in the creation of medical knowledge. He argues that people's medical knowledge is fragmentary and changes continuously with the changing circumstances in which they find themselves. What we call knowledge often proves – in Western terminology – mere rationalisation. Medical 'knowledge' both precedes and follows therapeutic decisions.[1]

> ...An actor's medical knowledge (belief) and his statements are not epistemologically homogeneous. That is, he does not know all of his facts in the same way. This is accounted for by the fact that his knowledge is recursive and processual, in the sense that he continually evaluates it against his intentions, expectations, and perceptions of events, and sometimes he compares it with other bits of his knowledge of similar events (Young 1981:379).

It would be inconsistent for anthropologists not to apply the same analysis to

their own production of knowledge. Several authors (see, e.g., Marcus and Cushman 1982; Clifford and Marcus 1986; Geertz 1988) have discussed how ethnographic texts emerge. They emphasise that these texts, like literary ones, adhere to stylistic conventions which change from period to period. The scientific authority of a text may depend a great deal on its stylistic presentation. Many an anthropologist has come to discover that the journey from fieldwork to publication is long and winding. Along the way he may filter his experiences again and again, until he feels they display the right colours, which are likely to be those of the latest fashion.

In this paper I have set myself the task of demonstrating how medical as well as ethnographic knowledge are produced, more or less simultaneously, in a common effort. I shall describe how popular medical knowledge comes into being on a market in Ebolowa, a provincial town in the south of Cameroon. I will present three pieces of conversation between a vendor of medicines, two of his customers and myself. I hope to convince the reader that the medical knowledge which the three Cameroonians present is produced in, and is part of, a specific social setting. I shall include scrutiny of my own role in that production process, which was mainly one of eliciting statements. The article thus answers Kleinman's (1980) call for more research into popular medical beliefs and practices, especially into people's efforts at self-medication. The paper, triggered by observation of a poor vendor of often expired drugs and his clients, explores these people's situational and opportunistic explanations of illness and treatment.

RESEARCH SETTING AND CONVERSATIONS

In 1980 I carried out medical-anthropological research in the Ntem Division of Southern Cameroon. The research was not on 'traditional medicine', as one might expect from an anthropologist, but on the distribution and use of Western pharmaceuticals. At that time critics had started to blame the international pharmaceutical industry for dubious marketing practice in developing countries. It struck me that such accusations rarely included any eye-witness account of what happened to these medicines at the local level. Recalling my earlier research experience with the widespread informal sale of medicines in Ghana, I decided to concentrate my fieldwork on how pharmaceuticals were distributed outside official channels, i.e., outside hospitals, health centres and pharmacies. My initial hunch proved accurate: pharmaceuticals, including so-called prescription-only drugs, were sold freely (without a prescription) in shops, kiosks, market booths and even in the town's pharmacy.

The reasons for this soon became clear to me. The public health services did not function as they should. They were often short of medicines and other

materials and many of their nurses and doctors felt frustrated about their jobs; they could not do their work due to these shortages, their living conditions were often poor and their patients blamed them for not being able to provide proper care. Medicines and treatment in the public services were officially free of charge, but often patients had to pay something in order to get help. Not infrequently patients also discovered that no medicines were available and they had to travel to the nearest shop or pharmacy to buy the prescribed medications. 'Nearest' could mean up to a day of travel, including the time spent waiting for transportation. Sometimes they did not even find anyone present at the health centre. In actual practice, therefore, the so-called free service often proved to be quite expensive because it forced people to pay for transportation and to buy their medicines elsewhere. It also cost them considerable time.

Apart from the public services there were private, mostly church-related, hospitals and health centres and commercial pharmacies. All of these functioned relatively well. They had a regular supply of drugs and their personnel were at their posts.

Finally, there was the informal private sector where medicines were traded. Those taking part in this trade constituted a heterogeneous group. Most were ordinary vendors who sold general provisions, including medicines, in shops and kiosks. In the division capital Ebolowa there were approximately 75 such shops and kiosks where one could purchase at least one or two types of medicines. A second category consisted of market vendors who sold medicines alongside other products. A third group could best be referred to as 'hawkers'. They travelled from village to village during the cocoa harvest season when the villagers had some extra money at their disposal. These hawkers provided a variety of articles in addition to medicines. A fourth category consisted of traders who were specialized in the sale of medicines and had a much larger assortment than the previously-mentioned groups. In Ebolowa I encountered four such traders. They not only sold medicines but also gave medical advice when asked. One of them gave injections as well. A fifth group comprised medical institution personnel. Some of them privately sold medicines which were supposed to be provided to the patients free of charge.

Sellers of medicines in the informal sector mainly obtained their products from three sources: medicines were smuggled into Cameroon from neighboring Nigeria and distributed throughout the country; they were purchased – without prescriptions – from legally established pharmacies and sold at a profit; they were bought from medical service personnel who thus tried to earn some extra income.

