Lahiya vitesse and the quest for relief
A study of medical pluralism in Saga, Niamey, Niger

Report from a Minor Field Study

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ABSTRACT

This paper focuses on what people in Saga, a village on the periphery of Niamey, the capital of Niger, do in the face of illness. With limited economic assets and in a context of medical pluralism, to which therapeutic alternatives do they turn? And what factors are determinant in the choice that they make? Saga is an old village, which has become increasingly integrated into the expanding urban community of Niamey. It can be described as a semi-urban area in which elements of both rural and urban Niger are present. The therapeutic field in Saga is, as in all of Niger, characterised by medical pluralism. A number of therapeutic alternatives exist side by side. They range from ‘western’ or hospital medicine provided by the local public dispensary, the private confessional dispensary and by the unlicensed sale of medicine by ambulant vendors to ‘traditional’ treatments, such as Islamic medicine practised by marabouts and ‘traditional’ healing using herbal remedies and spirit possession rituals. This paper is about the various institutions and actors of ‘modern’ medicine in Saga, namely on the public dispensary, on the confessional dispensary and on the informal sale of pharmaceuticals. To better understand the quest for therapy in Saga this paper focuses on everyday practices of therapy seeking, on the actual and everyday choices people make in the face of illness. Special attention is paid to the therapeutic alternatives and to the relation between therapy seeker and therapy provider in what may be called the therapeutic encounter. It is argued that socio-economic factors as well as social relations, personal experiences and perceptions of trust are central to the therapeutic recourse taken. Furthermore, it is suggested that the ‘quest for therapy’ can and should be seen as a ‘quest for relief’.

Keywords medical anthropology, medical pluralism, therapy seeking, illness, health care, Niger, Niamey
# CONTENTS

ACKNOWLEDGEMENTS  4

1. INTRODUCTION  5
   1.1 Method  6
   1.2 Synopsis  7
   1.3 A point of departure  8

2. MEDICAL PLURALISM AND THERAPY SEEKING  9

3. THE LOCAL CONTEXT OF SAGA  14
   3.1 Culture and history  14
   3.2 Saga  16
   3.3 Medical pluralism in Saga  18

4. REPRESENTATIONS OF ILLNESS AND MEDICINE  22
   4.1 Illness representations  22
   4.2 Medicine  30

5. THE ‘PHARMACIE PAR TERRE’  33
   5.1 The informal market in pharmaceuticals  34
   5.2 The ‘pharmacie par terre’ in Saga  36

6. THE PUBLIC DISPENSARY  43
   6.1 The CSI in Saga  43
   6.2 Finding a way into the CSI  46
   6.3 The consultations  48
   6.4 The CSMI  52

7. THE CONFESSIONAL DISPENSARY  54
   7.1 Mother Theresa’s Missionaries of Charity in Saga  54
   7.2 The dispensary  56

8. THE QUEST FOR RELIEF IN SAGA  59

9. CONCLUSION  67

BIBLIOGRAPHY  69
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1. INTRODUCTION

This paper is the result of a Minor Field Study carried out in Saga, a village on the periphery of Niamey, the capital of Niger, on what people in Saga do in the face of illness. With limited economic assets and in a context of medical pluralism, which therapeutic alternatives do they turn to? And what factors are determinant to the therapeutic recourse they take? In other words, how can the ‘quest for therapy’ (Janzen, 1978) best be understood? Do cultural representations and understandings of illness determine the choice of therapy? Or is the therapeutic recourse taken largely dependent on social factors, such as social networks and personal relations? Or does it boil down to the often harsh reality of economics or financial means?

In addressing these questions this study focuses on everyday practices of therapy seeking in Saga. Special attention is paid to the therapeutic alternatives that people move between in the search for relief and to the relation between therapy seeker and therapy provider in what may be called the therapeutic encounter. It is held that taking a closer look at the relation between the ill persons and the institutions or practitioners from which they seek care can provide valuable insights into how medical pluralism functions in practice, namely in the everyday quest for cure or relief.

The therapeutic field in Saga is, as in all of Niger, characterised by medical pluralism. A number of therapeutic alternatives exist side by side. They range from ‘western’ or hospital medicine provided by the local public dispensary, the private confessional dispensary and by the unlicensed sale of medicine by ambulant vendors to ‘traditional’ treatments, such as Islamic medicine practised by marabouts and ‘traditional’ healing using herbal remedies and spirit possession rituals etc. However, this paper will focus on the institutions and actors of ‘modern’ medicine in Saga, namely on the public dispensary, the confessional dispensary and on the informal sale of pharmaceuticals.

It is suggested that social relations, personal experiences and perceptions of trust as well as socio-economic factors are central to the therapeutic recourse taken. Moreover, it is held that the ‘quest for therapy’ can and should be seen as a ‘quest for relief’. The everyday search for therapy is more often driven by a desire for relief, that is, to ease the pain, than by the
expectation that a cure or a state of perfect ‘health’ will be within reach. Finally, it is emphasised that studies, which focus on the local context and on the everyday realities of illness and therapy, are valuable in shedding light on important issues pertaining to health, especially in giving a primary place to experiences and to social relations often obscured in health statistics and international development policies.

1.1 Method

The paper is based on a three-month study carried out in Saga between February and April 2004. Saga is located on the periphery of Niamey, the capital of Niger. It is an old village and the administrative centre of the canton of Saga. The rapid growth of Niamey has led to the increasing integration of Saga into the urban community. Saga can be described as a semi-urban area in which elements of both rural and urban Niger are present.

The core of the study consists of research findings gathered through participant observation combining semi-structured interviews with direct observation. The semi-structured interviews were used to collect information about peoples’ views of illness as well as their views of the different therapeutic options available in Saga. The interviews also touched on people’s experiences of ill health, on illness episodes and therapeutic itineraries. To get a more complete picture of the therapeutic field in Saga, practitioners were also interviewed. The practitioners’ thoughts about illness and therapy and about their patients were thus also included in the study. Finally, direct observation provided material on the actual interactions between patients and practitioners. In total, about fifty semi-structured interviews were conducted. In-depth interviews, covering particular illness episodes, were also carried out to serve as a base for case studies. The ‘target groups’ interviewed included married women and men, elders, youths, local chiefs, ambulant medicine vendors, vendors of plants and local remedies, nurses at the local dispensary, nuns at the confessional dispensary, marabouts (Islamic priests and scholars) and zimas (the priests of the spirit possession cult). Direct observation was done in the local public dispensary, in the confessional dispensary, during a spirit possession ceremony as well as with ambulant medicine vendors. Last but not least, informal conversations and daily observations in Saga added greatly to my understanding and perception of the field and the issues at hand.
The interviews and the observations were carried out with the help of a female interpreter, fluent in French and Zarma and with knowledge of Hausa and Fulfulde. French is the official language in Niger but it is only spoken by a minority of the population. In Niamey, Zarma is the dominant language. Most interviews were carried out in Zarma, many of the interviewees, especially the married women, did not speak French or only had a limited knowledge of French. However some of the men and most of the youths spoke French as did the nurses at the local health centre.

The field study was carried out during the dry season, or more exactly during the end of the dry and cold season, which stretches from November to February, and the beginning of the dry and hot season, which stretches from March to June. This has had an influence on the information gathered. For instance, the prevalence of some illnesses varies between seasons. During the dry season meningitis and measles epidemics are common. Measles and meningitis were frequently mentioned during interviews. The beginning of the year (2004) saw the outbreak of a measles epidemic, which by May had caused 30,000 cases of contagion and the death of 500 children. Niamey and surrounding villages were among the regions most affected by the epidemic (AFP 12/05/2004). During the rainy season on the other hand it is malaria, the number one cause of morbidity and mortality in Niger that ravages and that is the focus of national health campaigns. Cases of malaria increase during the rainy season, although it should be noted that malaria is endemic and is a threat all year around. Especially in Saga which, due to its proximity to the river Niger and the rice fields that line the riverbank in combination with poor sanitation and drainage, is a breeding ground for mosquitoes.

1.2 Synopsis

The rest of the paper is organised in the following chapters. Chapter Two introduces the theoretical concepts and perspectives, which will be used in the paper, focusing on medical pluralism and therapy seeking. Chapter Three sets out to present the local context of Saga to the reader. First it gives a general portrayal of the culture and history of the region and then goes on to present Saga itself. Finally, it gives a brief description of medical pluralism in Saga. The main part of the ethnographic material is presented in chapters four to seven. Chapter Four gives an insight into common illness representations in Saga. It goes on to describe local perceptions of medicine. Chapter Five addresses the informal sale of pharmaceuticals in Saga. The focus is on the vendors themselves, on the use and perception of
the medicine they sell and on the relation between them and their clients. In Chapters Six and Seven the everyday practices or activities of the two local dispensaries, the public dispensary and the confessional dispensary, are described. Special attention is paid to the consultations and to the meeting and relation between the staff and the patients. Finally, Chapter Eight focuses on the relations between the population of Saga and the three institutions and actors of ‘modern’ medicine in an attempt to describe how medical pluralism works in practice. Chapter Nine provides a concluding summary of the paper.

1.3 A point of departure

One particular meeting, which occurred towards the very end of the study, proved to be crucial to my understanding of the field. To me it brought the issues at hand to the fore. My interpreter and I met Ramatou, a young mother, at the confessional dispensary in Saga. She had come for the daily meal and milk distributed by the nuns. One of the nuns had insisted that we talk to her. The nun told us that they suspected that Ramatou’s child was ill with tuberculosis, the child had been seriously ill for more than three months and its condition was quickly deteriorating. The nun was frustrated that Ramatou seemed unable to understand the gravity of her child’s condition. After having talked briefly with Ramatou we were left with a similar impression, her youth and appearance made her seem irresponsible and her vivacity contrasted starkly with the condition of her child. Nonetheless, we asked if we could talk to her again, she assented and gave us the directions to her house. A couple of days later we went to see her. She and her husband lived in a straw hut in Pays Bas, a poor neighbourhood on the outskirts of Niamey. Seated on a mat outside her home we listened as she told us about her situation and about her child's illness. Her husband who had recently recovered from tuberculosis could not find work and she had had to give up her job to care for her child. Finding food for the day had become more and more difficult. When her child had become ill Ramatou had gone to the nuns’ dispensary, however the treatment had not improved the child’s condition. Nonetheless, she returned by foot to the nuns every day to receive a daily meal and milk for the child. The nuns had told her they suspected the child had tuberculosis. She had thus gone to the national tuberculosis centre (the Centre National Anti-Tuberculeux) in the centre of Niamey, where her husband had received treatment. However she was turned away as she didn’t have the necessary papers. To be admitted she would need an official tuberculosis diagnosis, but she did not have the money necessary to get one. Listening to her story we realised that what we had interpreted as carelessness was in fact the
proof of an incredible resilience in the face of enormous difficulties. Before my departure, she finally, with the help of the nuns, got the necessary diagnosis and after three unproductive visits to the tuberculosis centre she had finally received the first round of treatment.

What follows will attempt to make sense of the mechanisms and dynamics at play in the quest for therapy. To do this it will explore the context within which Ramatou sought treatment for her ill child.

2. MEDICAL PLURALISM AND THERAPY SEEKING

The anthropological interest in medicine and in indigenous modes of healing dates back to the beginnings of the discipline. Still, the study of medicine was for a long time subsumed in the study of religion, ritual and magic. The participation of anthropologists, as consultants, in the international health-care programmes of the 1950s and 1960s, stimulated the emergence of medical anthropology as a special field of research. The programmes, which sought to spread the benefits of western biomedicine to the Third World, were met with widespread non-compliance on the part of the target populations (Leslie, 2001: 430). In line with the dominant modernisation paradigm the physicians and public health experts who directed the projects saw the problem of non-compliance as a conflict between modernity and tradition, superstition and science and rational and irrational cultures (Leslie, 2001: 430). Although many of the consultant anthropologists accepted this view, their examination of local and cultural understandings of health and illness did encourage a cultural relativism that was absent from the programme plans (Leslie, 2001: 430).

As medical anthropology evolved so did a distinctively anthropological analysis of illness and medicine. The 1970s and 1980s especially saw a significant increase in ethnographic and theoretical work in medical anthropology. Medical anthropologists started to challenge the hegemonic claims of western biomedicine. At the same time a cultural critique of biomedicine emerged and the truth claims of biomedicine were challenged. The comparative study of medical systems showed that biomedicine was merely one system of many and that the spread of biomedicine had not led to the disappearance of so-called traditional medical systems and practices. The deeply rooted dichotomy between tradition and modernity was also challenged. As Leslie illustrates in his work on Asian medical systems, all medical systems, modern as well as traditional, are inherently dynamic and responsive to social and political changes.
The spread of biomedicine did not result in the complete integration of traditional medicine systems into a dominant modern system based on the principles of biomedicine. Instead plurality and complementarity dominated. For instance, in South Asia the revivalism of Ayurveda lead to the development of a syncretic Ayurvedic medicine which existed side by side, in a complementary and conflictual relationship, with ritual curing and cosmopolitan medicine (Leslie, 1992: 204). Similarly in Latin America and Africa folk practitioners integrated antibiotic injections into ritual curing and herbal medicine (Leslie, 2001: 431). Medical pluralism and syncretism were thus finally acknowledged and medical pluralism became a central concept in medical anthropology.

The study of therapy seeking, like the study of medical pluralism, has illustrated that different therapeutic practices exist side by side and that the opposition between ‘traditional’ and ‘modern’ medicine is overcome in daily life and practices as people make use of different therapeutic alternatives in the search for treatment. Early studies of medical pluralism emphasised that patients are pragmatic and see nothing inconsistent about liberally combining different forms of therapy in their quest for restored health (Nichter and Lock, 2001: 4). Janzen’s ethnography *The Quest for Therapy in Lower Zaire* (1978) is an early and influential study of medical pluralism and therapy seeking. Janzen emphasised that in Zaire indigenous therapeutic traditions had not disappeared with the adoption of western medicine, instead ‘…a modus vivendi has developed in which different forms of therapy play complementary rather than competitive roles in the thoughts and lives of the people.’ (Janzen, 1978: 3). Janzen’s study focuses on what he calls ‘the quest for therapy’, on the ways in which people use and evaluate the different therapies available to them. Janzen also introduces the ‘lay therapy managing group’, consisting mainly of close kin, as an important actor in the quest for therapy. The group is central to the management of illness and therapy as it amongst other functions offers support to the ill person, takes decisions regarding the therapeutic course and mediates between practitioner and patient (Janzen, 1978: 4).

Janzen’s ethnography has been followed by numerous studies of medical pluralism and therapy seeking. Studies which all point to the existence and parallel use of different therapeutic alternatives. Focusing on for instance the coexistence and interaction of different ways of representing and treating illness and on the different factors that influence people’s therapeutic recourse. Attention has also been drawn to the dangers of an all too narrow and uncritical analysis of medical pluralism. Lock, in an article on the revival of traditional
medicine in Japan, points to a number of assumptions that have hampered the anthropological analysis of medical pluralism. These assumptions include a romanticised and conservative view of traditional medicine, a negative and hostile view of biomedicine and a generalisation of both traditional (indigenous) and western medicine (Lock, 1990: 42). However most important, Lock argues, has been the failure of medical anthropologists, studying pluralistic health systems, to recognise and to examine the political and ideological nature of medical systems (Lock, 1990: 42). Lock also points to the problem of seeing the incorporation of traditional medicine into the dominant institutionalised and state supported medical system as unreservedly good. Lock argues that in Japan herbal medicine was appropriated by the biomedical system and by its practitioners. Consequently, the potential benefits of herbal medicine as a counter-balance to the existing medical system were lost and the social origins of sickness remained unexamined (Lock, 1990).

Lock’s analysis points to the ways in which the dominant (bio)medical system might be used to justify unequal social and political relations in for instance medicalising socially produced health problems. It clearly illustrates the importance of attending to the political and ideological aspects of medical systems and to the need to examine the competing interests of various groups, for instance, patients, families, healers and government, in issues of health and illness (Lock, 1990: 45). Lock’s analysis further highlights the dominance or power of biomedicine, the state supported system of medicine, vis-à-vis other medical systems or traditions. This has also been pointed out in discussions about the recommendations of the 1978 Alma Ata Conference on Primary Health Care to integrate ‘traditional healing’ into public health care systems. Some critics argue that as ‘traditional healing’ was incorporated into public health it was evaluated not on its own terms but on the terms of biomedicine. Consequently, knowledge of pharmacopoeia was privileged over the social, symbolic and cultural aspects of healing (Van Wolputte, 2002: 18-20).