These private services – both formal and informal – are living proof of the malfunctioning of public health care. They exist because and where the public services do not achieve their objectives. My estimate is that about one-half of all modern health care delivery in Cameroon occurs outside the public services. The

informal circuit has acquired a crucial position in daily health care, next to the private hospitals and health centres.

There are at least four reasons why informal drug vendors respond even better to the needs of poor people than the formal institutions. All four are related to availability and attainability. First, drugs from vendors are more affordable. Clients can purchase as little or as much as they need for self-treatment at that moment. Second, drug vendors are geographically more accessible than other sources. A vendor can always be found within a radius of a few kilometers from where one lives, but a pharmacy or health centre with drugs may be 50 or more kilometers away. Third, most vendors are available day and night. Their shops only close when everybody goes to bed; even after 'closing', it is usually possible to buy medicines if necessary. This flexibility contrasts sharply with the strict time schedule to which the formal services adhere. The fourth reason for the drug vendors' popularity is that the social distance between them and their clients is much smaller than that in the formal sector. In a shop it is possible to look around, examine various products and ask questions about how they should be used. Such behaviour is not possible in a hospital or pharmacy.

There are, however, also disadvantages to buying from a drug vendor. Clients know, for example, that the products they buy are often of inferior quality. The choice of medicines is limited and vendors are known to have little medical knowledge. The preference for a drug vendor should be viewed within the context of the total range of therapeutic choices. People with a medical problem will first try a treatment which costs them little. Only when this fails will other, more costly and more inconvenient, steps be taken (see further Van der Geest 1982, 1987, 1988).

It was in the informal circuit that I came to know Mr. D., an old man who sold Western medicines in one of the three markets of Ebolowa. The man, a Bulu, had been a cocoa farmer before. Since losing one of his legs after an accident on his farm, he had tried to eke out an existence by selling medicines. Some forty different Western drugs were usually spread out on a small table in from of him. Of some kinds of medicine, only a small supply appeared available, of others much more was in evidence. Some were in their original packing, others were in jars and boxes without a label. I estimate some 75% of his products would fall under the category of 'prescription-only'.

The old man's sitation, let me emphasise, was extremely miserable. Owing to his handicap he could not move. He spent day and night on his corner at the 'market', not the real town market but the former lorry station, a place in the centre of the town. Here many people were always passing by, those who arrived in town and those who were waiting for a taxi. I noticed that some people left their luggage with the old man while they did their shopping. The 'market' was a covered place about 10 meters wide and 30 meters long. It held an estimated ten booths where one could buy snacks, drinks and daily neces-

sities. In two booths medicines were sold. Between the booths stood wooden benches where people sat to eat or relax in the shade, waiting for transport, conversing, or taking a nap.

In 1980 the old man had received a grant of 30,000 CFA (about £.60) from the local Department of Social Affairs to set up his small business (although strictly speaking it was illegal). The report of his case, made by the social worker, contained the following description of his condition:

Mr D., incapable de continuer l'entretien de sa cacoyère, diminué, n'ayant aucun moyen de déplacement, vit en plein air à l'ancien stationnement des cars ou il demande l'aide journalière aux gens de bonne volonté et sympathisants de la ville d'Ebolowa. Il fut ménacé par son frère qui ne voulait plus vivre avec lui, raison pour laquelle Mr. D. quitta son village natal pour aller vivre en ville.

Mr. D., divorcé pendant un bon temps, confia son fils à sa mère qui demeure à M-E. Cette dernière, vieille et fatiquée, s'occupe de l'entretien de son petit fils, consideré comme orphelin complet. Mr. D. est purement et simplement indigent.

Compte tenu de tout ce qui précède, il serait souhaitable d'accorder un secours à l'interessé pour lui permettre de s'installer.

The old man had made a little shop out of plywood in one of the hollow pillars that supported the roof of the market. In the night he withdrew to the back of his shop where he had a bed and some possessions, most of them in old bags. Everything looked sordid, and I never fully understood how he managed to live. When I passed in the night, I found his place closed. He was at loggerheads with most of his relatives whom he accused of taking the profits from his cocoa farms without paying him a penny. An old woman seemed to concern herself with him to some extent. I am not sure if she was related to him, nor did I ask him whether he paid her for her help. I had the impression that she carried out her chores when very few people were around. Once, very early in the morning I saw her emptying his chamberpot in the street, just behind his store. The other vendors on the marked had little contact with him. They found him a peculiar and unpleasant person. He often shouted at people and children were afraid of him. He profoundly mistrusted people. Once, when after my arrival in town I had sent a young boy to bring my bag to the old man's place, he rebuked me for giving the bag to someone I did not know. I should "Trust nobody", he said.

My visits to him were a change in his dreary and somber routine. He clearly appreciated the attention I paid him. He used my concern, I suspect, as a proof to others that he was somebody after all. That's how in any event it seemed to work out. People spoke to me about him and referred to him as my friend. The old man called me *docteur* but at the same time we addressed each other with *tu*, a distinction which in Cameroon is of less significance than it would be in France, however.

In our relationship we were definitely not equals. The old man hoped to benefit from me in social and material respects. He never, however, made his requests in a submissive way. He kept his dignity and often emphasised his age

and greater experience while he advised or criticised me. He had clever ways of persuading me to do what he wanted. One request he made continuously for example, was for me to buy medicines for him on my trips to Yaoundé and other towns. One day, when I told him that I did not intend to supply him with medicines, he started to laugh and said: "You (*tu*) are my deceased brother who has returned to help me." I guess it meant that I had to do what he wished because there was no one else to help him. I give this example to illustrate that while he certainly depended on me for a number of things, rather than beg he chose to exert pressure on me.

There were other instances, however, where his utter helplessness and dependence could hardly be concealed. He tried to convince me that I should buy a wheelchair for him. I did not but arranged something which I thought would be more useful: I had an artificial leg made for him at the hospital. He agreed and I took him a couple of times to the hospital to fit the prosthesis. I had hoped that it would make him more independent, but when the leg finally arrived he refused to wear it. It strained our relationship to some extent.

In 1983 I revisited Cameroon and spent two weeks in Ebolowa. During one week I paid daily visits to the old man. I bought food at the market which we ate together and we discussed his business. Usually I sat next to him and wrote down which medicines he sold. I asked him about the use of the medicines and whenever he had clients (business was rarely brisk), I noted down what I heard and saw and tried to talk with the clients about what they had bought. At first I found it difficult. I felt uneasy in this rather informal situation and feared that I would disturb the old man's trade. He, however, saw it very differently. He was pleased with my presence and apparently thought that I would attract customers. After a few days I had become a familiar sight at the market. Some passers-by and other market vendors jokingly asked the old man if he had employed a white secretary (I was always writing). Sometimes the clients asked my advice about a particular medicine. Usually I answered, truthfully, that I did not know and referred them to the old man.

I shall now report three conversations which took place at the old man's shop, the first two about gonorrhoea, the third about '*filaires*'. All were originally conducted in French. The conversations are hardly more than anecdotes which will serve as a starting-point for a discussion. They gave direction to my thoughts, but they did not provide anything like 'data' on which I have based my interpretation. It is rather the other way round: the conversations posed questions which I can only hope to answer by viewing them in the total context of people's (sellers' and customers') daily struggle to survive, which was the real topic of my research.

Conversation 1

A young man, looking through the vials of injectable antibiotics on the old man's table, finds *Almopen*. He notices its date of expiration – 1978 (five years ago) – and finally chooses *Pénextilline*.[2] When I ask why he needs it, his answer is elusive. "It is an antibiotic, you can use if for all kinds of things, rheumatism for example." "But for what will *you* use it?" I insist. "It is not for myself, it is for my brother, I don't know why he needs it." I ask: "Is it for '*chaude pisse*' (gonorrhoea)?" He laughs: "Perhaps yes, because he is a bachelor." "But why are you buying it here? Isn't there a dispensary in your village?" "Under construction," he advises me. "Moreover," he adds somewhat contradictorily, "the nurse is hardly ever at his post."

I ask him, "Is the *Almopen* no good because the date has expired?" "You can't use it any more for an injection," he answers, "but it is still good for sprinkling onto a wound." When I discuss this conversation later on with others, a pharmacologist comments that the sprinkling is not a bad idea. Other remarks by the young man are criticised, however. It is not true that *Pénextilline* can be used against rheumatism. Nor is one vial of *Pénextilline* sufficient for the treatment of gonorrhoea, from which he is more likely to suffer than 'his brother'.

Conversation 2

A young man picks up a vial with *Procain*. The old man says, "It has expired." After some deliberation the customers buys two *Penicillin* tablets (each 500,000 units). I ask why he needs them. He is a prisoner (some prisoners move freely in town and can be hired for work by the town's notables for very low wages). Yesterday he visited a woman and this morning, when he urinated, he felt pain. So he thinks he has caught '*chaude pisse*'. I ask him if two *Penicillin* tablets are sufficient. His answer is no, but he hasn't any more money. In any event, two are better than none. He asks if I can help him. I give him 200 francs. He buys another two tablets. He will take two tonight, two tomorrow morning.

When I discuss this conversation with a doctor, he remarks that no venereal disease symptoms could appear so quickly. Furthermore a dose of four such tablets is not sufficient for treating gonorrhoea. The tablets, he adds, are not well absorbed in the body. The conversation further shows how economic constraints may lead to the wrong use of medicines and to subsequent rationalisations ("Two are better than none").