A wide and critical approach to medical pluralism contributes to the recognition that medical pluralism does not exist in a vacuum independent of social, political, economic, and cultural influences and that the parallel use of therapeutic alternatives is influenced by a number of different factors. Janzen has himself emphasised the importance of seeing ‘the quest for therapy’ in a broader historical, political and cultural framework, including for instance colonial history and national policy (Whyte, 1992: 164). Similarly, as Lock points out, Janzen
has called for a micro-analytic approach to be complemented with a macro-analysis in which issues of power, resource allocation etc. are taken into account (Lock, 1990: 45).

The above discussion has attempted to point to some important anthropological perspectives on medical pluralism and therapy seeking. As Benoist points out, in the conclusion of a collection of studies on medical pluralism, medical pluralism is merely a basic fact (‘*donnée de base*’), the point of departure for reflection and analysis (Benoist, 1996: 492). The origins of medical pluralism vary between different places and pluralistic health care behaviours are influenced or driven by diverse social, economic and cultural forces (Benoist, 1996: 492). The remainder of this chapter will outline the approach taken in this paper to medical pluralism and therapy seeking, namely a focus on the relations and interactions between actors and the different institutions of therapy and on the social, political and economic aspects of illness and therapy seeking.

This approach draws on the work of Fassin (1992), Hours (1985), Jaffré and Olivier de Sardan (2003), and Berche (1998) on illness and therapy in West Africa. These scholars focus especially on the social and political aspects of illness and therapy. Their version of *anthropologie de la santé* (or a ‘social anthropology of health’) is a reaction against the work on illness and therapy within the French africanist tradition. This tradition was grounded in an analytical interest in religion and concentrated on the analysis of representations of illness, on illness as a symbolic object, and on ‘traditional’ medicine. Little attention was thus paid to ‘modern’ medicine and its practitioners (Jaffré and Olivier de Sardan, 2003: 12). In contrast, the ‘new’ *anthropologie de la santé* turns its attention to ‘modern’ medicine, especially to the public health care services as well as to other therapeutic alternatives, such as the informal market in pharmaceuticals, and traditional healers and diviners. The perspective also widens the analytical concern, beyond illness as the sole object of interest, to an interest in the social and political relations and interactions that are, so it is argued, inseparable from illness and therapy. Attention is paid to the wider ‘social, relational and institutional’ context of health (Olivier de Sardan, 1999b:1).

Fassin in *Pouvoir et maladie en Afrique* (1992) focuses on questions of social inequality and power in the study of health and illness in Pikine (Dakar). He argues that a social, economic and political point of view reveals amongst other things the relations of domination, the mechanisms of differentiation and the power games that surround health and illness (Fassin,
Fassin also emphasises that illness is a ‘fait social’ (a social fact) and that illness representations and curative practices are inseparable from social representations and practices (Fassin, 1992: 24). Moreover, any study of health and illness, Fassin argues, must pay attention to all the social relations that illness puts into play - family/kinship relations, relations to neighbours, to political structures, religious institutions etc.- and not only to illness itself (Fassin, 1992: 24). Hours in L’état sorcier (1985) places the analytic focus on public health care and society in Cameroon. He studies the relations between the patients and the medical staff in four different health services. Hours argues that illness should not only be seen as social and as socially represented but also as a ‘rapport social suivi’ (a continuous social relation) that takes place or unfolds in health institutions (Hours, 1985:13). The title, ‘the sorcery state’, reflects the experience of the sick of the dysfunction of the public health services as a form of violence and a negation of social links and solidarity. The collection of essays in Une médecine inhospitalière (2003) edited by Jaffré and Olivier de Sardan, provides a detailed anthropological account and analysis of the public health services in urban West Africa (Abidjan, Bamako, Conakry, Dakar, and Niamey). The analytical focus is on the everyday functioning (or rather dysfunctions) of the public health care services. It focuses on what happens when the population comes into contact with the public health services and especially on the often problematic relations between medical staff and patients. Berche in Anthropologie et santé publique en pays dogon (1998) analyses a public health project in Mali. His focus is on the interactions and relations between the different social groups and individual actors in the public health project. The relational dimensions, such as the social dynamics, the strategies and the power games that surround the health project, are at the centre of his analysis. He emphasises that illness should be approached from a wide perspective, which is not limited to the analysis of, for instance, illness representations, but which looks at the larger social relations, representations and strategies which are put into play around health institutions.

This chapter has discussed anthropological perspectives on medical pluralism and therapy seeking. It has also pointed to the centrality of the study of medical pluralism to the emergence and development of medical anthropology. It has, in particular, emphasised the importance of attending to the many social, political, ideological, economic and cultural factors that influence medical pluralism and therapy seeking, necessitating a wide approach that goes beyond merely pointing to the existence of medical pluralism and to the parallel use of therapeutic alternatives in the quest for therapy. One way of doing this is illustrated by the
studies carried out in West Africa discussed above which amongst other things focus on the social and political aspects of illness and therapy and on the relational and institutional context of illness and therapy. The following part of the paper will focus on medical pluralism on the outskirts of the Nigerien capital Niamey.

3. THE LOCAL CONTEXT OF SAGA

3.1 Culture and history

Niger is a land-locked country in West Africa. It borders Algeria and Libya to the north, Chad to the east, Nigeria and Benin to the south and Burkina-Faso and Mali to the west. Niger has a surface area of 1,187,000 square km (Fugelstad, 1983: 1). The population of Niger is estimated at 11,544,000 (WHO, 2004). About 80% of its territory lies in the Saharan climatic zone and about 20%, the south of the country, in the Sahelian climatic zone (Charlick, 1991: 2). It is the southern part of the country which has the highest population density and the majority of the agricultural production. Niger’s economy is predominantly agricultural, 80% of the population is engaged in full-time or part-time farming, but there are also small sectors in mining (coal and uranium) and industry as well as a relatively large urban public sector (Charlick, 1991: 98). The United Nations Human Development Index ranks Niger as the 176th of 177 countries (UNDP, 2004).

According to the World Health Report (2002) life expectancy at birth in Niger is 42.7 years for females and 42.6 years for males. Infant mortality is 121.7 deaths per 1,000 live births and child mortality is 256 per 1,000 females and 249 per 1,000 males (WHO, 2002a). The coverage of public health services is poor. According to WHO there are 3.5 physicians, 22.9 nurses and 5.5 midwives per 100,000 people (WHO, 2002b). Moreover, the majority of the public health services are concentrated in the urban areas. Statistics of the urban community of Niamey show that the majority of health personnel are concentrated in Niamey and that the ratio there between health personnel/population is the best in the country.¹

¹ The figures for the public health care infrastructure in Niamey are as follows. Two (of three) national hospitals are located in Niamey (Hôpital National Niamey and Hôpital National Lamordé) and one (of five) regional hospitals is located in Niamey. There are 48 centre de santé intégrés as well as 8 maternity centres. There are 42 pharmacies (of which 7 are pharmacies populaires) and there are 55 private clinics/salle de soins. (Report Annuel de la Communauté Urbaine de Niamey, 2000).
Niamey (Saga) is located in the western part of Niger. The western region is usually described as the country of the Songhay-Zarma. However, Fugelstad describes the history of the region as one of a succession of migrations with a constant ethnic shaping and reshaping as groups merged or crystallised or split up (Fugelstad, 1983: 33). Moreover, the Songhay-Zarma is not a homogenous ethnic group but encompasses many different groups. People tend to view themselves as Kado, Wogo, Kurtey etc. rather than as Songhay (Fugelstad, 1983: 33, Olivier de Sardan, 1984: 25). This has also been true for the groups referred to as Zarma as people often attach a greater importance to their particular identity as Kalle, Gube, Mauri etc. (Olivier de Sardan, 1984: 25). Nonetheless, Zarma is more widely used than Songhay (ibid. 272). What unites these different groups is a common language (Songhay-Zarma) as well as certain cultural traits, for instance, the spirit possession cult, the cult of the holey. They are also traditionally sedentary agriculturists in opposition to Fulbe and Tuareg pastoralists and semi-nomads and they share a similar social structure (Olivier de Sardan, 1983: 25-6). Songhay-Zarma is seen as one language, although there are different (regional) dialects linked to distinct identities, for instance, Zarma cine is spoken by the Zarma and so on (ibid. 270).

As described by Bernus and Dulucq Niamey was but a small village when it became a colonial administrative centre, the chef lieu de cercle du Zarma, in 1903 (Dulucq, 1997: 187, Bernus, 1969: 7). For a brief period it was also the chef lieu (the administrative capital) of the vast Territoire Militarie du Niger (military territory of Niger). However the chef lieu was moved to the more significant town of Zinder in 1911. Shortly after Niger became a civilian governed colony, plans were made to move the capital back to Niamey. This was done in 1927 (Dulucq, 1997: 188). Urban investments in the new capital, such as the construction of lodgings for functionaries, buildings for the administration, markets etc., took off, as did the number of inhabitants (ibid. 188). In 1939 the population of Niamey was only 1,730 inhabitants (ibid. 193). In 1950 the population had increased to 12,000, but it was not until the 1960s at independence that the population started to grow rapidly (ibid. 217).² Since then Niamey has rapidly expanded and in 1997 the population was estimated to be more than 700,000 (Alpha Gado, 1997: 51). The public investments had remained minimal during most of the colonial period and the only significant investments were made in the European neighbourhoods and in the colonial administration. As the capital grew it drastically expanded. This led to the progressive integration of peripheral villages and neighbourhoods

² Niamey grew from 80,000 in 1969 to 225,000 in 1978 and to more than 400,000 inhabitants in 1980 (Dulucq, 1997: 188).
such as Saga and Gamkallé into the city. However, as Dulucq points out, such peripheral areas were the ‘poor cousins’ of urban politics (‘*les parents pauvres des politiques urbaines*’) and remained marginalised in the urban agglomeration (Dulucq, 1997: 284). The city centre was favoured to the detriment of the peripheral neighbourhoods, a pattern which continued after independence.

### 3.2 Saga

Saga is located on the southeastern outskirts of Niamey, on the bank of the river Niger. Saga is an old village and the *chef lieu* of the canton of Saga. According to Bernus, at the same time as the present day site of Niamey was still a no-mans land, Saga and other surrounding villages, were since long established (Bernus, 1969: 15). With the expansion of the capital, Saga has become increasingly integrated into the urban community of Niamey. However, it is still physically separated from Niamey by the capital’s main industrial area. The road to Kollo (a town 40 km south east of Niamey) runs through the centre of Saga. Both sides of the road are lined by stores and stalls selling food staples, vegetables and fruit, fish, condiments, bread, clothes and pharmaceuticals etc. The road bustles with activity both day and night. The stores and the stalls give way to houses and unpaved roads. The houses vary in size and material, from simple four wall banco houses to larger houses made of brick and concrete. All compounds have a yard, which is enclosed by straw, brick or concrete walls of various sizes. Many compounds have running water (a tap), those who do not have a tap collect water from one of the public pumps or buy it from ambulant water sellers. The roads, which are dusty and sandy during the dry period, fill with water during the rainy season, some of them becoming impassable. Several roads lead down to the river, the edge of which is lined by rice paddies and gardens. The rice paddies are an important source of income in Saga.

According to a 2001 survey of the population of the urban community of Niamey, the population of Saga was estimated to be around 24,000. The main language spoken is Zarma. Saga was originally a predominantly Songhay-Zarma village. According to the *chef de canton* (canton chief), the first inhabitants were Zarma and so is the family that since the establishment of Saga has held the chiefship. However, there are many different ethnic groups in Saga, for instance Hausa, Fulani and Mawri etc. As in the rest of Niger the majority of the population is Muslim. According to the canton chief the name Saga comes from two trees, *sefow* and *sagay*, which, he said, had grown together and had been given the name Saga. The
canton chief named Moussa Djermakoye as the founder of Saga and Sambou Nangou as the first chief. The neighbourhood Sambou Kouara is named after him. The present chief claims to be the 12th chief of Saga and a direct descendent of the first chief.

Agriculture, in particular rice growing, is the dominant economic activity in Saga and occupies a significant part of its population. An ‘aménagement hydro-agricole’ (hydro-agricultural scheme) was created in the 1970s. It is now run by the rice co-operative in Saga. The rice fields are divided up into parcels owned and worked by families in Saga. The rice harvested is used to feed the family and any surplus rice is sold to cover family expenses. People also grow vegetables, such as cabbage, lettuce, tomatoes, carrots, onions, cucumbers, peppers, aubergines and manioc next to the rice fields. The vegetables are grown for domestic consumption but are also sold. Fishing and cattle farming are important subsistence and economic activities. The fishermen and cattle farmers have their own local associations. Informal activities such as hairdressing, hawking and temporary manual labour also employ people. Petty trade is another important economic activity. Especially for women who by selling, for instance, beignets (fritters) and cooked food contribute to the family budget. Some men are employed as unskilled labourers in the factories in the nearby industrial area. There are some civil servants in Saga. Unemployment is a major source of frustration for the youth; some find temporary manual work here and there to support themselves and their family.

There are three public primary schools (Saga I, II and III) and one secondary school (CES Saga). There is a public dispensary and a confessional dispensary run by Mother Theresa’s Missionaries of Charity. Further down the road to Kollo about 4 km from the centre of Saga there is also small private dispensary. There are several mosques in Saga and three mosques de vendredi (‘Friday mosques’). There is an evangelical church located at quite a distance from the centre of Saga and Mother Theresa’s Missionaries of Charity run a small catholic parish.

The canton de Saga is made up of several villages and quartiers (neighbourhoods). Saga is the capital of the canton of Saga and the canton chief resides there. Saga is divided into six quartiers; Saga Gongou, Saga Fondobon, Saga Gassia Kwara, Saga Sambou Kouara, Saga

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3 According to the chef de canton the canton of Saga consists of the villages Bossey Bangou, Kongou Gorou, Kongou Gorou Zarmangande, Kongou Gonga, Saga Gourou 1 and 2, Gourou Kayna, Gourou Gareydo and Kofo Kouara and the quartiers Talladjé, Aeroport 1 and 2 as well as those in the village Saga.
Kourtey and Saga Peuhl. Each neighbourhood has a *chef de quartier* (neighbourhood chief). The urban community of Niamey is divided into three *communes* (councils); *commune I, II* and *III*. Saga is part of *commune II*. The *canton* and the office of the *chef de canton* were created during the colonial period, for administrative purposes.\(^4\) Notably they are still part of the local administration.

The interviews were mainly carried out in Saga Fandobon and Saga Kourtey. Saga Fandobon, with a population of 11,024 lies in the heart of Saga and so does Saga Kourtey with an estimated population of 7,559. However only a small part of the population of Saga Kourtey live in the original Saga Kourtey. The majority live in Pays-Bas, a neighbourhood located along the road that leads to the airport of Niamey, about 3.5 km from the centre of Saga. Saga Fandobon and Saga Kourtey, are part of the old and established Saga. Pays-Bas, on the other hand, was for a long time not recognised by the authorities and sprung from the ‘spontaneous occupation’ of land, with no legal rights of tenure. It lacks basic infrastructure such as water provision, health centres and schools etc.

### 3.3 Medical pluralism in Saga

The government health care system is represented by a public dispensary, the CSI (*centre de santé intégrée*) which also houses the services of the CSMI (*centre de santé maternelle et infantile*), the centre for maternal and childcare. The dispensary, which is located in the centre of Saga just off the main road, was established in 1996. An additional building, meant to house a maternity centre, was constructed two years ago but it is still not functioning due to a lack of equipment. The dispensary runs a small pharmacy in which prescriptions can be filled. The medical staff consists of five nurses, three midwives and a handful of local volunteers. There is also a confessional dispensary run by Mother Theresa’s Missionaries of Charity. The confessional dispensary, which was established in the early 1990s, is located right next door to the public dispensary. The confessional dispensary, which is open three days a week, draws patients from all of Niamey as well as from surrounding villages. In addition to the dispensary the nuns run a small nursing home for malnourished children. Finally, a retired nurse runs a

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\(^4\) During the early colonial period the French in seeking to establish a local administration created *cantons* headed by a *chef de canton*. The colonial power sought to use the authority and the legitimacy of the traditional *chefferie* to legitimise the administrative *chefferie* by building on already existent institutional frameworks. However the role of the chiefs was transformed to one of collecting taxes and recruiting forced labour (Fugelstad, 1983: 66) (Olivier de Sardan, 1984: 207).
small private dispensary or cabinet, which is located further down the road to Kollo about 4 km from the centre of Saga.

There is no pharmacy in Saga, apart from the one in the public dispensary. However, during the field study a small ‘pharmaceutical depot’ opened up in one of the shops on the side of the main road. It is run by a former pharmacy employee. He said that he hopes that people will come to him instead of having to go to the pharmacies in the centre of Niamey. He was also careful to point out that the pharmaceuticals he sells are bought at the ‘pharmacie centrale d’achat à Niamey’ and are different from the pharmaceuticals sold by ambulant medicine vendors. The informal sale of pharmaceuticals is common in Saga. A couple of general stores sell pharmaceuticals along with other merchandise, such as foodstuffs, soap, detergent, plastic wares etc. although in small quantities. There is also a small store, located just across the road from the public dispensary, which only sells pharmaceuticals. A varying number of ambulant medicine vendors circulate in the streets of Saga.

‘Traditional’ medicine has an important place in the therapeutic field in Saga. The practitioners of traditional medicine are a diverse group, with different specialisation and orientation. Like the vendors of pharmaceuticals, ambulant vendors of medicinal plants come to Saga to sell. Some wheel a small cart full of plants and others carry baskets. They sell bunches of dried leaves, roots and bark from medicinal plants. The prices vary from 25 CFA to 100 CFA per bunch. The vendors are not herbalists as they do not diagnose and treat illnesses, they merely sell medicinal plants and indicate how they should be used. Some of the traditional healers are specialists in one particular therapeutic area. For instance, the bone setter heals fractures and the blacksmith (forgerons) heals burns. The wanzam or barber is a kind of traditional surgeon who in addition to shaving and cutting hair also performs specialised surgery, such as circumcision, bloodletting and ritual and therapeutic scarifications (Prual et al, 1994: 1079). Of the traditional healers or practitioners the most frequently consulted are the zimas and the marabouts.

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5 ‘Traditional’ medicine is here used to refer to those medical or healing practices which people themselves designate as traditional such as the work of the marabout and of the zima or medicinal plants. ‘Traditional’ does not mean something static, a remnant of the past, because tradition is dynamic and changing. This is also true of traditional medicine in Niger. Conversely, ‘modern’ medicine is used to refer to the medical and healing practices which people refer to as modern, namely pharmaceuticals and hospital and dispensary treatments.
The zima is the priest of the cult of the holey, a spirit possession cult that lies at the heart of Songhay-Zarma religion. In his seminal work on Songhay religion and magic Rouch describes the cult of the holey as the most important manifestation of Songhay religion. The spirit possession cult with its public rituals and wide geographical reach has replaced older private and localised ancestor worship cults. External influences, such as neighbouring cults and Islam, have been incorporated into the cult of the holey (Rouch, 1989: 21). The spirits (the holey) control the forces of nature and are the masters of the human world. During possession ceremonies they temporarily enter the social world by taking over their medium’s body. Rouch divides the ceremonies of the cult of the holey into annual and occasional ceremonies. The annual ceremonies are obligatory while the occasional ceremonies are responses to fortuitous events such as illness (Rouch, 1989: 235). Of the annual ceremonies the yenaandi is the most popular and important one. The yenaandi is held in each village at the end of the hot-dry season in order to ensure a good rainfall and a bountiful harvest. Occasional ceremonies are held for individual members of the spirit possession troupe, for instance in the case of illness or death. Of these occasional ceremonies the initiation ceremonies of new mediums are especially important.

The cult of the holey involves many different actors who together form what Stoller refers to as a ‘spirit possession troupe’ and what Rouch refers to as a ‘religious society’ (Stoller, 1989; Rouch, 1989). The core actors are the zimas, the possession priests, the spirit mediums or the holey bari (‘chevaux des génies’), the musicians, players of the violin and the calabash drum, and the sorko, masters of the river and praise-singers. There are also the adherents or followers who, although to differing degrees, are involved in the cult of the holey. The zima is, like the mediums, chosen by the spirits, although the position is often also inherited. The zima can be either a man or a woman and member of any social grouping (Stoller, 1989: 37). The zima directs the cult of the holey in his or her village or quartier and it is the zima who organises the possession ceremonies, who opens the dance, supervises the ceremony, procures the objects the spirits ask for, collects the plants needed for the ceremonies in the bush etc. (Rouch, 1989: 206).

The choice of a new medium by a spirit is manifested by illness. Attacks or fits, a refusal to eat and incoherent speech are some of the signs of spirit aggression (Vidal, 1990: 50). The zima is the expert in matters of spirit aggression or spirit sickness. However recourse to the zima is usually preceded by recourse to other therapeutic alternatives, it is only when there is
no visible improvement that the help of a zima is sought (Vidal, 1990: 54). If a spirit has possessed the person with the aim of making the person his/her medium the illness can only be cured through the holding of an initiation ceremony. The initiation ceremony usually lasts for seven days. The role of the zima is essential in the initiation, as it is the zima who identifies the invading spirit and knows how to proceed during the initiation to ensure that it is successful. The initiation ceremony restores the health of the ill person who emerges as a fully-fledged medium, the spirit returning to his/her body when beckoned (Stoller, 1989).

The marabout, or alfa in Zarma, is a Koranic scholar and Islamic priest. The marabout can have many different religious, social and therapeutic functions. Wall, in his study of health and illness among the Hausa in Nigeria, points to the multiple functions of the marabout as a counsellor, diviner, astrologer, fortune-teller, spiritual adviser, pharmacist and physician (Wall, 1988: 352). The marabout, through his ability to read the Koran, has access to the realm of Islamic thought and to its secrets and spiritual power (Wall, 1988: 352). Rouch points to the perception in Songhay-Zarma country of marabouts as learned men with magical powers (Rouch, 1989: 289). The marabout is consulted in quite diverse matters and he is called upon in all human activities, such as illness, harvest, war, glory, travel and wealth (Rouch, 1989: 289). The main areas of intervention of the marabout are the healing of illnesses and the bringing of fortune and protection. The Koran, or verses from the Koran, is at the centre of the treatment. A verse specific for the complaint is selected and written out several times on a wooden slate, the ink is washed off and collected in a bowl and the inky water is drunk by the patient. Alternatively, Koranic verses are written on small pieces of paper, which are sewn into a leather pouch worn around the neck. It can also be placed over a doorway to protect the house or buried to ward of evil and help bring good fortune (Rouch, 1989: 289; Wall, 1988: 236). As a marabout explained, there is a verse for every misfortune. There is a verse for a successful marriage, for finding employment, to reverse spells and to ease headaches etc. Medicinal plants are also used in combination with the verses.

Lastly, self-medication, using pharmaceuticals bought from ambulant vendors as well as medicinal plants and home remedies, is widespread and dominates therapeutic itineraries. Self-medication is usually the first recourse, and it is only when the condition becomes serious that people turn elsewhere.
Traditional medicine, or at least the Songhay-Zarma possession cult, has received a fair amount of ethnographic attention (Rouch, 1989; Stoller, 1989; Vidal, 1990). The focus in this paper will be on ‘modern’ medicine and the institutions and actors of ‘modern’ medicine in Saga, that is, on the public dispensary, the confessional dispensary and the informal sale of pharmaceuticals. Before going into a discussion of these three therapeutic alternatives the following chapter will discuss some local representations of illness and medicine in order to provide a background to the search for therapy in Saga.

4. REPRESENTATIONS OF ILLNESS AND MEDICINE

The focus of this chapter is on everyday experiences of illness, approached through a discussion of common representations of illness and medicine. The first part of the chapter will discuss some of the illnesses that occupy a central place in people’s concern with ill health. The aim is not to present an exhaustive account of Songhay-Zarma illness representations, but to present some common representations encountered in Saga. Illness representation is here defined as the way in which people represent, conceptualise or simply talk about and describe different illnesses, for instance the designation, the symptoms, the cause as well as the treatment of a particular illness. The second part of the chapter will discuss local perceptions of medicine. It will in particular point to the parallel use of ‘traditional’ and ‘modern’ medicine.

4.1 Illness representations

The anthropological analysis of illness clearly illustrates that it is not merely biological but also social and cultural. This is clearly expressed in the distinction between disease, illness and sickness first formulated by Kleinman and elaborated on by Young (1982). While ‘disease’ is the biomedical definition or objectification of a bodily disorder (the pathology) ‘illness’ is the subjective and individual experience, perception and understanding of the disease. Finally, ‘sickness’ signifies the socialisation of disease, through which it is given socially recognisable meanings (Young, 1982: 270).

The tendency of anthropologists to create vast classificatory systems when analysing illness representations has been pointed to and criticised by various authors. Fassin points to the
difficulties he encountered when trying to elaborate illness classifications on the basis of
interviews with different healers in Pikine (Dakar) Senegal. These difficulties led him to the
conclusion that illness classifications are always unstable, often incoherent and very much
dependent on the person and on the situation (Fassin, 1992:190-94). Similarly, in their
analysis of the social construction of illness in West Africa, Jaffré and Olivier de Sardan
emphasise that illness representations do not necessarily form a coherent system or structure
and are better thought of as an ensemble of units of different size, complexity and
composition, following different and overlapping logics (Olivier de Sardan, 1999a: 26). This
is not to say that there is no order or coherence in illness representations, some shared and
stable representations do exist (Olivier de Sardan, 1999a: 19). But it is crucial to recognise the
syncretism, heterogeneity, discontinuity and change that characterise popular representations.
Illness representations are not static and inert and external influences, such as biomedical
discourses and rapid urbanisation, engender transformations. Syncretism, the combination or
blending of elements from different religious or cultural - and in this case medical - traditions,
characterises many of the illness representations described below (Seymour-Smith, 1993:
274). For instance, as biomedical discourse spreads through health information campaigns and
through experiences with public health services it is integrated into popular illness
representations. Illness representations thus often draw on and combine ‘local’ knowledge and
biomedical discourse.

Olivier de Sardan point to the tendency of the anthropological gaze to privilege illnesses of a
symbolically expressive and spectacular kind and to emphasise the social, cultural and
symbolic significance of illness representations in claiming that bodily disorder indicates
social rupture, conflict or disorder and mobilises a large number of people and social relations
(Olivier de Sardan, 1999a: 16). He points out that such spectacular afflictions represent only a
minority of the illnesses which people experience on a daily basis. It is the ‘common’ or
‘prosaic’ illnesses which dominate the quest for relief and therapy (Olivier de Sardan, 1999a:
17). Yet, these more prosaic illnesses are often overlooked. Olivier de Sardan further argues
that the everyday experience of illness in most cases involves more pragmatism and banality
than is generally acknowledged (Olivier de Sardan, 1999a: 16). This not to say that the search
for meaning is completely absent in conceptions of illness and in the search for therapy but to
suggest that in the case of most common (prosaic or everyday) illnesses the search for relief
or cure often takes priority over a search for meaning.
Illnesses of God and illnesses of the spirits

The illnesses discussed below are in Zarma referred to as illnesses of God, *Irkooy doori* (Olivier de Sardan, 1999a: 23). Illnesses of God are opposed to illnesses of the spirits, *ganji doori*. The expression *Irkooy doori* does not mean that God is the causal agent. Illnesses of God are natural or prosaic illnesses and are a matter of fate or destiny. In the same way that it is said that an illness comes from God so it is said that God provides the treatment for the illness. *Ganji doori*, on the other hand, are caused by a supernatural aggression, such as sorcerers (*cerkow*), spirits or black magic (magic attacks) (Olivier de Sardan, 1999a: 27).

Failure to treat an illness, after having taken recourse to several different treatments, often leads to the suspicion that the illness is caused by supernatural aggression, most frequently spirit aggression. The *zima*, the priest of the cult of the *holey*, is the main figure in dealing with spirit aggression. The designation of an illness as an illness of God or as an illness of the spirits is thus not set as it can shift between the two categories in the same illness episode depending on the success or failure of the treatment.

The representations (the local designations, symptoms, cause and treatment) of malaria, *weyno*, bilharzia, hypertension and gastric ulcer will be discussed below. They were all mentioned by interviewees as being frequent illnesses and thus play important roles in everyday experiences of illness.

Malaria

The Zarma designation of malaria is *heemar-ize*. *Heemar-ize* means product or child of the *hivernage*, the harvest period or rainy season, during which people fell ill with malaria. Olivier de Sardan notes that the appearance of malaria during the *hivernage* was imputed to a change in alimentation as crops such as millet were harvested during this period (Olivier de Sardan, 1999b: 265). However with the diffusion of public health messages that identify mosquitoes as the cause of malaria, *heemar-ize* has become increasingly linked to mosquitoes and is frequently referred to as the ‘fever or illness of mosquitoes’. Traces of public health messages were evident in comments about malaria, such as ‘health workers say that malaria is caused by mosquitoes’. One old woman remarked that malaria was caused by ‘l’anophèle’.  

Another woman pointed out the following regarding the changing definition of malaria:

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6 Anopheles are mosquitoes that can carry the malaria parasite and transmit the disease to human beings.
In the past, malaria [heemar-ize] only appeared after the emergence of millet during the harvest period. That is malaria [heemar-ize]. But now it is the ‘illness of mosquitoes’ that we mistakenly call malaria [heemar-ize].

Medical ‘knowledge’ or representations about malaria have become a part of popular representations of heemari-ze. The connection with the hivernage still persisted. Malaria was said to ravage and to be especially dangerous during the rainy season. Many pointed out that nowadays malaria is a threat all year around. This is especially true in Saga, where the river and the rice fields as well as stagnant refuse water due to poor sanitation and drainage provide plenty of breeding grounds for mosquitoes.

The symptoms of malaria mentioned were fatigue, a high fever, headaches, vomiting and diarrhoea. People were more or less certain as to the symptoms, which indicate that a person has malaria. Malaria was usually diagnosed as well as treated at home. In the past medicinal plants were used to treat malaria but the use of plants has been largely replaced by the use of pharmaceuticals which now seem to dominate its treatment. As one woman put it:

Our elders treated malaria with the leaves of nafa nafa, which one applied on the body of the ill person. Whatever the temperature of the fever, it decreases after the application…but now we no longer use nafa nafa. You know as we have become white we don’t believe in the efficacy of plants, because we prefer to go to the hospital.

Anti-malarial drugs such as chloroquine and nivaquine were widely used to treat malaria. They were even identified as the treatment against malaria, as one man pointed out ‘…chloroquine is the remedy against malaria’. Chloroquine and nivaquine were easily available. Both were sold as generics in pharmacies and in health care centres. They were cheap. However, in pharmacies as well as in health care centres, they were only sold in packages or in bags of at least 20 pills. Ambulant medicine vendors, on the other hand, sold them by the piece, thus enabling people to buy the number of pills that they felt they needed and that they could afford. It was only when the symptoms persisted that people went to the local dispensary, where they most frequently were treated with anti-malarial injections like quinimax.

Weyno
Although not a priority from the point of view of public health, weyno is an extremely common complaint and occupies an important place in peoples concerns with ill health.
Unlike *heemar-ize*, which has become increasingly synonymous with malaria, *weyno* has no medical designation. In French *weyno* is often referred to as haemorrhoids, however haemorrhoids is merely one of the many manifestations of *weyno*.

The symptoms of *weyno* are numerous. The tradipractitioners interviewed distinguished between different kinds of *weyno*. One made a distinction between an internal *weyno*, causing buttons and lesions on the lips, sexual organs and anus, and an external *weyno*, causing the ‘the big intestine to exit’. Another tradipractitioner mentioned three kinds of *weyno*: the first manifested by haemorrhoids, the second by ‘the exit of the large intestine’ and the third in the stomach by a loss of appetite. In interviews with the population in general most people simply named different symptoms or manifestations without classifying them as evidence of different kinds of *weyno*. Most people pointed to a lack or loss of appetite as a symptom of *weyno*. Other symptoms mentioned were fever, weight-loss, fatigue, headaches, vomiting, haemorrhoids, diarrhoea or constipation. Eating excessively fatty, oily, sugary and in particular spicy food or not eating *à sa faim* (one’s fill), skipping a meal and eating at irregular hours were said to provoke *weyno*. People also mentioned drinking excessive amounts of tea and being exposed to heat as provoking *weyno*. One young man pointed to a stint as a *transporteur* on the large trucks that go to Cotonou as having in part caused *weyno* as he spent many hours seated on a bench close to the hot motor of the truck. *Weyno* is also a frequent complaint among taxi drivers. What in the village was the illness of hard working peasants has in the city become the illness of taxi drivers, condoned to long periods of sitting down said to activate *weyno* (Olivier de Sardan, 1999b: 270).