Conversation 3

The old man often talks about '*filaires*', which is unlikely to be equivalent to the biomedical diagnosis 'filaria'. I decide to choose a quiet moment, Sunday morning, when most people are at church, for a special discussion on this subject.

"There are two kinds of '*filaires*'," the old man tells me, and from what follows I deduce that he is referring to a type of worm. "There are *filaires intestinaux* and *filaires du corps*."

"The *filaires intestinaux* eat the food. They arrive with food, especially greens, which have been kept in a place where there are mosquitoes that give *filaires*. These *filaires* move with the *vers intestinaux*, but are not the same thing. They are a different size, but they move together." I ask, "So you should always treat them together?" The answer is yes.

"The *filaires du corps* eat the blood. They get into the blood through the bite of a mosquito." I ask, "Is it the same mosquito that causes malaria?" The answer is yes. "But how is it possible that a mosquito sometimes brings malaria and sometimes *filaires*?" He answers, "If the mosquito has first bitten someone with malaria, it will bring malaria. If it has bitten someone with *filaires*, it will bring *filaires*."

Our discussion continues. It is my impression that the old man develops his ideas about '*filaires*' as he goes along, wishing to appear as knowledgeable and coherent as possible.

THE PRODUCTION OF MEDICAL KNOWLEDGE

What people at the market told me about illness and medicines did not agree with biomedical knowledge, nor was it 'traditional knowledge'. Their ideas belong rather to what has been called 'the popular sector' of the health care system (Kleinman 1980:50–53). That sector is believed to be far greater in terms of number of people adhering to its ideas and practices than the professional sector, the biomedical as well as the indigenous one. Complaints receive their first diagnosis in the popular or lay sector and it is from this sector that health care action is initiated. Sometimes, particularly in Western countries, the popular sector tends to overlap partly with the professional, for people are inclined to absorb biomedical knowledge through books and journals, radio and TV-programmes.

The situation in Cameroon is quite different. People are eager to learn more about the use of pharmaceuticals, but rarely have reliable sources of information at their disposal. As a consequence, popular knowledge of medicines becomes an extremely varied jumble of ideas that hardly agrees with professional

biomedical knowledge at all. Anthropologists have frequently studied the ideas and practices of traditional medical specialists, while largely neglecting the world of popular medical knowledge. Medical notions current in the lay sector, however, are likely to have a far greater impact on health care practices than the specialist knowledge of medical doctors, herbalists and priest-healers.

Drawing from conversations as reported above I hope to suggest how lay explanations of illness and pharmaceutical efficacy come into being. Two contexts seem particularly important for understanding the generation of popular medical knowledge: the basic market situation of selling and buying, and the interview situation with its questions and answers.

THE MARKET SITUATION

Medicines are commodities. Clients pay for them, sellers make money from them. Both parties adapt their ideas about medicines to their respective position in the transaction. In very simple terms, the seller will be inclined to present 'his' medicines as capable of curing a large number of complaints and to ignore possible side-effects, contra-indications or other problems. He hopes to stimulate sales. Yet, in praising his wares, the seller may also actually *believe* in their potency.

Much has been written lately about the over-optimistic picture of the effects of medicines propagated by pharmaceutical companies. It has been pointed out that inserts in drugs sold in the Third World mention more indications and fewer side-effects and counter-indications than inserts in the West (see, e.g., Silverman et al. 1982). Still, I would be surprised if the people writing those promotive texts did not indeed believe in their positive messages, at least to a considerable extent.

The old man selling medicines on the market does much the same thing. He recommends his products for a wide range of complaints and should a customer make a wrong choice, he will rarely correct him. What matters for him is the sale. His optimism about the efficacy of his products is facilitated by his limited knowledge of biomedicine and pharmaceutics.

But we also have seen that the old man will draw a client's attention to an expiration date. This observation does not contradict what I have just said. The expiration of the date would eventually be discovered by the customer. Pointing it out to him at once prevents difficulties later and enhances the old man's image as an upright tradesman.

In Cameroon buyers of medication find themselves in the opposite position. Although poor, they still must pay for medicines. The remedy prescribed by a biomedical doctor for a particular infection may require more medicine than the customer can afford. He has to content himself with a smaller dose. It is likely

that such a financial constraint will be rationalised in medical terms. Taking only two or four tablets instead of ten or twenty is *made* right by *talking and thinking* it so. People cut their coat of medical knowledge according to their cloth.

Particularly in the field of medicine there is ample room for self-justifying rationalisations. It is difficult to prove that a specific medical intervention has had a specific effect. Both illness and recovery allow for multiple interpretations and explanations. It is well known, moreover, that explanations 'generate their own efficacy'. Estimates of the influence of the placebo effect on the outcome of medical treatment vary from 20% to 80%. One might say that medical knowledge, whether professional or 'popular', causes health effects among its believers. Whether such knowledge is 'true' in biological or chemical terms may well be of secondary importance. As in religion, the main thing is that the theory or assumption is satisfactory. A plausible explanation can be a powerful medicine, and plausibility, as we know, has both a 'subjective' and an 'objective' dimension.

Applying these considerations to the market situation in Ebolowa I suggest that buyers of medicines are likely to adjust their therapeutic beliefs to fit their means. More well-to-do customers, for example, worry about the efficacy of drugs available at the market, certainly the cheaper ones. They require the best and prefer costly medicines from private pharmacies. Such customers live mainly in the cities of Yaoundé and Douala. Indeed this affluent category is known to oppose any blanket implementation of an essential drugs policy, which would mean that only about two hundred, mainly inexpensive medicines would be available throughout the country. The rich appear convinced that these two hundred essential drugs would not include the medicines best able to cure *their* medical complaints.

It is understandable that most pharmacists, private physicians and others who make a profit from medicines also resist the essential drugs plan. For them, congruence of their therapeutic beliefs and financial interests implies pessimism about the quality of many so-called 'essential drugs' and doubt that the proposed package is sufficient to treat existing health problems.

Well-to-do people, however, do not visit the Ebolowa medicine market. That is clearly a poor man's alternative. Sick people who cannot afford to buy a whole package of a given medicine, as they are obliged to do in the town's pharmacy, come to the market to buy just the amount they can pay for (and think is sufficient for the moment).[3] Young men suffering from gonorrhea slap down money for a few Tetracyclin capsules and come back the next day for more if they think they need to continue treatment (and have the money).[4] That the young man in Conversation 1 selected an insufficient quantity of antibiotics, can probably be attributed to his purchasing power at the time. In Conversation 2 the roving prisoner was in much the same situation. He rationalises his buying only

two penicillin tablets by remarking that two are better than none at all.

The instant production of popular medical knowledge during market transactions comes close to what more than thirty years ago Festinger called 'reduction of cognitive dissonance'. From such a perspective knowledge can be viewed as a cultural device to assuage or avoid the pain of any discrepancy between what is and what ought to be. The Ebolowa market shows us in miniature how culture 'works' all the time, smoothing over, alleviating irreconcilable differences. For the poor customer this means he manages to believe in the efficacy of the few medicines he can buy. For him Douglas and Isherwood's (1980:127) remark, that "it is part of rationality to fix aspirations at some feasible level," clearly obtains.

Considering these processes of dissonance prevention and reduction from an anthropological point of view, we should stress that all human knowledge is to some extent self-fulfilling prophecy, as Lakoff and Johnson (1980:156) have pointed out with regard to the use of metaphors. For them the truth of metaphor is merely a matter of perception, however:

> The acceptance of the metaphor, which forces us to focus *only* on those aspects of our experience that it highlights, leads us to view the entailments of the metaphor as being *true*. Such 'truths' may be true, of course, only relative to the reality defined by the metaphor (pp. 157–158).

In the case of medical metaphors the achievement of establishing 'truth' is more spectacular. The sick body responds to the metaphor and, for that matter, to medical knowledge in general.[5] We may cautiously suggest, therefore, that popular medical knowledge should not be seen merely as 'erroneous', leading to 'irrational drug use' which will aggravate the complaint in question. It should not be ruled out that 'defective' use of medicines may indeed bring relief. Above I compared medical knowledge to religion, pointing out the therapeutic potential of a satisfactory explanation. We might stretch that comparison further, applying it to the poor customer at Ebolowa market who has little choice other than to adapt his 'knowledge' to his means. His case looks like that of the biblical poor widow whose two copper coins proved more effective than all the money paid by the rich (Luke 21:2).

Caution nonetheless remains necessary. We should not take utterances at the market too seriously. What is offered as knowledge may be hardly more than a cover-up for ignorance and doubt. Later on we shall discuss this aspect of knowledge production in more detail. Here it suffices to emphasise that a considerable amount of not-knowing may be camouflaged as assurance and thus partly nullify the placebo effect. Conversation 2 illustrates this point, for the prisoner's comment, "Two are better than none," also expresses a measure of doubt about the rationality of his transaction. His subsequent action demonstrates this clearly: the presence of an interested European prompts him to ask for money to buy more medicines.

Yet another aspect of the market situation contributes to the production of popular knowledge: the availability or non-availability of medicines. We see this to be true in the first conversation. Not only limited finances may restrict the choice of medicines, but also a limited supply of the medicines themselves. At the market, although not exclusively there, such shortages are common. For a customer who fails to locate the right medicine, the most sensible course of action would seem to be to look for it elsewhere. Another solution is to revise his request according to what is on hand. This second strategy is of course indicated if he knows that the availability of medicines is limited elsewhere as well. The young man in Conversation 1 contents himself with *Pénextilline*, one of the few injectable antibiotics on the old man's table. What also is interesting to us is that his pharmaceutical knowledge leaves room for expired antibiotics which, according to biomedical rules, should no longer be used. The powder in such capsules can still be sprinkled on wounds. This penny-wise knowledge is widespread in Africa. Such adjustment of knowledge to accomodate the hard facts of reality is closely related to the production of knowledge to reduce cognitive dissonance that might arise from financial constraints.