*Weyno* is inherent in the person, congenital (Chilliot, 2003: 437). As one tradipractitioner stated, ‘everyone has *weyno*’. *Weyno* is said to originate in the lower stomach (Olivier de Sardan, 1999b: 256). When provoked, due to for instance a change in food habits, *weyno* ‘rises’ and causes the person trouble such as loss of appetite, fatigue and headaches (Chilliot, 2003: 437). Consequently, as one interviewee pointed out, one is never cured of *weyno*, it is only ‘calmed’, ‘the illness lies down’ (*la maladie se couche*).

Home treatment or local remedies dominate the treatment of *weyno* and ‘modern’ medicine was not seen as being very efficacious. *Weyno safari* (medicine against *weyno*) usually refers to local remedies based on medicinal plants. Knowledge about *weyno* and how to treat it is generalised and widespread, and the intervention of a healer is usually not required (Olivier de
Sardan, 1999b: 260). People who have the necessary knowledge pick the medicinal plants themselves. Saga’s location on the river and the abundant vegetation of the riverbanks facilitates the self-acquisition of the plants needed. There are also ambulant plant vendors who regularly circulate in the streets of Saga. In the centre of Niamey vendors of remedies, concoctions or potions against weyno are numerous. Some circulate in the streets of Niamey, others have stalls in the markets or stores from which they sell their remedies. Even though the anti-weyno potions sold in the city centre differ from ‘traditional’ preparations and home remedies they were considered to be ‘traditional’ medicines, in contrast to pharmaceuticals (Oliver de Sardan, 1999b: 269).

Weyno clearly holds a central place in everyday concerns of health and ill-health. The centrality of weyno was illustrated by the constant stream of customers to a well-known vendor of weyno safari in Balafondon, right next to the grand marché in Niamey. At the height of the vendor’s popularity there was a constant queue of taxis outside his store. One well-dressed customer, working with an NGO, told us how after a failed attempt to treat his stomach troubles with pharmaceuticals he took the vendor’s remedy against weyno and was cured.

Bilharzia

Like malaria bilharzia has been the focus of numerous health education or information campaigns. Bilharzia is usually referred to as tootosi in Zarma. The designation of bilharzia as tootosi is recent. In the past tootosi designated primarily urinary problems, pain and urinating blood, seen as a manifestation of weyno (Olivier de Sardan, 1999b: 257). But in zones with hydro-agricultural schemes, with a high prevalence of bilharzia, tootosi have increasingly come to signify bilharzia (Olivier de Sardan, 1999b: 258). Health education campaigns and radio emissions have most probably engendered the equation of tootosi and bilharzia. The defining symptom of tootosi is still the urination of blood but in accordance with public health messages, tootosi is now also seen to be contagious (Olivier de Sardan, 1999b: 259). In Saga the symptoms mentioned were primarily blood in urine but even abdominal pains and pain when urinating. Bilharzia or tootosi was seen as contagious and the primary site of transmission mentioned was river water. The urine of someone who is ill was also said to carry a high risk of contamination. Children who play in the river and men who work in the rice fields were seen to be especially prone to catch bilharzia. It seemed to be generally held that to treat and to diagnose bilharzia one should go to the health centre. However, one
woman said that sometimes people think that it is weyno and use remedies against weyno to calm the illness.

**Gastric ulcer and hypertension**

During the interviews hypertension, gastric ulcer and diabetes, locally referred to as tension, estomac and diabete, were frequently mentioned, often together and as ‘new illnesses’ that people knew little about. Here medical illness entities had been appropriated and infused with local interpretations. Health information messages on the radio as well as an increasing diagnosis of hypertension, gastric ulcer and diabetes in the city are likely origins of the new illness representations. Only tension and estomac will be discussed below as diabetes was only mentioned in passing by the interviewees.

Some examples of the manifestations of tension mentioned in the interviews were throbbing of the heart, heart pains, nausea, dizziness, fever, difficulties breathing and headaches. According to a tradipractitioner a person has hypertension when the heart beats too fast and the blood circulates too fast in the organism. Knowledge about tension was attributed to health workers and to western or modern medicine. But even if the intimate connection between tension and modern medicine made people turn to health centres for help, a continuous treatment with pharmaceuticals was often not economically viable. Hence, ‘traditional’ medicine provided an attractive alternative to an economically costly hospital treatment. For instance, the tradipractitioner mentioned above offered a treatment with medicinal plants which he said together with a decrease in the amount of salt consumed lowered the tension. One old man, who had been diagnosed with hypertension at the hospital, was at first given pharmaceutical products, paid for with the help of his son’s white employer who also brought him medicine from the United States. Yet, he stopped taking the medicine as the white man no longer paid for it. Instead he bought medicine (nifluril, paracetamol, médic…) from ambulant vendors, mainly when he had a fever or a headache. He had, since the start of the illness, been using medicinal plants. The course of action taken by the old man to find relief from his hypertension thus varied depending on the circumstance and his economic situation.

Gastric ulcer was commonly referred to as estomac. Like tension, estomac was seen as a ‘new illness’. Estomac was said to be centred in the stomach but to manifest itself through heart pains or burns:
It’s an illness in the stomach but one feels the pain in the heart. It’s like someone is burning the heart with fire…The illness is located in the intestines all the way to the oesophagus, it is not the heart that is ill.

Another old woman explained *estomac* in the following way:

It attacks the intestine making sores everywhere and you feel the pain in the heart. One has to vomit to calm it down.

In addition to heart pain or heartburn other signs of *estomac* mentioned were fever, vomiting and diarrhoea. Hunger and eating spicy food was said to aggravate the condition. Recourse was at times taken to the health centre. A cheaper, more accessible, and often effective alternative was the use of traditional medicine such as plants. One young mother had been diagnosed with gastric ulcer at the health centre but successfully treated herself with plants (*bani* and *hai ga hampa*) as she could not afford to buy medicine at the dispensary. An old woman with gastric ulcer had stopped going to the health centre as she said she could no longer afford it. Instead she used pills bought from ambulant vendors and medicinal plants that she had bought from a tradipractitioner. She emphasised that when one is ill one takes whatever medicine that is available to calm the illness. Satisfaction with a treatment was judged on whether the condition had improved or not. One sign of improvement mentioned was the ability to consume spices without feeling pain.

*Food and health*

The link between food and ill-health is evident in the above discussion of illness representations, especially in the case of *weyno*. The importance of food habits in maintaining strength and good health was mentioned by many. Eating at regular times, ‘to eat one’s fill’ (*manger à sa faim*) and eating the right kind of food was said to help ensure strength and good health. An older woman stressed the importance of *manger à sa faim* the following way:

If your stomach is not full anything can happen to you…if you are ‘satisfied’ [*rassasię*] certain illnesses won’t catch you. When you eat your fill you won’t even feel the cold.

She also emphasised the importance of eating the right kind of food and that one has to eat food with vitamins. Skipping meals and eating at irregular hours was said to weaken the body, making it more susceptible to illnesses. Many elders saw changes in food habits as having
caused an increase in illnesses. In the past, they said, people were not as frequently ill as they are now. The number of illnesses was also said to have increased. Illnesses such as tension, estomac and diabete were said to be new and frequent. A group of old women explained the increase in illness the following way:

Before we ate sauces made of gombo and baobab leaves but now women put l’ârome Maggi in everything…we don’t even know where it is produced.

In the link made between an increase in illnesses and changing food habits, l’ârome Maggi seemed to be the main culprit. L’ârome Maggi is sold in liquid form and as stock cubes. It is extensively used in most dishes and can easily be found in any marketplace and small grocery stall. Billboards and television commercials also proclaim its merits as an easy flavour enhancer. Comments about l’ârome Maggi and its deleterious effects often touched on its foreign origin. Its place of fabrication as well as its ingredients were said to be unknown. This reasoning is in line with the more general assumption about the importance of ‘a good alimentation’ to good health and the deleterious effect of changing and irregular food habits. Other reasons given for the increase in illnesses were the increasing population movement because of labour migration (exode) which was said to bring illnesses such as polio and AIDS back home.

4.2 Medicine

Medicine is called safari in Zarma. Safari refers to plants and other substances, for instance animals and minerals, used for medicinal ends as well as to pharmaceutical products such as pills and injections (Chilliot, 2003: 428). It should be noted that safari has a wide meaning, it not only refers to medicine used to cure illnesses but also to substances, objects or techniques, used to prevent illness (for instance vaccination) and as a form of protection from misfortune (for instance amulets) (Chilliot, 2003: 430). However, when asked to define or to explain safari most people in Saga responded that it cures illness. One woman stated that safari is the remedy that permits you to be cured. Similarly, a young man explained that safari is a remedy that permits you to bien guèrir, to illustrate he pointed out that weyno safari is used against weyno and bon dori safari is used against headaches (bon dori is headache in Zarma). Many pointed out that there are different kinds of safari. On the one hand, there are medicines made on the basis of plants and other natural substances. These were referred to as boro bi safari,
which means medicine of the black man. They were also called kwaraa safari, which means medicine of the village. This category also included the curative and preventative (or protective) remedies offered by various healers, such as, kotte or charms made by the zima, the amulets, pieces of paper with Koranic verses written on them enclosed in a leather pouch, made by the marabout or the incantations of the blacksmiths (forgerons) who treat burns. One man stated:

One can go to the zima, the charlatan, or the marabout, that it also a safari, it is like a lottery, it might not work at all, personally I don’t believe in it, but people do.

Boro bi safari was opposed to annassara safari, which means medicine of the white man. Annassara safari or lokotoro kwaraa safari, medicine of the doctor/nurse (or alternatively the medicine of the hospital/dispensary), referred to pharmaceutical products such as pills (kini) and injections (pikir) and other hospital treatments.

Booro bi safari and annassara safari were often opposed, or defined in opposition to one another. Booro bi safari, was seen as traditional medicine whereas annassara safari, was seen as modern medicine. One young man explained booro bi safari in the following way:

It is a medicine or a remedy against an illness that is not modern, that is traditional, that is made by an African. Boroo bi signifies black skin, thus one defines it in relation to Africa.

Another man emphasised that traditional medicine existed long before modern medicine, since the time of the ancestors. Annassara safari on the other hand makes reference to the foreign and colonial origin of pharmaceuticals, even though primarily Nigerien doctors and nurses staff the dispensaries and the hospitals and there are few European practitioners, with the exception of technical assistants working with various development projects. And despite the increased availability and use of pharmaceuticals, hospital medicine was still associated with white people, at least when compared or opposed to medicinal plants and local remedies. One woman described a pharmaceutical product by saying that it is for white people. This association is also evident in another woman’s comment about the abandonment of plants in the treatment of malaria and the dominance of pharmaceuticals:

…as we have become white we don’t believe in the efficacy of plants, because we prefer to go to the hospital.
With regard to the efficacy of traditional and modern medicine opinions diverged. Some people emphasised the virtues of medicinal plants. These virtues included the capacity of medicinal plants to completely heal illnesses, to quickly heal illnesses and to bring about a lasting positive effect. In contrast, pharmaceuticals were said to merely calm or soothe the pain without actually curing the illness. Still, pharmaceuticals were often held to be effective in treating or lowering fevers. Many mothers said that they either take their feverish children to the dispensary for fever reducing injections or give them pharmaceuticals, such as paracetamol, at home.

Most people were nonetheless reluctant to ascribe exclusive efficacy to either ‘modern’ or ‘traditional’ medicine. It was frequently stated that at times traditional medicine cures and at times hospital treatment or pharmaceuticals do. To treat some illnesses traditional medicine was preferred and for other illnesses modern medicine was preferred. While pharmaceuticals such as nivaquine and chloroquine were said to be effective in treating malaria, medicinal plants and local remedies were considered to be the most effective in treating weyno. Likewise, it was said that jaundice (moo say) (which is associated with weyno) could only be treated with medicinal plants, treating it with hospital medicine was futile and could even be dangerous. However, in most cases recourse was taken to both traditional medicine and modern medicine. For instance, an unsuccessful treatment with traditional medicine might bring a person to seek hospital treatment. Equally, an unsuccessful hospital treatment might bring a person to turn to traditional medicine. It was frequently stated that ‘there is a cure/treatment for every illness’. The key is to find the ‘right’ safari, which can bring relief and help one to regain one’s health. As one old woman remarked, ‘…when one is sick one seeks medicine everywhere until one is cured.’. This search involved the entire spectrum of remedies and did not exclude either medicinal plants or pharmaceuticals. In the search for relief and cure, traditional and modern medicine were thus complementary.

At the same time the economic situation played an important role in determining (limiting or enabling) the choice of medicine. A recurrent comment was that hospital or even dispensary treatment is for the privileged few who can pay the hospital fees and for the medicine prescribed. Taking recourse to plants was seen by some as a necessity when lacking the means to turn elsewhere. The informal market in pharmaceuticals has made pharmaceuticals, formerly confined to the health services, available to the population at large. However medicine sold by ambulant vendors was seen as medicine for the poor, without the means to
seek treatment at the dispensary or hospital or to buy medicine from licensed pharmacies. In general medicine sold on the street was not seen as being as effective as the medicine sold in pharmacies.

This chapter has discussed local representations of illness and medicine, it has highlighted the illnesses that people experience on a daily basis and their perception and use of medicine. The following chapters will deal with the therapeutic options available in Saga, starting with the informal sale of pharmaceuticals.

5. THE ‘PHARMACIE PAR TERRE’

This chapter will discuss the pharmacie par terre in Saga. Pharmacie par terre (‘pharmacy on the ground or in the street’) is used to refer to the informal sale of pharmaceuticals. In order to provide the reader with the larger context of the pharmacie par terre in Saga the first part of the chapter gives a general picture of the informal market in pharmaceuticals and then describes the informal sale of pharmaceuticals in Niamey. The second part of the chapter addresses the sale of pharmaceuticals in Saga, it focuses on the ambulant vendors, on the medicine they sell and on the relation between them and their customers.

5.1 The informal market in pharmaceuticals

The informal market in pharmaceuticals has, in sub-Saharan Africa as in other regions of the world, rapidly expanded during the last two decades. The informal market has dramatically increased the accessibility of pharmaceuticals. Which are no longer confined to the often financially inaccessible official circuits of distribution, such as public dispensaries, hospitals and licensed pharmacies. Pharmaceuticals can be bought in boutiques, in market stalls and on street corners in rural as well as in urban areas. The appearance and growth of the informal market in pharmaceuticals is connected to the structural adjustment policies imposed by the IMF on indebted developing countries following the debt crisis of the 1980s which drastically cut government expenditures, including public health budgets. The informal market in pharmaceuticals grew out of the difficult access to public health care and affordable medicine. The 1994 devaluation of the CFA franc further accelerated the extension of the informal market in the CFA countries in West Africa as people’s purchasing power was greatly
diminished (Maritoux, 2000: 223). Masquelier notes that in Niger, following the devaluation of the CFA, the price of imported drugs doubled and subsequently some patients were unable to afford even basic treatments (Masquelier, 2001: 277).

The informal market in pharmaceuticals is extensive and its turnover is significant. It is thus in no way a marginal phenomenon. In Benin, for instance, the illicit sale of pharmaceuticals comprises 40% of the entire pharmaceutical market (Maritoux et al., 2000: 223). In Nigeria and neighbouring countries the traffic of imitation drugs and medicine sold beyond their expiry date accounts for as much as 70% of the market (Masquelier, 2001: 278). Jaffré estimates that the sale of pharmaceuticals in the main markets (197 vendors) of Bamako has a turnover of approximately 10 million CFA a day, which would add up to a monetary flow of more than 2 billion CFA a year (Jaffré, 1999; 65).

The informal sale of pharmaceuticals in Niamey

The grand marché, the largest, most central and most established market in Niamey is the hub of the informal sale of pharmaceuticals. The vendors of pharmaceuticals are found at the heart of the grand marché where they occupy several rows of market stalls, all stacked with boxes of pharmaceuticals. The vendors at the grand marché are ‘wholesalers’. Most of the small-scale vendors or retailers in Niamey buy their merchandise from them. They are thus dependent on the vendors in the grand marché. The small-scale vendors vary in their specialisation. Some run a boutique, or a general store, in which they sell all kinds of goods, mainly foodstuffs, as well as a small amount of pharmaceuticals. Others run a small stall in which they sell cigarettes, sweets, detergent, sugar etc. along with painkillers such as efferalgam and paracetamol. More specialised vendors sell mainly pharmaceuticals in a stall or a boutique. Most noticeable of the small-scale vendors are the ambulant medicine vendors, who roam the streets of Niamey in search for customers, congregating around the markets, bus stations, dispensaries and hospitals of the capital. They are easily spotted by the tête de médicaments, a cylindrical display covered with pharmaceutical packages in vivid colours, which they carry above their heads on an upstretched arm. All of the vendors of pharmaceuticals encountered were men.

Most of the pharmaceuticals sold on the informal market in Niamey come from Nigeria. They are smuggled across the border from Nigeria, the hub of the informal market in pharmaceuticals in the region. Other sources are the public health services as well as
international donations of medicine, from which pharmaceuticals are diverted. Although the informal sale of pharmaceuticals undermines the official channels of distribution and is seen as illegal the trade prospers right under the eyes of the authorities. Large amounts of pharmaceuticals are clandestinely brought into the country on a daily basis, wholesalers sell pharmaceuticals in the heart of the largest formal market in Niamey and ambulant vendors freely and openly peddle pharmaceuticals on the streets of the capital.

There have been few decisive attempts by the authorities to stop the sale. Police raids have been directed against the wholesale vendors in the grand marché. However, according to an editorial in the Nigerien newspaper *La Libération* in 2001, only days after a police raid in the grand marché which was ordered by the Ministry of Health, during which large quantities of pharmaceuticals were seized, the authorities in Niamey ordered that the pharmaceuticals be returned (*La Libération* no.72, 2004). The sensitisation of the population has been another axe of intervention. Posters warning of the dangers of pharmaceuticals sold on the street with the message ‘Medicines of the street kill’ (‘Les médicaments de rue tuent’) were found here and there in the capital, although mostly in pharmacies and health centres.

Jaffré (1999) in Mali and Fassin (1992) in Senegal describe a similar situation, both point to the tacit acceptance of the illicit sale of pharmaceuticals on the part of the authorities. In Dakar, although illegal, the commerce is carried out under the eyes and to the knowledge of everyone; moreover the vendors at the markets are recognised by the authorities. Like all market vendors they pay a daily tax to the town council and contribute to the payment of the gardienage (Fassin, 1992; 92). The legal and the illegal, the formal and the informal, are inseparable when it comes to the black market in pharmaceuticals (van der Geest, 1988; Fassin, 1985). For one, the development of commerce in pharmaceuticals is intimately related to the failure of public health care services to provide financially accessible treatment and medicine. Furthermore, the official acceptance or tolerance of the informal market in pharmaceuticals is linked to the state’s incapacity to provide health care and medicine for the poor. The informal sale of pharmaceuticals fills the gap left by the public health services.

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5.2 The *pharmacie par terre* in Saga

In Saga the *pharmacie par terre* is the main source of pharmaceuticals. There is no pharmacy in Saga, apart from the pharmacy at the public dispensary. As in the rest of Niamey, there are different variants of the informal sale of pharmaceuticals. There are two general stores located on the side of the main road, which sell a relatively large amount of pharmaceuticals along with other goods. There is also a small shop or *boutique*, which only sells pharmaceuticals. The *boutique* is located on the side of the main road that passes through Saga just opposite the public dispensary. Ambulant medicine vendors circulate in the different *quartiers* of Saga and are most easily found taking a break in the middle of the day sitting in the shadow on the side of the main road. It is difficult to estimate how many vendors frequent Saga. According to the *chef de canton* the ambulant medicine vendors are taxed, like other vendors:

The ambulant vendors pay a tax that enters into the budget, because we don’t let them walk around like that. We make them pay and it enters into the economy of the country.

*The ambulant medicine vendors*

The Zarma designation of ambulant medicine vendors is *kini tallakoi* (or *tallayze*) which translates as *colporteur* or hawker of pills/pharmaceuticals. In general, ambulant medicine vendors are young men in their twenties or thirties. Many come to the capital from rural villages in search for money. Selling pharmaceuticals is above all a way of making a living, if only for a short period of time, as it is not a very profitable activity. Most vendors are illiterate and have little or no education. Nor do they have any formal medical training or any specialised knowledge about pharmaceuticals. As pointed out by Jaffré, selling pharmaceuticals is a ‘new’ profession/trade in the informal sector, requiring knowledge about commerce, and the provision of products, rather than knowledge about diagnosis and treatment (Jaffré, 1999: 64).

All ambulant vendors interviewed in Saga came from outside Saga. One, the owner of the *boutique*, came from the nearby village of Liboré and the others came from more distant villages. The vendor from Liboré had been to school but the others had not, although one had been to adult literacy classes in his village. They had all been selling pharmaceuticals for about two to three years. Selling pharmaceuticals was their main economic activity. One also worked in the fields in his village, but sold pharmaceuticals after the rainy season (harvest).
All vendors learned the trade by following someone, an older brother, a friend etc. already in the profession, for a couple of days. The main reason given for entering the profession was making a living. This was the reason given for coming to Saga.

It should be noted that it was difficult to interview medicine vendors. They were generally reluctant to be interviewed. Those who accepted being interviewed only summarily answered the questions and cut the interview short. Being well aware of the controversies surrounding their trade they seemed to be suspicious of our intentions. The best contact was established with Ousmane, the owner of the boutique. However, initially quite open and curious, the attention that we attracted made him nervous and he finally told us that it was best if we did not come to his boutique as he feared that it would be bad for his business.

The following is a brief description of Ousmane and his enterprise. He came from Liboré, a village located about 5 km down the road to Kollo. He was in his early twenties and had been to school. Before becoming a medicine vendor he had worked in his uncle’s télécentre. But after a fight with his uncle he left the télécentre and started selling pharmaceuticals. At first he went from village to village on his bike peddling pharmaceuticals. When he had earned enough money, he opened up the shop in Saga. The shop was located on the main road, right opposite the public dispensary. It was small and constructed with metal sheets. Inside the shop the shelves were lined with boxes of pharmaceuticals and glass jars full of pills. Customers as well as ambulant vendors stopped by the shop now and then. Ousmane bought medicine from the grand marché in Niamey. He provided local ambulant vendors with medicine. He still travelled to surrounding villages to sell pharmaceuticals. On market days he sold medicine to the villagers himself, but on non-market days he provided various shop owners with the medicine. He said that he earned more in the villages than in Niamey, as villagers did not know the standard price of pharmaceuticals. To earn extra money he took odd jobs now and then, for instance agricultural work. His younger brother tended the store when he was away working in the rice fields, selling pharmaceuticals in surrounding villages or buying medicine at the grand marché. Ousmane said that he earns about 10,000 CFA a day.

The medicine sold

The medicine sold by ambulant vendors is referred to as Nigeria kini, which means pills from Nigeria. The most common kinds of medicine sold on the informal market are analgesics,
antipyretics, anti-inflammatory drugs, antibiotics, anti-malarial drugs, corticoids and vitamins
(from own interviews, c/f also van der Geest, 1987; Jaffré, 1999; Chilliot, 2003).  

The following is a short review of some of the medicines, including product names, popular
designation and use, sold by ambulant vendors in Saga. The analgesics aspirin, paracetamol
and efferalgan were often referred to with these names (eg. aspirin), they were said to be
effective against fatigue, headaches and fevers. Antibiotics, such as tetracycline, which was
also called ‘two colours’ after its red and yellow colour, were referred to as tupay. Ampiciline
and amoxicilone were two other popular antibiotics. The use of antibiotics was very diverse.
According to Chilliot they are used for abdominal pains, diarrhoea, fatigue, headaches,
muscular pains, sexually transmitted diseases etc. (Chilliot, 2003; 456). 

Lahiya vitesse, the
local designation of an analgesic with the product name Sudrex, was very popular. Lahiya
vitesse, roughly translates as health fast (lahiya health in Hausa, vitesse French for fast). It
was said to be effective against headaches, fatigue and other general signs of ill health. Other
popular remedies were the anti-inflammatories Buta 100 (Phenylbutazone) and
Indomethacine, often called indo da buta and said to be effective against fatigue. Indocap,
also an anti-inflammatory, was used against rheumatic symptoms or other pains and aches
caused by hard physical labour. Corticoids or steroids such as Dexone (Dexamethasone) were
used by women to gain weight. One local designation of such cortcoides was lafusi, which
means ‘grossir’ (to gain weight) in French. Vitamins (vitamins) were also popular, some of
the product names were Everiday multivitamin, Rich or Super Appetit and Cod Liver Oil.
Vitamins were said to increase appetite and strength and to aid in gaining weight. Birth
control pills were also sold by ambulant vendors and were often referred to as ‘medicine for
birth spacing’ (‘medicaments permettant d’espacer les naissances’). Flagile (metronidazole,
antibacterial) used for various stomach and digestive problems, nivaquine (chloroquine, anti-
malarial) used against malaria and fevers and nifluril (anti-inflammatory) were other
frequently mentioned medicines.

Ambulant medicine vendors were also known to sell amphetamine, pills with very powerful
effects. That medicine enables one to work hard a whole day without tiring, and is also
consumed for its drug like effects. As one young man asserted:

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8 Analgesics are pain relievers, antipyretics are fever reducers and corticodes are cortex steroids produced within
the adrenal cortex often used as anti-inflammatories. Dexamethasone is used against arthritis, allergies and
asthma etc.
Everybody in Saga and Niamey buys it, especially the youth, as the ambulant vendors sell pills that intoxicate…it’s economical, it’s enough if you take pills for 50 CFA but if you buy beer you need 1,500 CFA. The pills make you crazy…but others take them when they work because when you take the pills you don’t get tired, in Saga there are a lot of people who do work that requires a lot of strength.

There were many different local designations for such pills, for instance, baliyo (le muscle or the strong) and Ben Laden or simply le médicament. No ambulant vendor admitted to selling such pills. When asked about them they simply responded that it was illegal and that if you were to be caught selling them you would be sent to jail.

As is evident from the above, although brief, review of some of the medicine sold by ambulant vendors the local designations of the products as well as knowledge about their use were widely shared. The growth of the informal market in pharmaceuticals has seen the development of common or popular knowledge. As Jaffré notes, in the case of Bamako, a sort of ‘pharmo-linguistique’, ‘...composed of pains, words and pills, linguistic games of nomination…’, has been created surrounding the medicine sold on the informal market (Jaffré, 1999: 67).

The relations between ambulant vendors and their customers

The vendors are easily available at all times of the day. As the pharmacist in charge of the pharmacie populaire in Talladjé lamented, ambulant vendors are in constant contact with the population, they are door-to-door salesmen, people prefer to buy from them on their doorstep than to make the trip to the nearest pharmacy. Moreover, it is usually the same vendors who frequent a particular area like Saga, which enables more or less regular vendor-customer relations to develop. One ambulant vendor said that he sells medicine on credit to customers he knows and trusts. A woman in Pays Bas said that she always buys medicine from an ambulant vendor that she knows and trusts and who helps her read the notice. The transaction between vendor and customer is a simple market transaction, a monetary exchange, in seeming contrast to the doctor-patient relation. However it is important to note that proximity and familiarity often characterise market relations. As Jaffré notes, in the market there is little that separates seller from buyer. The medicine vendor and the customer speak the same language, share understandings of various symptoms and illnesses as well as the local designations of medicines and their use. Moreover, the familiarity and proximity of the
market stands in contrast to the often unfamiliar and hostile procedures of the public health services (Jaffré, 1999). The easy access to ambulant vendors was also often compared to the costly and time-consuming procedures at the local public dispensary and the public health services in general. As one man described the ambulant vendor: ‘He is a doctor, pharmacist and laboratory assistant all in one’ (‘Il est médecin, pharmacien et laborantin à la fois’).

Regarding the actual transaction, if the customer knew what they wanted they simply asked for it, otherwise they described their symptoms and asked the vendor for a medicine that might help them. It was common that children were sent to buy medicine. People also came, with or without a prescription, after having been to the local dispensary, in which case they knew what they suffered from and what medicine they needed, but could not or were not willing to pay for the entire prescription at the dispensary’s pharmacy. The cost of the medicine sold by ambulant vendors varied between 15 CFA and 150 CFA apiece. The medicine was not necessarily cheaper than generics bought at the dispensary, where a bag of 20 pills might cost 400 CFA. But at the dispensary and the pharmacy one had to buy an entire package or a bag of pills, as pills are not sold a piece. Thus many people preferred to buy a couple of pills from an ambulant vendor. The following observation of a vendor client transaction illustrates the parallel use of the public dispensary and medicine vendors, in this case the boutique across the road of the public dispensary:

A first client comes. She wants to buy products against dermatitis. She asks if he has an ointment. He responds that he doesn’t. He asks her if she wants to buy pills. She asks him if he has amoxicilin 250 mg. He says yes. She leaves to go and see the major so that he can give her a prescription. Soon she returns. She hasn’t been able to see the major. She explains her troubles for the vendor. She has a backache and feels tired. She buys amoxicilin, four of 250 mg. The vendor asks her to go and see the major. He did not explain how to use the products (field notes, 22/3/04).

According to the boutiquier Ousmane, people often come to him with prescriptions from the CSI. If patients cannot afford to buy medicine in the dispensary’s pharmacy the major, the chief nurse, even tells people to go and buy their medicine from him. However, the major refuted this.

‘The poor man’s pharmacy’
The pharmacie par terre is seen as ‘the poor man’s pharmacy’. Ambulant vendors sell medicine to the poor, to those who cannot afford to go to the dispensary or to buy medicine in
licensed pharmacies. One old woman explained the reason why people buy medicine from ambulant vendors by saying, ‘It is the lack of means people pay to get some relief’. Not having enough money to pay for care leads people to take recourse to ambulant vendors. As one man remarked:

Today, if I fall ill or if someone in my family falls ill, as I don’t have the means to pay for care, we are obliged to take recourse to ambulant vendors.

Mistrust of ambulant vendors and of the medicine they sell, Nigeria kini, was often expressed. In general Nigeria kini was not seen as being as effective or of as good quality as the medicine sold in pharmacies. Many pointed to the fact that the products sold by ambulant vendors are kept in the sun and are exposed to heat and dust. In the pharmacy on the other hand they are kept in a cold or cool and clean place. One woman, comparing pharmaceuticals sold in pharmacies and pharmaceuticals sold by ambulant vendors, pointed out that the writing on the plaquettes sold by ambulant vendors is often unreadable, the pills have changed colour, and their use causes stomach aches. Others emphasised that the medicine sold by ambulant vendors might be toxic and dangerous for one’s health. It was said that even if Nigeria kini can provide relief and even a cure they might equally cause health problems. One man expressed this distrust of Nigeria kini in pointing out that much of the medicine sold by ambulant vendors is clandestinely produced in Nigeria.

Mistrust of the ambulant vendors was frequently expressed. Ambulant vendors were said to be illiterate and either ignorant or deceitful. One young mother stated that:

They sell anything that you ask them for, they sell medicines that you haven’t asked for…some ambulant vendors have no knowledge about medicines and still they sell them, that’s why I don’t buy medicines from them.

Similarly, a marabout asserted that ambulant vendors sell medicine that has expired as it is only making money which interests them, ‘…it’s business that they do’. The health workers interviewed were united in their condemnation of ambulant medicine vendors. They accused them of selling ‘n’importe quoi’ (anything). Products that were not well conserved, exposed to the sun and that had often expired and which was toxic, moreover they sold medicine without any regard to the indications of use (e.g. selling corticoids for gaining weight). They
emphasised that ambulant vendors do a lot of damage and are a danger to society. They should be controlled, they said, and the population should be sensitised as to the dangers of using medicine bought from them. Sensitisation or public health information campaigns have probably played a part in the growing perception of medicine sold in the street as being dangerous or bad for one’s health. As one man stated:

There are people who buy products sold in the street which we have been told are toxic and harmful. Since the sensitisation my family and I buy products at the pharmacy. Besides, chloroquine isn’t even expensive in the pharmacy. The medicine vendors in the streets are neither nurses nor pharmacists.

The most striking expressions of mistrust vis-à-vis ‘pharmacies par terre’ were the stories people told about the dangers of using medicine from ambulant vendors, for instance, stories about people having been sold the wrong medicine. One young man told us the following:

A friend had a stomach ache, he told me that he was going to buy pills, he went to buy them and he was given espacement de naissances [birth control pills]…he took them and later he showed me the plaquette…he went to find the vendor but be couldn’t find him. The vendors have no knowledge about the pills they sell.

There were stories of side effects caused by medicine bought from ambulant vendors. One woman said that she had seen a child who had been paralysed after his mother had given him lahiya vitesse. There were stories about the strong drug-like effects of the medicine. One woman recounted how an old woman she knows had taken pills bought from an ambulant vendor and had proceeded to do strenuous work all day without tiring or stopping for a break. Someone told us of an old man who was feeling tired and had gone to see an ambulant vendor who sold him Ben Laden, after which the old man had walked all the way home to Pays Bas from the grand marché.