THE INTERVIEW SITUATION

Last (1981) has argued that anthropologists seldom accept an informant's inability to answer a question. They have learnt that "I don't know" is not an answer, but an excuse. They have been taught to repeat the same question, in slightly different words, until they receive a 'real' response. Last remarks however that in the end "I don't know" may be the honest answer, and anything else an attempt to placate and get rid of the anthropologist. Anyone who has ever tried putting the questions that he asks his informants to himself may well concede Last's point.

Last, however, fails to mention that informants may also have reasons for avoiding an "I don't know" answer. They may want not to appear ignorant. It strikes me as likely that the interview situation tends to elicit an exaggeratedly clear and coherent picture of what people think and feel on all kinds of topics, including medical knowledge. Last suggests that local medical knowledge will usually feature more blank areas and anarchy than anthropologists care for us to believe. This suggestion is confirmed by my conversation with the old medicine vendor. As our conversation unfortunately began to approximate an interrogation,[6] it became increasingly clear that the old man did not want to make an ignorant impression. To reveal that he did not know how to use the medicines he sold would be very embarassing indeed. Understanding the dynamics of the interview situation we should probably consider it first and foremost as an occasion for staging a performance. The informant finds himself in an extraordi-

nary situation. A strong risk of embarrassment is inherent. He may not have convenient routine answers at his disposal. The interviewer, who is very 'knowledgeable' yet ignorant at one and the same time, asks unusual questions. The informant may have no idea what or how to answer. He may even not understand the question. To admit this, however, might be too embarrassing. The interview situation may be experienced as one of high psychological pressure in which the informant is more concerned about not losing face, than about giving accurate or honest answers. In short, the interview situation seems to demand a performance which corroborates the informant's respectability.[7]

Psychological pressure will be acute as long as the relationship between interviewer and informant remains uneasy, if either one feels insecure in the other's presence. Feelings of insecurity are likely to be directly proportional to degree of felt inequality. This was certainly true about relations between me and the old man, as I have indicated earlier. He was infirm, dependent on others. During the period of my fieldwork, he was keen to benefit from my interest in him, so it was important to him not to disappoint me in any way. Probably my 'interrogation' about *'filaires'* created considerable anxiety for him fearing that unsatisfactory answers on his part might endanger the continuation of our good relations. His 'performance' should be seen in that light.[8] He constructed a more or less coherent account which, I suspect, was mainly improvised, built from several fragments of information that he had at his disposal. His main concern was that I would not lose interest in him. Not only was his respectability at stake but also his future ability to lay claim to my help. My help in the future, he believed, depended on my continuing to consider him an interesting and knowledgeable informant. Twice in Conversation 3 the old man answered 'yes' to a (perhaps too) suggestive question. That concise affirmative, too, may have been an indication of his desire to comply with my expectations.

My discussions with the old man's customers were not loaded with such specific psychological pressure. I did not have a personal relationship with them. They did not expect any rewards. Nonetheless some awareness of our inequality – and an accompanying feeling of being 'interrogated' – was definitely present. When I asked about the use of medicines, especially those they had purchased, they, too, seemed disinclined to answer "I don't know." They, too, found it important to appear knowledgeable and rational and to avoid the embarrassment inherent in admitting that they didn't fully know what they were doing.

CULTURAL REINTERPRETATION

A short while ago I suggested that the old man constructed his story about *'filaires'* on the spot, forging it from fragments of knowledge that he had at his disposal. Indeed people don't create medical knowledge out of nothing, but

rather make grateful use of building materials they find lying around in their own culture.

Here Lévi-Strauss' (1972) concept of '*bricolage*' comes to mind. He contrasts the '*bricoleur*' with the 'engineer' or 'scientist'. The latter, he says, constructs his theories by trying to go beyond the constraints of his own culture, questioning his own universe, while the *bricoleur* tinkers within his culture. He is, one could say, a 'primitive' scientist, imprisoned within the confines of his (popular) everyday knowledge. To build meaning for himself he uses cultural fragments, 'second hand materials' that are familiar to him. The *bricoleur* is practical by bent. The scientist, on the other hand, transcends what is taken for granted in daily experience and persistently seeks to challenge established truths with alternative explanations.[9]

A *bricoleur* is in an awkward situation as soon as he has to 'make sense' out of concepts or objects that are not indigenous to his world. Such a situation, however, is not at all rare. Put somewhat paradoxically: meeting the extraordinary has become an ordinary experience for people everywhere. Anthropologists, therefore, have spent considerable energy studying the processes of acculturation and enculturation. How people reconcile the foreign and the familiar into new, meaningful, often syncretic, concepts has become a main topic in present-day anthropology.