The above discussion has pointed to the widespread use of the ‘pharmacie par terre’. Buying medicine on the informal market is an important part of everyday practices of therapy seeking. Nonetheless, mistrust of the ‘pharmacie par terre’ is common. The stories described above reveal both experiences of the harmful effects of the medicine sold by ambulant vendors as well as concerns or anxieties about using it which for many is too often seen as a necessity. The reasons behind the widespread use of the ‘pharmacie par terre’ will be explored in more detail in chapter eight. But first the two formal providers of modern medicine in Saga, the public dispensary and the confessional dispensary, will be discussed. This will allow for a
clearer picture of the interaction between the different institutions to develop, as people move between them in the search for relief

6. THE PUBLIC DISPENSARY

In the previous chapter the informal sale of pharmaceuticals was described, in this chapter the public dispensary, the representative of the public health care services in Saga, will be discussed. The chapter will present the everyday functioning of the dispensary, including its main activities and organisation. Special attention will be paid to the relation between the staff and the patients.

6.1 The CSI in Saga

The public dispensary or the CSI (centre de santé intégré) was constructed in 1996. It is located in the centre of Saga, just off the main road. Mud coloured walls enclose the area of the dispensary and ward it off from the bustling road outside. The main building of the dispensary houses the consultation rooms and the pharmacy. On the left side of the main building there is a small building in which the activities of the CSMI (centre de santé maternelle et infantile) are carried out. The recently built maternity centre is located on the right side of the main building. Although constructed two or three years ago due to a lack of equipment it is still not functioning. Behind the main building the état civil (the registry office) runs an office in which births are registered and birth certificates are issued. The buildings are all in good condition, there is water and electricity, but little in the way of medical or technical equipment. The CSI has no vehicle at its disposal.

As in most dispensaries in Niger there is no doctor at the dispensary. The staff is made up of nurses, midwives and volunteers. The head of the dispensary, the major is an infirmier diplômé d’état (‘state qualified nurse’).9 The major is the central figure in the dispensary. He has been the infirmier chef of the dispensary in Saga for six years and after 36 years in the health profession he is on the brink of retirement. Apart from the major there are four nurses;

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9 In the past the infirmier chef was often from the military, especially during the colonial period, hence major (Souley, 2000: 17).
three infirmier diplômé d’état and one infirmier certifié (‘certified nurse’).¹⁰ There are also three sages-femmes (midwives) all diplômé d’état and a gestionnaire (administrator of the pharmacy). The rest of the staff is made up of one agent d’hygiene (‘hygienic assistant’), several filles de salle, untrained volunteers who assist in various tasks at the CSI, one guardian (caretaker) and two handymen. To the outsider the dispensary staff is distinguished by the colour of their coats, the nurses wear white coats, the midwives pink coats and the filles de salle yellow coats.

The dispensary is a centre de santé intégré (CSI). These centres make up the most basic level of the public health services in Niger. There are 48 such centres in Niamey. The work of the dispensary centres on curative care, on the consultation of children and adults, and on the treatment of infections and common illnesses. According to a quarterly report (January to April 2003) the most common illnesses treated at the CSI were malaria, common colds, diarrhoea and conjunctivitis. Maternal and childcare, such as pre-natal consultation, health controls of infants and vaccination are also offered. The matronnes (‘community birth attendants’) also work in collaboration with the CSI. The CSI takes part in national vaccination campaigns, by for instance organising and executing the vaccination campaign in its local area (e.g. provide volunteers for vaccination foraine, mobile vaccination teams). It participates in public health campaigns, for instance through the organisation of sensitisation sessions.

The dispensary has recently seen the introduction of a cost recovery system. The Ministry of Health adopted cost recovery, following the guidelines of the Bamako Initiative, as the national model in 1995.¹¹ In the face of serious economic crisis it was seen as an opportunity to improve the health care services and to recover the cost of drugs and administration (Meuwissen, 2002:305). User fees were introduced. The system introduced in the CSI in Saga is referred to as le système de la tarification éclatée. The same system is used in all of commune II. In practice, this system means that the patient pays twice (or in two instalments): first for the consultation and secondly for the medicine prescribed. Each patient is required to buy a carnet de soins (a health care notebook), in which personal information as well as

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¹⁰ The first qualification (infirmier diplômé d’état) is valued more highly than the second (infirmier certifié) and usually means more responsibility and authority (Souley, 2000; 20).

¹¹ The Bamako Initiative was signed by Niger in 1987. The goal of the Initiative was to increase the coverage and the quality of health services through the encouragement of community financing and participation in health service organisation. It advocated the adoption of an essential generic drugs policy (Meuwissen, 2002:305).
details of the consultation and prescription are recorded. The carnet costs 200 CFA. In addition to the carnet the patient has to pay the consultation fee. The consultation fees are 300 CFA for adults, 200 CFA for 0 to 5 year olds and 100 CFA for newborns. Pre-natal consultations are free. The fees are paid in the pharmacy. According to the cost recovery system the prescribed medicine should also be purchased in the dispensary pharmacy, which only stocks generics in accordance to the essential drugs policy, also a part of the Bamako Initiative.

It should be noted that the CSI in Saga is performing poorly. The patient numbers are extremely low in comparison to other dispensaries. The cost recovery system is not functioning. In order to explain the low patient numbers all of the staff referred to the presence of the confessional dispensary next door.

A note on the period during which the observations were carried out

The beginning of the year saw the outbreak of a measles epidemic, which by May had reportedly caused 30,000 cases of contagion and the death of 500 children. In response the Nigerien Ministry of Health together with MFS (Médecins Sans Frontières) and WHO (the World Health Organisation) started a vaccination campaign in the regions most affected by the epidemic, amongst them Niamey and surrounding villages (AFP 12/05/2004). The staff at the CSI noted a significant rise in cases of measles, all of which were reported to the district. Frequent vaccination sessions offering free vaccination against measles ordered by the district were held at the dispensary and mothers came in large numbers to vaccinate their children.

6.2 Finding a way into the CSI

The following section will present the daily functioning of the CSI through a description of a day at the dispensary. The patients sometimes confused course through the system and the pharmacy, which is at the centre of the CSI and at the heart of the cost recovery system, will also be described.

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A day at the CSI

When the staff arrived between 8.30 and 9.00 a.m. there were already some patients, mostly mothers with children, waiting in the corridor of the main building, which acted as a waiting room, the guardian having already unlocked the doors of the dispensary. As there was a vaccination session planned for that day mothers, carrying their infants on their backs, were waiting outside the CSMI where the vaccination session was to be held. It was the arrival of the major in his car at 9.00 a.m. which got the activities of the day started. The staff, some of whom had been sitting and chatting on a bench outside the main building, set about their work. Before settling down in his room the major made the rounds and checked that everything was in order. The major had his own office/consultation room where he received his patients. The subordinate nurses shared a consultation room on the other side of the main corridor. When the consultations finally started about ten patients were seated on the benches in the corridor. Most patients were seated outside the major’s office. From the start of the consultations the stream of patients to the major was more or less constant. The major’s room was the busiest room in the CSI. Patients as well as staff passed in and out of the major’s room, the door being constantly opened and closed. The other nurses, on the other hand, only received about three or four patients at most. Thus, while the nurses, having no more patients to consult, sat and talked in their consultation room, the major continued to receive patients. Around 1 p.m. a handful of patients remained and the staff started to head home for their midday meal. The major, together with his assistant, a stagiaire (intern) stayed in the dispensary. Only a couple of filles de salle, the gestionnaire of the pharmacy and the guardian returned in the afternoon. The major remained until 4.30 p.m. and received the few patients who arrived in the afternoon. After 5 p.m. the dispensary was, once again, empty.

The patients’ course through the CSI

The patient’s course through the CSI is meant to start at the pharmacy. The carnets de soins are sold at the pharmacy and the consultation fees are supposed to be paid there. However there are no indications, in writing or in pictures, of how to proceed through the CSI nor are there any lists of carnet and consultation prices. During our visits to the dispensary we observed a notable difference in the behaviour or demeanour of the patients. Some patients went directly to the pharmacy window to pay for the consultation before sitting down in the waiting area. Others went to the waiting area directly. Many had brought a schoolbook (a cahier) cut in half, which they were clutching in their hands. However, once admitted to the consultation room, patients without a carnet de soins were sent back to the pharmacy to
purchase one and to pay for the consultation. Admittance to the consultation rooms followed the order of arrival, the patients themselves keeping track of their turn. Following consultation the patients were sent back to the pharmacy with a prescription to purchase the medicine prescribed by the nurse. Once having purchased the medicine the patients returned to the nurse for instructions of how to use it or for the administration of injections with the needle, syringe and medicine bought by the patient. Patients already following a course of treatment and who came for the administration of an injection brought the syringe, needle and medicine with them to the consultation.

Every consultation ended with a prescription being written. Yet the patients could not always afford to buy the prescribed products, in which case they paid for a part of the prescription, after deliberating with the nurse and the *gestionnaire* about what medicine was most efficient. Many patients left the CSI with a diagnosis and a prescription but without medicine. They either returned when they had the money needed or tried to procure the medicine elsewhere, for instance from ambulant medicine vendors.

*The pharmacy*

The pharmacy is, in a way, at the heart of the cost recovery system as it manages the consultation fees and the sale of medicine. The pharmacy is run by the *gestionnaire*, the pharmacy manager. Only generics are sold there. According to the *gestionnaire* the products sold the most are chloroquine, paracetamol, aspirin, coitrime, amoxciline, flagyl, mebendazole, ampicilline and quinimax. The pills are all sold by the package or in plastic bags of 20 pills. The *gestionnaire* also puts cotton, alcohol, disinfectant, compresses, bandages and thermometers at the disposal of the staff. The products sold in the pharmacy are mainly procured from the ONPPC (*Office National des Produits Pharmaceutiques et Chimiques*) and from Pharmatec. The *gestionnaire* and the *major* make the orders, the *gestionnaire* notes what products are needed and the *major* orders new deliveries. The *major* complained that nowadays there is nothing at the CSI in the way of medicines (‘…*le CSI ne dispose de rien’*) whereas before they had ‘everything’. According to the *major* after 36 years of experience he can with confidence say that there is a significant difference in the efficacy of generics and specialities. He argued that the essential drugs policy is merely a way for the West to cut down on costs, at the expense of quality and efficient treatments. Consequently, if the patient can afford to pay he prescribes specialities that have to be bought in private pharmacies.
6.3 The consultations

The previous section described the activities of the CSI and the patients’ entry into and course through the CSI. This section will focus on the interaction between the nurses and the patients during the consultations. Two consultation sessions that we observed, one with the subordinate nurses and the other with the major will be described. The consultations were conducted in Zarma.

A consultation session with the nurses

The nurses’ consultation room was sparsely equipped. In the middle of the room there was a table and three chairs and a bunk stood in a corner next to the sink. Above the table a fan cooled the warm air. The three nurses were seated behind the table. The table was empty except for a couple of pens and a large registry book in which details of each consultation were to be recorded. The nurses sat and chatted. The first patient quietly entered the consultation room at 9.30 a.m., stopping right next to the door. A short word exchange followed and the woman sat down on the chair that was placed close to the door, with her child on her lap. Her child had only just been released from the hospital although the treatment was not yet finished and she had come for the daily administration of an injection. She carried a plastic bag with the products in it, which she handed over to one of the nurses. The nurse, exasperated, exclaimed that the phial (dose) she had brought was for an adult as was the syringe, the needle being too big. The nurse said that they had had the same problem the day before. She had already told the woman that she had bought the wrong dose and syringe. Nonetheless, the nurse administered the injection but used only half of the phial, using no cotton or alcohol, after which the woman quickly exited the room.

No new patient was called to enter but the door to the consultation room was left open. After a while a mother with a daughter of about ten entered the room. She too stopped next to the door. A brief word exchange followed, after which the woman was sent to the pharmacy. She had brought a notebook instead of a carnet. One of the nurses commented that some patients fait exprès or pretend that they don’t know that they have to buy a carnet. The woman returned with a carnet. Like the previous patient she had also come to have an injection administered. She handed the products to one of the nurses. She had to restrain her daughter, who was already screaming, for the nurse to be able to administer the injection. Mother and daughter then quickly exited the room, the daughter still crying.
Soon, a third patient entered the room, a mother with a three-year old son. Once having entered the room she handed the *carnet de soins* to one of the nurses. She then sat down on the chair with her boy on her lap. She feared that he had the measles. One of the nurses looked more closely at the child and concluded that he showed no signs of the measles and that he probably just had a cold. The nurse recorded the case in the registry book. She then wrote a prescription for amoxicilina, paracetamol, chloroquine and cough syrup. The woman took the prescription and went to the pharmacy only to return after a couple of minutes. The products prescribed added up to 3,000 CFA and she only had 1,000 CFA with her. The nurses advised her to buy at least one of the products and one of them accompanied her to the pharmacy to explain the situation to the pharmacist. After a while she returned with the medicine she had been able to buy and one of the nurses explained to her how to use it. Another nurse examined the *carnet* and suddenly brightened, she had assisted at the birth of the child in 2001. A conversation ensued. The nurse had noticed that the woman had not followed the vaccination calendar. The nurse thus sent her to see someone about the possibility of getting the vaccinations that were missing. Three more patients were seen that day. At 11 a.m. there were no more patients waiting to be seen. (field notes, 17/3/04)

*A consultation session with the major*

The major’s office was cluttered. On the desk there were piles of paper and the registry book lay in the middle of the table, posters (public health messages, pharmaceutical ads etc.) and family photos filled the walls. Apart from the desk and three chairs there was a bunk, a sink and a fridge. The room was the only room in the CSI with an air conditioner.

When the major arrived at 9.00 a.m. four patients were seated on the bench outside his office. After having settled in the major called on the first patient, a woman with an ill child, to enter. She sat down on a chair next to the major’s desk. He greeted the woman and asked what was wrong with her child. The woman said that the child had vomited, had diarrhoea and a fever. She had brought a notebook cut in half so the major told her to go and buy a carnet and to go and see one of the *filles de salles* so that the child’s temperature could be taken. The woman left.

Shortly thereafter, there was a knock on the door and a man entered. The major asked us to leave. A woman with a child soon joined the two in the major’s room. The women waiting on the bench joked that apparently one has to bring one’s husband to receive treatment. Meanwhile, in the waiting area a *fille de salle* passed around a thermometer for the mothers to take their children’s temperature, the temperature was recorded on a piece of paper which was
to be handed to the major at the beginning of the consultation. After about twenty minutes the couple exited the room together with the major, the major brought them to another room and asked one of the nurses to prepare a drip (IV).

The major then returned to his office and invited us to enter. A second patient followed us into the room. Shortly thereafter, the first patient returned with a carnet, the major wrote a prescription and sent her to the pharmacy to buy the products. He then recorded the case in the registry book. The second patient was a friend of the major and a conversation ensued between the two. The patient then gave the major the piece of paper with the child’s temperature on it. The child had been ill for some time and she had come to continue with the treatment. She had brought the products with her and she handed them over to the major. The major administered the injection using alcohol and cotton. The child started crying. The major joked with the child.

As the second patient left the room a third patient, a young woman, entered. She had been for a consultation the day before and had been tested for the measles. The test had come out positive. The major wrote a prescription and talked to her for a while. When she asked him to prescribe something to give her back her appetite he teased her.

A fourth patient entered. She had brought products with her, which she handed to the major. The major looked at them and said that one product was missing. Nonetheless he explained how to use the products that she had brought with her. He then told her to go and buy the remaining product from a vendor outside the CSI (the pharmaceutical depot). He gave her directions and explained that the vendor did not sell Nigeria kini. The woman left to go and find the vendor.

A fifth patient entered the room. She also had products with her. The major asked to see the prescription as it was issued at another dispensary. He then administered an injection (using alcohol and cotton) and talked some more with the patient. The two next patients both had the measles. The consultations proceeded in a similar manner as the consultations described above. The major asking a lot of questions and constantly jokes with the patients. During the consultations patients who had been sent to buy a carnet returned and the major wrote prescriptions for them and sent them to the pharmacy to buy the products after which they came back for an explanation of how to use the medicine.

After a while the woman who had been sent away (to the pharmaceutical depot) returned. She had not found the vendor. The major called for the gestionnaire and told him to go and buy the missing product from another pharmacy. The gestionnaire left. After the eighth patient was sent off to take the child’s temperature, the major asked us to leave as he had a lot of
patients to see and had to work faster. Thus at 11 a.m. we left his room. (field notes, 23/3/2004)

**Impressions from the consultations**

The consultations were brief with little conversation. Examination and physical contact was minimal. The patients described their symptoms on the basis of which the nurses gave a diagnosis and wrote a prescription. The new cases were registered in the registry book. At least half of the patients consulted were already following a treatment. The contrast between the consultations of the *major* and of the subordinate nurses was striking. The three nurses that shared a consultation room treated about five patients whereas the *major* treated three times as many. The patients clearly preferred to go to the *major*. Even when the nurses had no patients, there were people waiting outside the *major’s* room. In contrast to the nurses who seemed reserved and stand-offish the *major* boisterously greeted his patients and asked them many questions both related to their illness and to other matters. These observed differences were reflected in the way the subordinate nurses and the *major* talked about their job. The nurses expressed a marked frustration and resignation whereas the *major* asserted his experience and importance to the CSI. The nurses commented that their work was not very interesting as they mostly treated cases of malaria, diarrhoea, colds and intestinal worms and administered injections. Certain days, they said, they might not receive any patients, at other times the number of patients fluctuated between 5 and 10 a day. The *major* on the other hand exuded confidence and authority when talking about his work. On the verge of retirement, he emphasised his long and extensive experience and his excellent relations with the patients. He said that one had to be good with the patients and that the welcome was especially important, as well as listening to them and getting them to talk. This, he said, was why people preferred to come to see him rather than the other nurses. He did not seem to be very concerned about the division of work. The *major* in a position of power at the top of the staff hierarchy could direct all of the resources and patients to him. His age and gender as well as his long experience probably weighed in his favour in his relation to the subordinate nurses and to the patients.

**6.4 The CSMI**

This section will describe the CSMI (*centre de santé maternelle et infantile*), which deals with maternity and childcare. It will focus especially on vaccinations and on the relation between the midwives and the mothers.
Activities

Most of the activities of the CSMI are carried out in a building separate from the rest of the CSI. The building houses a room and an adjoining veranda, which serves as a waiting room. The room is equipped with a desk, a couple of chairs, a refrigerator for the vaccines and a scale for the weighing of infants. The work at the CSMI is carried by the three midwives. The focus lies on prevention, especially on pre-natal consultations, check-up consultations of healthy infants, vaccination, and health information. The health information touches on routine vaccination, nutrition, the importance of consultations for infants and on family planning.

Vaccinations

Polio, BCG, DTC, measles, meningitis, yellow fever and tetanus vaccinations are administered by the CSMI. In the *carnet de santé de l’enfant* (the child’s health notebook) there is a vaccination calendar which indicates at what intervals the child should receive each vaccine. In the back of the *carnet* there is also a list from which each vaccination received is ticked off. The midwives emphasised the importance of following the vaccination calendar. However, they complained that the mothers do not follow the calendar and that attendance to consultations and vaccination sessions was low and irregular. They attributed this to the ignorance of the mothers who, they said, did not realise the importance of the consultations and vaccination.

A vaccination session

The CSMI regularly organises vaccination sessions for infants and pregnant women. During the period of the field study several vaccination sessions against measles were organised. The midwives said that they try to get as many mothers as possible to come with their children on the same day. As one phial (dose) contained enough vaccine for 10 children it would be a waste to use the whole dose to vaccinate only one or two children. The following briefly describes a vaccination session.

The session started when the staff arrived at around 9 a.m. in the morning. Two midwives were working, one kept track of the *carnets*, the weighing and the registry book and the other administered the vaccinations. At the collection of the *carnets* between 20 and 30 women with

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13 BCG is a vaccine to prevent tuberculosis. DTC is a vaccine against diphtheria, tetanus and whooping cough.
children were present. One nurse was seated behind the desk and the other on a chair in reach of a table on which the box of needles was placed, and of the refrigerator in which the vaccines were stored. After the *carnet* had been checked and filled in and the weight of the child had been recorded the vaccination was administered. The other nurse, seated on a chair, quickly administered the injections to the children held by their mothers, using no cotton or alcohol. The room was constantly busy and crowded. In a hurry the mothers ignored the urges of the nurses to wait for their turn outside. At times the nurses admonished or reprimanded a mother for having failed to follow the vaccination calendar. Others were reprimanded for having dressed their child too lightly, as it was a cool and windy morning. Sometimes the nurse administering the vaccinations advised the mother to give the child aspirin (½ or ¼ depending on the weigh of the child) to calm possible side effects such as fevers. At noon there were no patients left. (field notes, 5/3/04)

Whereas the midwives held that the mothers did not think that vaccination was important, many of the mothers interviewed said that they had not vaccinated their children as the nurses always asked them for money. There seemed to be general confusion about whether vaccines were free or not. According to the two midwives vaccinations are free during the child’s first year. However, in the interviews women said that they had been asked to pay for the vaccinations, ranging from 25 CFA for the syringe and needle to 1,000 CFA or more. Hence, they said that there was no point of going if you had no money.

This chapter has described the public dispensary in Saga, focusing especially on the meeting between the staff and the patients. The following chapter will present the confessional dispensary, which was said to take patients away from the CSI.

7. THE CONFESSIONAL DISPENSARY

This chapter will present the confessional dispensary in Saga. The confessional dispensary is very popular and well known in Saga and surrounding areas. In contrast to the public dispensary it attracts hundreds of patients every day. This chapter will describe the activities of the nuns, the relations between the dispensary and the public health care services, and the daily functioning of the dispensary.
7.1 Mother Theresa’s Missionaries of Charity in Saga

The confessional dispensary is located on a street which leads to the quartier Saga Fondobon, just off the main road, right next door to the CSI. In fact only a wall separates the two from one another. Like the CSI the confessional dispensary is enclosed by red mud coloured walls. The gate to the compound is always kept closed and is guarded by the nuns’ caretaker. On the premises apart from the dispensary there is a home with about ten beds for malnourished children and a large free-standing roof-covered veranda in which the distribution of meals is carried out. A small parish church and the nuns’ living quarters are partitioned off from the dispensary by a fence lined by trees, bushes and flowerbeds tended by the nuns. The courtyard between the dispensary and the nuns living quarters is covered with pebbles and trees provide plenty of shade. A bit further away a larger building, which will serve as a hospice, is being constructed. The nuns first came to Saga in the early 1990s on the initiative of the Archbishop of Niamey. In search for an area to set up a dispensary the archbishop was directed to Saga. In Saga land on which to build the dispensary was available, at that time moreover, there was no public dispensary. This together with Saga’s peripheral location, rural character and relatively poor population motivated the choice.

Activities

The nuns described their mission as one of helping the poorest of the poor, the destitute. As in Niger the destitute cannot access medical care, offering free care is the main focus of their work. The dispensary is open three days a week. Apart from the dispensary the nuns run a small home where they treat malnourished children. The children kept in the home are seriously or gravely malnourished, others are given daily meals and those who come from far away are given a ration of milk and other foodstuffs every Tuesday. Another larger home is being constructed. It will function as a hospice for sick and dying adults who are destitute and whose families can no longer care for them. The nuns organise alphabetisation classes for children, sewing classes for girls, visit the prison once a week to give medicine to prisoners and give out daily meals to les cas sociaux (the indigent). The nuns also run a catholic parish, which is part of the Catholic Church in Niamey. The nuns’ activities are entirely dependent on donations. The charitable work of the nuns is well known in Saga and beyond. When talking about them people mention the dispensary as well as the help they give to the poor. ‘The nuns help us a lot’ was a frequent comment. There are usually six nuns, of varying nationalities, staying in Saga at one time. The nuns all have medical training. The nuns also take on people
to help them. But they were careful to point out that they do not employ people, they take on people in need to help them get back on their feet. French volunteers also help them. When we were there two French nurses took turns to give them a hand in the dispensary.

The relations between the confessional dispensary and the public health services

The nuns’ dispensary is independent from the public health services. However the dispensary is recognised, it is listed as CSI Saga Confessionnel in the review of sanitary infrastructure in commune II, and like the public dispensaries the nuns send weekly reports to the health district. Council representatives come by on a regular basis. The relationship between the Nigerien authorities and the nuns has nonetheless been antagonistic in the past. The main reason being that the provision of free care is not in line with government health policy, which follows the guidelines of the Bamako Initiative. To avoid conflict with the authorities patient fees were initially introduced. The introduction of patient fees was organised by a local association, ACOVIS (l’Association pour l’amélioration des conditions de vie à Saga) which from the beginning was involved with the installation of the nuns in Saga. The fee was set at 300 CFA per family and yellow cards which ensured free access were issued to those in need. The association, operating independently of the nuns, was in charge of collecting the fees and of managing the money. About two years ago the nuns nevertheless put a stop to the collection of patient fees. As one of the nuns explained, patient fees are not compatible with their vow to help the poorest of the poor. The nuns hoped that they would be allowed to continue to practice in this manner.

The malfunctioning of the public dispensary in Saga and its low patient numbers since its establishment, has in particular put the spotlight on the nuns. They are blamed, by the staff of the CSI and initially also by the officials of the district, for taking patients from the CSI. The nuns defended their practice by pointing out that they do not do the same work as the public dispensary. They said that they treat only those who are not able to pay for treatment. They emphasised that their focus lies on treating women and children, especially malnourished children, whereas the CSI offers more general services, such as consultations for adults, vaccination and pre-natal care. They send patients to the public dispensary, for instance to receive vaccinations or to attend pre-natal consultations They pointed out that each morning there are enough people for two dispensaries waiting outside their gate and they are forced to send at least half of them away. There is thus, they said, clearly a demand for treatment that they alone cannot meet. As one nun said, if the CSI would receive and treat people properly
they would come to the CSI. Still, the nuns admitted that the situation was not ideal and that a good public health system that makes special provisions for the poor would be preferred. But as the situation is now, they said, there is a great need for their services, as poor people cannot afford to pay for treatment.

7.2 The dispensary

The dispensary is open three mornings a week, on Mondays, Wednesdays and Fridays. The nuns are well known for offering free treatment. The demand for treatment at the nuns’ dispensary is high; on the mornings when the dispensary is open, there is often at least two hundred people waiting outside the gate. As one interviewee commented ‘…you see there are a lot of people waiting outside the gate because they are not asked for money’. However only about one hundred are admitted. In choosing whom to treat the nuns said that they prioritise the most destitute and mothers and children. Those seeking treatment are not only from Saga. People come all the way from Niamey, from surrounding villages and from more distant villages such as Kollo and Dosso.

The nuns have the capacity to treat relatively simple cases. The most frequent illnesses are malaria, bilharzia, urinary infections, respiratory infections, colds, skin diseases, wounds, eye infections, diarrhoea and intestinal worms. They give their patients the medicine needed to complete the entire treatment. Difficult or serious cases are referred to the national hospital in the centre of Niamey. However this is often problematic, as the patients cannot afford to pay the hospital fees and the hospital refuses to receive patients who cannot pay. In the past the nuns have covered the costs for the hospital treatment, but they are now trying not to do so, as it is untenable in the long run. It is too expensive and they get too many requests as word of mouth spreads.

A day in the dispensary

The following will describe a day at the dispensary so as to give some insight into its daily work and into the interaction between the nuns and the patients as well as the ways in which it differs from the public dispensary.

Early in the morning there was already a crowd of people waiting in front of the gate. The men were lined up on one side of the gate and women and children on the other. Around 8.00
a.m. one of the nuns came out carrying a basket of numbers. The nun walked along the line of waiting people and distributed the numbers. There were almost twice as many people waiting as the nuns could consult. The lucky ones, who had received a number, entered through the gate. The rest slowly walked away. The majority of the people chosen were mothers with young children. The patients were directed towards the waiting room, where they sat down. Those who could not find a seat were told to wait outside. Each patient held a notebook cut in half. Notebooks were sold by one of the nuns’ aides to people who did not have one. A female assistant passed from patient to patient, filling in the notebooks and taking and recording temperatures. Another male assistant filled in a registry book. One of the nuns and a French nurse consulted the patients. There was also an assistant in the consultation room who acted as an interpreter, as the nuns did not speak Zarma. The patients entered the consultation room one by one. The door was constantly kept closed. After the consultation the patient was given the medicine needed for the treatment. No one but the patients were allowed to enter the consultation room, neither was anyone allowed into the centre de soins. The women waiting talked amongst themselves; now and then a child started to cry. The assistants admonished the mothers who left their children unsupervised.

One of the nuns took the opportunity of talking to the women in the waiting room about the importance of vaccination against the measles. As the nun spoke in French a female assistant translated into Zarma. The nun tried to get a discussion going about vaccination. She wanted to know why the women did not vaccinate their children, after all she said, it is free. She said that there was a lot of measles going around and if they vaccinated their children they would not get a bad case of the measles. They only had to pay for the carnet and even if they were forced to pay 150 CFA for the needle it would still cost them less than an eventual treatment for the measles. Her frustration was obvious as she pointed to the futility of children dying of the measles. But her questions provoked few responses. The women looked ill at ease as the nun continued to hammer home her message. Finally the nun requested that in the future they should all bring both the cahier (notebook) and a carnet from the CSI, so that she could check that they had vaccinated their children. The waiting room progressively emptied and at noon the consultations were finished. All in all a hundred patients had been consulted. (fieldnotes, 26/3/04)
Relations between the nuns and their patients

The relations between the nuns and the mothers were not unproblematic. Misunderstandings seemed to be common. One nun pointed out that they had had cases of a child starting to recover only to suddenly relapse and die. She suspected that in such cases the mother had given the child some kind of traditional medicine or medicine bought from ambulant vendors. She said that the mothers used different treatments at the same time. Instead of waiting until the end of the treatment for complete recovery, they became impatient and took recourse to other treatments. She said that they often saw signs or evidence of traditional treatments on the children, such as scarifications, convulsions caused by toxic traditional medicine and a refusal to take medicine, which she interpreted as originating from the trauma of traditional treatments. The nuns were critical of mothers who bought medicine from ambulant vendors. The nuns admitted to a lack of knowledge about other therapeutic alternatives, especially about traditional treatments. Another source of frustration for the nuns seemed to be what they saw as the irresponsibility of the mothers in not having their children vaccinated or in failing to follow the advice given by them.

The case of Ramatou and her ill child is illustrative of the relation between the nuns and their patients and the work they do. Ramatou had taken her child to the confessional dispensary, as she was ill with a fever. The nuns had taken her in for treatment but despite the medicine given the child did not get better. The nun who had treated her child said that it was malnourished. Ramatou came for treatment and food everyday. As the child’s condition did not improve, the nuns suspected that it was suffering from something else. After Ramatou had told them that the child’s father had had tuberculosis, they told her to get the child tested and to take her to the tuberculosis centre in the centre of town. However time passed and Ramatou still had not managed to get the child tested, she had told the nuns that she had no money. The nun was frustrated that nothing was being done for the child and feared that it would soon be too late. Finally, they decided to send Ramatou and two other mothers, to have their children tested for tuberculosis at the private clinic in Gamkallé, where they knew a French doctor who would do the tests for them. The test came out positive and Ramatou could thus finally be referred to the national tuberculosis centre to receive free treatment. The case of Ramatou gives a picture of the type of help the nuns offer, not only when it comes to free treatment and medicine but also in giving food and in following up the cases that come under their care. It is indicative of the frustration and misunderstandings that lines their work as they are faced with mothers who for different reasons do not follow their advice.
This chapter has presented the confessional dispensary in Saga, the last of the three therapeutic alternatives described in this paper. The following chapter will bring together the issues raised in a final discussion of the quest for relief in Saga.

8. THE QUEST FOR RELIEF IN SAGA

In this chapter the key issues raised in the paper will be brought together in order to give a more integrated view of the quest for relief in Saga. Firstly it will discuss the quest for relief and the relation between illness representations and therapy seeking. Secondly it will examine the relations between the people in Saga and the *pharmacie par terre*, public dispensary and confessional dispensary. Thirdly it will point to the importance of attending to how medical pluralism works in practice.