For understanding the old man's *bricolage* the concept of 'cultural reinterpretation', coined by Herskovits as early as 1948 and recently used again by Bledsoe and Goubaud (1985), seems a useful tool. Herskovits (1955:492) defined cultural reinterpretation as follows: "It is the process by which old meanings are ascribed to new elements or by which new values change the cultural significance of old forms. It operates internally, from generation to generation, no less than in integrating a borrowed element into a receiving culture" (Herskovits 1955:492). Herskovits used the concept to come to grips with processes of culture change: "Why do...people take over one new idea or thing presented to them and reject another?" (Herskovits 1955:495).

This analytical concept has also proved useful in the study of the development of cultural ideas regarding health and illness. The impact of biomedicine on non-Western cultures has been enormous. Modern hospitals, health centres and other services have cropped up the whole world over. Western-trained medical doctors and other health workers have extended their practices into the most outlying communities of developing countries. Almost everywhere people are reported to be making use of these opportunities on a large scale. At the same time it has been cogently observed that *using* biomedicine does not yet mean *thinking* it. A great number of researchers have pointed out how people may 'appropriate' biomedicine on their own cultural terms. Their ideas about how Western medicines and other interventions work may be widely divorced from the views held by the medical personnel who treat them.

The concept of 'cultural reinterpretation' enables us to better comprehend that process of appropriation. Bledsoe and Goubaud (1985) applied Herskovits' concept in their research about the use and perception of Western pharmaceuticals among Mende informants in Sierra Leone. They argued that indigenous medical ideas (e.g., about the colour and taste of medicines) provide an explanatory framework for interpreting Western pharmaceuticals. Other medical anthropologists have pointed to analogous processes of syncretic change in people's perception and acceptance of Western medicine (e.g., Logan 1973; McClain 1977; Nichter 1980; Whyte 1988; Etkin et al. 1990).

In an article about the way in which indigenous medical practitioners adapt their role under the impact of biomedicine, Landy (1977:477) advances the concept of 'cultural resynthesis' to describe a similar phenomenon: healers use new, biomedical, elements in their traditional practices (for example: antibiotics administered by Ayurvedic practitioners; see Burghart 1988 and Wolffers 1988). In Landy's article the emphasis lies on behaviour, whereas Herskovits' term applies to cognition. In both concepts it is assumed that changes take on syncretic features, that people's new ideas and practices are the result of the fission of familiar ones. As Herkovits suggests, any innovation that has nothing in common with preceding patterns of culture is likely to be rejected, unless or until it can be redefined and transformed into something that seems sufficiently familiar to be acceptable.

My conversation with the old man in Ebolowa can be analysed in that light. He endows the disease term *'filaire'*, which he finds printed on the wrappings of his medicines and in their inserts, with a new meaning, one which includes aspects of the traditional Bulu concept of the illness *Nson* ('worms'). The Bulu maintain that a great many different complaints derive from worms. The worms live and develop in the human body. They eat the organs of the body and can thus be associated with pain and discomfort in the heart, the liver, the intestines, the genital organs, the blood, etc. It may be that the worms enter someone 'naturally', but it is also believed that they can be 'thrown' into a body by a sorcerer. The traditional concept of *nson* admits both a naturalising and a personalising explanation for illness.[10] The old man's theories about the *'filaires'* bore a great resemblance to odd bits I had earlier heard about *nson*. His explanations illustrate how new popular knowledge masquerading as 'scientific' may be constructed under pressure from available indigenous concepts.

CONCLUSION

Until recently, in most anthropological accounts local medical knowledge appeared as *static and in conflict with Western medical thinking*. Anthropologists now tend to view local ideas as versatile and adaptive. Welsch

(1983), who did research among the Ningerum of Papua New Guinea, has described their flexible and syncretic ideas about health and medicine. The Ningerum had in fact integrated Western medical concepts and practices into their own culture in such a way that they did not perceive any real discontinuity or contradiction between their own medical views and those held by Western-trained aid post orderlies. The existence of such a 'liberal' theoretical framework explains why the Ningerum found no difficulty for example in combining divination with aid post medications. Tedlock (1987) describes a similar situation among the Maya in Guatemala, where both folk healers and lay informants borrow and amalgamate elements from various traditions freely when asked to explain their medical thoughts and practices.

The Ningerum and Maya, I maintain, are no exceptions in their syncretic production of new medical knowledge. Reports of a high frequency of therapeutic shopping between Western and indigenous systems continue to arrive from all over the world. Now we are starting to fill in the cognitive processes accompanying these practices. In this paper I have presented fragments from three conversations I had with two buyers and one seller of medicines at a market in the South of Cameroon. In these conversations popular medical knowledge was produced to serve very practical ends: to rationalise concrete actions (buying or selling medicines), to avoid embarrassment, to satisfy an inquisitive anthropologist and to safeguard a profitable relationship. Two contexts seemed particularly conducive to the generation of such opportunistic medical knowledge. The first was the context of the marketplace, where costs and profits have to be accounted for in medical-rational terms by those involved in the transaction. The second was the context of the interview during which both researcher and informant have motives of their own to do their best to come up with what at least may pass for coherent medical explanations. Concepts already on hand form the building material for the informant's production of knowledge.

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NOTES

[1] Many anthropologists have provided case studies which show how people continuously adjust their diagnosis and therapeutic decisions to new bits of information, e.g., Janzen 1978; Van Binsbergen 1979a; Feldman-Savelsberg 1988.

[2] Pénextilline: Benzylpénicilline sodique (800,000 units) and Benzathine-benzylpénicilline (200,000 units).

[3] Official regulation prohibits the opening of medicine packages by the pharmacist, so clients can buy only whole packages. Pharmacists stick to this rule as it is not in their interest to sell small quantities of medicines. Poor people, who cannot afford to buy whole packages, have to go to the informal vendors who do not object to selling medicines per piece.

[4] Simoni and Ball (1975:179), who studied the selling of medicines on Mexican markets, make a similar remark:

> There is evidence that the poor are predisposed to strategies which tend to minimize risks rather than to those which tend to maximize gains, especially under conditions of anxiety. To get less than what might be preferred, but at low cost, is usually more appealing than to pay much more than one can begin to afford for the best of treatment – especially when there is no complete guarantee that it will succeed either.

Similar problems occur when patients receive a doctor's prescription which they cannot afford to have filled completely at the pharmacy. Selecting just one or two of the prescribed medications may be the only practical solution, but that solution needs to be rationalized in medical terms to ward off feelings of not being treated well. For some references to physicians' lack of concern for their patients' financial problems in their writing out prescriptions and to the subsequent 'faulty' follow-up of their prescriptions, see: Fabricant and Hirschhorn 1987; Hardon 1987; Kapil 1988; Melrose 1982; Shatrughna n.d.

[5] Awareness of the placebo effect has now become part of popular medical knowledge in Western societies. While writing this article I heard on the BBC World Service about an experiment carried out in a British hospital, where women undergoing a total hysterectomy under anesthesia 'listen to' a tape with a reassuring text telling them that they can trust the doctor and that everything will be O.K. Patients who – subconsciously – 'heard' the tape were ready to leave the hospital one day earlier than others... "Mind over matter on the operation table," the BBC reporter concluded.

[6] The term 'interrogation' also appears in an article by Rosaldo pointing out the context of domination which gave birth to two famous ethnographies, Le Roy Ladurie's "Montaillou" and Evans-Pritchard's "Nuer". The former work is based on confessions extracted from 14th century peasants by an inquisitor. The fieldwork for the latter study took place in a period when British colonial troops were raiding the camps of these African herdsmen. Rosaldo speaks of an 'unequal dialogue' (the term is from Le Roy Ladurie) and emphasises that the instruments through which such data was 'collected' cannot be separated from the final ethnographic product. Power and knowledge are

closely linked. It seems likely that some features of the 14th century inquisitor also inform the bearing of many present-day anthropological fieldworkers.

[7] For striking examples of informants considering their own respectability to be more important than giving correct answers to interview questions, see Bleek's (1987) report about "lying informants" during Family Planning research in Ghana.

[8] But a fieldworker can also suffer considerable anxiety in interview situations (see Henry and Saberwal 1969). He may establish personal relationships with informants who are so poor that his own possessions become a burden and embarrassment for him. The situation may prompt him to a performance to avoid informants' envy and to allay his own uneasiness. Four scenarios for such a performance are provided by Foster (1972) in his "Anatomy of Envy": concealing your riches, denying that they are yours, giving the other a token ('sop') to buy off his envy, and true sharing. All scenarios are enervating, however (see also Bleek 1979; van Binsbergen 1979b).

[9] This is not the place to criticise Lévi-Strauss' idealised and de-culturalised image of the scientist. The work of, among others, Polanyi (1958), Kuhn (1970) and Latour and Woolgar (1977) suggests that (Western) science is more bound to its cultural premises and situational contexts than is usually assumed or admitted. In Lévi-Strauss' terms, there seems to be a lot of *bricolage* going on in science.

[10] Preoccupation with 'worms' and 'throwers-of-worms' has been described by Mallart Guimera (1977 and 1981) for the Evuzok, the Bulu's neighbours in Southern Cameroon.

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