*The quest for relief*

The daily ‘practices’ of therapy seeking discussed in this paper can usefully be described as a quest for relief. As stated in the introduction the everyday search for therapy is more often driven by a desire for relief, that is, to ease the pain, than by the expectation that a cure or a state of perfect ‘health’ will be within reach. The quest for relief, for soothing or alleviation, is reflective of people’s daily experience of illness and therapy. When recounting an illness episode many described the end of the illness by saying that that ‘the illness calmed down’ (*la maladie s’est calmé*), the symptoms disappeared and the pain eased. Similarly the effectiveness of a treatment was often judged on whether it had managed to relieve the pain or not. A diagnosis was either out of reach or of little interest, of more importance was the disappearance of painful or disquieting symptoms. In the quest for therapy recourse was primarily taken to the therapy or treatment which could provide relief and which was within reach. *Lahiya vitesse* is illustrative of the centrality of the quest for relief in daily practices of health seeking. As described in chapter five *lahiya vitesse* which means ‘health fast’ is the local designation of a popular analgesic. As its name promised, *lahiya vitesse* was said to offer fast (and cheap) relief and was extensively bought and taken against headaches, fatigue and other general signs of ill-health. The daily quest for relief most often involves illnesses and symptoms, which in chapter four were described as ‘prosaic’. As was pointed out such ‘ordinary’ illnesses rarely put elaborate systems of representations and meaning into play. In the process of finding relief pragmatism takes precedence.
Illness representations, medicine and quest for relief

The discussion of representations of illness and medicine in Saga points to the relation between illness representations and the choice of treatment. Some illnesses were associated with a particular treatment, a standard or preferred form of therapy. Weyno for instance was almost exclusively treated with various forms of ‘traditional’ medicine, such as home remedies, anti-weyno potions and medicinal plants. This was also true for jaundice (moo sey), seen as closely related to weyno, which it was said, cannot, and should not be treated with hospital medicine. Malaria on the other hand was most frequently treated with pharmaceuticals, in particular with the anti-malarial chloroquine. In the case of serious or persistent episodes of malaria recourse was taken to a dispensary or hospital. For malaria and weyno, both common and ‘well known’ illnesses for which relatively cheap and accessible treatments were available, the illness representations were closely linked to the treatment sought. In the case of chronic illnesses such as hypertension and gastric ulcer the quest for therapy took various forms. A continuous hospital or dispensary treatment was out of reach for most people. In the search for relief recourse was taken to diverse forms of treatment such as medicinal plants and pills bought from ambulant vendors.

The complementary and parallel use of different kinds of medicine in the search for relief was also pointed to in the discussion of medicine. People frequently stated ‘there is a cure/treatment for every illness’ and in the search for ‘the right’ treatment different medicines were used. The search involved the entire spectrum of remedies and did not exclude either traditional medicine (annasaara safari) or modern medicine (booro bi safari). Recourse was taken to those therapeutic alternatives that were both available and attainable. Moreover, the recourse taken was often dependent on the circumstances, such as the economic resources available, which either limited or enabled the choice of treatment.

In most cases illness representations were not determinant to the therapeutic recourse taken as other factors such as a lack of economic means often intervened. Much has often been made of illness representations in studies of, for instance, the use of public health services, which posit faulty illness representations (‘culture’) as obstacles to the use of public health services. Yet, as was illustrated in the case of Ramatou the problem is often not one of representations but of poverty.
The success of the pharmacie par terre

The manque de moyens (‘lack of means’) was the main reason given for turning to the pharmacie par terre in the interviews. As mentioned in chapter five the pharmacie par terre was seen as the ‘the poor man’s pharmacy’. Van der Geest, working in Cameroon, points out that the drug vendors responded better to the needs of the poor than the formal institutions, such as hospitals, health centres and pharmacies. He describes four reasons for this, namely affordability, accessibility, availability and social proximity (van der Geest, 1987; 297). This was also evident in Saga. The possibility of buying pills apiece for self-medication, in accordance to the need felt and the money available was one important reason for the popularity of the pharmacie par terre. In the public health services medicine was only sold by the package. Moreover buying or procuring medicine at the dispensary necessitated other costs both direct - consultation fees - and indirect - like losing time. The easy access to ambulant vendors stood in contrast to the costly, time-consuming and sometimes hostile procedures at the public dispensary. Ambulant vendors were easily found in the streets of Saga, virtually on people’s doorsteps. Moreover they were available at most times of the day. Granted that the public dispensary in Saga was located in the centre and was thus geographically accessible, ambulant medicine vendors were more economically and socially accessible. The social distance between the vendors and their customers was generally smaller than that between patients and the staff of the dispensary. The ambulant vendors were found in the quartier, alongside other vendors, and were thus part of the same network of social relations. As Jaffré points out in his study of the pharmacie par terre in Bamako, the market is a place of proximity, of a shared language and illness representations and of sociability, familiarity and confidentiality (Jaffré, 1999: 69). The staff of the public dispensary on the other hand are not as easily accessible as they are part of an institution, closed to many. Moreover the ‘popular knowledge’ about the medicine sold by ambulant vendors was to a large extent shared by the customers and the vendors and provided a more or less direct link between symptoms felt and treatment, in the form of one or more pills. As Jaffré argues, the medicine sold on the informal market (‘médicaments “par terre”’) are ‘medicines of a cultural proximity’, they are adapted to local conceptions and offer a direct correspondence between the illness or symptoms and their treatment (Jaffré, 1999: 68).

Ambivalent views of the public dispensary

Patient/population views of the public dispensary revealed a marked ambivalence towards the CSI and its staff. On the one hand, the medical knowledge of the health workers, in contrast to
the ignorance and lack of medical knowledge of ambulant vendors, was acknowledged and their services sought after. On the other hand the experience of being met by sometimes dismissive and unhelpful medical staff dissuaded people from seeking treatment at the public dispensary. Stories of corruption, of staff who divert medicine from the dispensaries and hospitals and from international donations for personal profit, have led to a widespread distrust of health workers and of the public health services. With regards to donations of medicines one woman made the following remark:

We usually see on the television donations destined to the population. The truth is that they don’t give us the medicine unless you have a family member working in the health centre. Foreign countries give these donations but the health personnel sell them.

Widespread clientelism was also pointed to. Knowing someone working at the public dispensary was often mentioned as the only way of ensuring good reception and care. As one woman remarked, ‘…those who have no relatives in the health centres have to suffer’. There was also a marked tendency of people to seek help or care where they knew someone, even if the health centre in question was located far away. In many of the illness episodes described by interviewees recourse had been taken to health centres outside Saga, for instance in the centre of Niamey, as a brother or sister, child, nephew or niece, neighbour or friend worked there. However, this distrust was not shared by everyone. One young mother expressed trust in the role of health personnel as ‘healers’ and pointed out that there are both good and bad health personnel:

I trust them because they are here to care for us. There are some that are good and some that are bad, when you meet a good health worker, the welcome will be warm. This contributes to easing the pain, and if you meet a bad one you are discouraged. There are some that do the interrogation calmly before prescribing the medicine. In all professions one encounters people who are welcoming and others who are not.

The most common complaint regarding the public dispensary was the fees. This was also the main reason given for the non-frequentation of public health centres. It was frequently said that if you go to the health centre without money you would not be treated, even if you were seriously ill. Hence, people said, there was no point in going if you had no money. One woman asserted that if you bring someone who has no money to the dispensary he risks dying (‘…il risque de mourir.’). People made a distinction between the past when treatment was free and the quite recent introduction of fees under the auspices of the cost recovery system.
There seems to have been little information about the cost recovery system and consequently confusion about and dissatisfaction with the new user fees abound. Moreover, resentment was often directed against the health workers who appeared cold and unfeeling in refusing to care for the ill and the poor. The confusion about vaccination costs mentioned in chapter six also reflects a conflict over payment and a distrust of health workers who were accused of imposing arbitrary fees.

That the user fees were a source of conflict and antagonism between health workers and patients was evident during the consultations at the CSI. For example the conflicts or the bewilderment over the cahier and the carnet de soins. As noted in the description of the consultations in chapter six, people often came to the CSI with a cahier, a notebook, cut in half in the place a carnet de soins. The nurses interpreted this as an attempt to escape patient fees. It should be noted that such notebooks were used in the confessional dispensary. The carnet de soins was the key, and for some the barrier, to the CSI. At the other end the prescription was the palpable result of the consultation. It was of central importance to the patient-nurse relationship as it showed that the nurse had done his or her job and that the patient had received care/treatment for his or her illness. However, many left the CSI with an unfilled or ‘half-filled’ prescription as they were unable to pay for the entire prescription. The carnet and the prescription in a way dissuaded people to seek treatment at the CSI. If one did not have a carnet de soins one would not be admitted and once admitted the consultation would be concluded with the inevitable prescription, necessitating more expense.

The popularity of the confessional dispensary

When talking about the nuns many interviewees emphasised the free care they offer. The free care given by the nuns was often compared with the fees and prescriptions of the public health services. People also pointed out that it was difficult to get treatment at the confessional dispensary, as the nuns choose who they will treat out of a large number of people. As one mother remarked, one has to have a lot of luck to get the ticket for the consultation. Some people recalled times when they had gone to the nuns to seek treatment only to be overlooked and turned away. It was also remarked, both by the nuns and the ‘population’ that people dress in poor clothes so that they will be chosen. The reputation of the nuns also stemmed from their other charitable activities, which were frequently mentioned, such as the daily giving out of cooked meals to those in need, of milk to infants and children and the handing out of other essentials (staples, soap, blankets etc.) to the destitute.
That the nuns offer free care is not the only reason for the popularity of the confessional dispensary. The treatment offered by the nuns was often valued more highly than that of the public dispensary. The care of the nuns was thought to be of a better quality. The medicine at the confessional dispensary was thought to be more effective than the medicine in the public dispensaries. The nuns also have a reputation of treating patients with care and respect. As one woman remarked:

If we can get a consultation with the nuns we will not have to go to the CSI. Whites [the nuns] treat people without ulterior motives but the African [the CSI staff] doesn’t treat people decently [convenablement].

Such remarks reflect a trust of the nuns, who are seen as helping people, offering free treatment, food etc., without personal gain in contrast to medicine vendors and sometimes also the staff of the public health services.

The relations between the three institutions

As has been shown in this paper the three representatives of ‘modern’ medicine in Saga have developed different relations with the population. While the confessional dispensary and the 

pharmacie par terre were thriving, the public dispensary was faltering. The following discussion will focus on why.

The public dispensary in Saga was facing difficulties. The patient numbers were remarkably low. At the same time the confessional dispensary had more patients than they could handle. The difference between the two was easily perceptible in the crowds of people waiting outside the gate to the nuns’ compound and the half empty waiting area of the public dispensary. This difference can be explained in various ways. For one, Saga has a rural character and a relatively poor population, for whom the costs of consultations and prescriptions exceed their economic means. Secondly, the popular perception of the public dispensary and its staff was ambivalent. The relations between the patients and the staff were at times antagonistic-especially over fees. Moreover, the unwelcoming and condescending attitude of the nurses drove people away from the dispensary. The stories of widespread clientelism and corruption in the public services reflected back on the dispensary in Saga. The views expressed reflect a widespread dissatisfaction with and distrust of the public health care services. As described by Jaffré and Olivier de Sardan in Une medicine inhospitalière (2003), in urban West Africa the behaviour of health care personnel and the ubiquity of corruption and clientelism has
ultimately created an inhospitable environment and alienated those without the economic or social capital necessary to access good and conscientious care. The dissatisfaction with the public dispensary also reflects back on the state, the provider of public health care. Masquelier, working in a rural town in Dogondoutchi, points to the disenchantment with the state sponsored public health services, due to constant shortages, expensive prescriptions and chargers of corruption and clientelism. Moreover, she argues, the dysfunction of public health services is experienced as an absence or failure of the state (Masquelier, 2001).

In this environment the popularity of the nuns is not surprising. Firstly, they offer free treatment. Secondly, they prioritise the poor who have no access to the public dispensary due to their economic and social situation. Most importantly they are perceived as being professional, trustworthy and as giving good care. Comments about the nuns reflected a trust and confidence in their healing powers and medical knowledge. That the Catholic nuns were working in a predominantly Muslim society seemed not to pose a problem. It should be noted that Catholic nuns and other Christian denominations have been present in Niger and Niamey for a long time, running schools and dispensaries. They are thus well known for such activities and the trust vis-à-vis the nuns - observed in Saga - was thus already well established.

Like the confessional dispensary, the *pharmacie par terre* played an important role in the therapeutic field in Saga. The medicine vendors had adapted their selling strategies to the needs and demands of the population. In providing a way of getting fast and cheap relief, they played an important role in self-medication, the dominant therapeutic recourse in Saga. What van der Geest points out regarding the popularity of drug vendors in Cameroon is also applicable to Saga: ‘The preference for a drug vendor has to be viewed within the total range of therapeutic choices. People with a medical problem will first try treatment which costs them little. Only when this fails will other, more costly, inconvenient steps be taken.’ (van der Geest, 1987: 297). The informal sale of pharmaceuticals should also be placed in the context of the formal provision of health care. The growth of the informal market in pharmaceuticals is related to the failure of the state to provide health care for its population. It fills the gap left by the public health services.
Medical pluralism in practice

Chapter two described the centrality of the international health-care programmes of the 1950s and 1960s to the emergence of medical anthropology. It pointed to how the non-compliance on the part of the target populations was interpreted as an expression of irrationality and superstition, of societies and cultures mired in tradition. Such interpretations and assumptions are still present, although in different and more moderate forms. Public health studies which in seeking to explain the low frequentation of public health services or the non-compliance to public health programmes, conclude that it is due to false illness representations or other cultural constraints and consequently people have to be educated and sensitised. Traces of such rhetoric were evident in the comments of health personnel in Saga, who stated that, for instance, the low-attendance of vaccination sessions, the failure of people to follow prescribed treatments and the habit of buying medicine from ambulant vendors, was all due to ignorance.

Approaches to issues of public health care, which start with the presumption of what people rationally should do and conclude that the reason that they do not do so is due to culture or ignorance, are unhelpful and misleading. The starting point should instead be on what people actually do and on the context within which they seek care. It should be to look at the harsh economic reality, which limit the choice of therapeutic recourse. It should further be to look at the dysfunction of the public health services, which drive people away from them. This point has been forcefully made by Farmer who has criticised the tendency of anthropologists to confuse cultural differences with structural injustices of inequality and poverty (Farmer, 1999).

This paper started with the description of one young mother’s quest for treatment for her child ill with tuberculosis. The obstacle was not ‘culture’, ignorance or irresponsibility. She knew tuberculosis from personal experience and she knew what treatment her child needed. However her precarious socio-economic situation made it nearly impossible for her to access the necessary treatment. The problem was not one of representations but of poverty. As the case of Ramatou illustrates, the study of therapy seeking and of medical pluralism needs to pay attention to the context within which therapy seeking takes place. Furthermore it has to focus on the therapeutic alternatives available and on the economic factors as well as on the social and political relations which might limit or enable the choices that people can make. In other words, attention has to be paid to how medical pluralism works in practice.
9. CONCLUSION

In the material presented I have attempted to give some insights into the daily practices or realities of medical pluralism and therapy seeking in Saga. Looking at daily experiences of illness, as described for instance in illness episode and common illness representations, and attending to the details of the interactions between care-seekers and care-givers has hopefully shed some light on important issues of illness and therapy. In conclusion, I would once again like to emphasise that the quest for relief is reflective of daily experiences of illness and therapy. This is so both because a diagnosis/cure or a state of perfect health is not always within reach and because the priority in everyday illness episodes or in the face of prosaic/ordinary illnesses and symptoms is for the symptoms to disappear, for the pain to calm down. Good and efficacious medicine, such as *lahiya vitesse*, is thus highly valued.

Returning to the initial question of this study on which factors influence people’s choice of therapy. Firstly, poverty is a crucial and undeniable factor in the search for therapy/relief. It is an obstacle for many, for whom the quest for therapy is less a question of choosing between different alternatives but of turning to the alternatives that are within reach. The success of the *pharmacie par terre* is inseparable from poverty. Secondly, social relations are an important factor in the search for therapy/relief. Social networks can help in accessing a particular treatment, for instance through personal relations with people working in the public health services. Part of the success of the ambulant medicine vendors is due to their physical as well as to their social and cultural proximity to their customers, to their adaptation to the social environment (the ‘proximity of the market place’). In contrast, in the public health services, relations with patients are often characterised by distance and indifference. Thirdly, perceptions of trust are very important. This is most evident in the contrasting views that the population expressed between the nuns and the public dispensary. The nuns fill an important place in the therapeutic field of Saga and Niamey in offering free treatment to, as they expressed it, the ‘poorest of the poor’. Yet, their good reputation and popularity is not only due to the free care that they offer but also to the relations that they maintain with their patients and with the population in general. They are perceived as helping people and of being honest, knowledgeable and offering quality care. Conversely, although the fees of the cost recovery system were mentioned by many as a reason for why they never sought treatment at the public dispensary, mistrust of the health personnel was widespread as they were accused
of being cold and uncaring, corrupt etc. The low patient numbers of the public dispensary is not only due to fees but also to distrust.

In conclusion, it is emphasised that ignorance and irresponsibility have little to do with why people make the choices they make in the search for therapy/relief. The reasons for their choices are inseparable from the harsh economic reality experienced by many. This reality is compounded by faltering public health care services perceived and experienced as being corrupt and uncaring. In this environment people make do (se débrouille) with the resources at their disposal and they show incredible resilience in their struggle for therapy/relief.
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