

**Reworking Efficacy:
The Social Life of Medicine in Northern Togo**

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Abstract

When considering the local, indigenous, “traditional” healing practices of non-Western societies, Euro-Americans often ask whether or not they are efficacious – “do they work?” Posed from a biomedical paradigm, the concept of work adheres to a narrow definition. This thesis seeks to expand constrained prevailing views of medical efficacy, challenging conception of the “work” medical systems perform. Rooted in ethnographic fieldwork conducted in the village of Kuwdé, Northern Togo, I apply the question of work to the Kabre local medical system. I consider how the purposeful distribution of remedies among houses in Kuwdé orients the individual body to community, clan, and history through health and disease. I draw upon theories of embodiment, relationality, and power to show that a medical system does social, relational, and political work as well as physiological work. In doing so, I aim to move from a conception of health solely as biological-pathway-to-biological-impact, to situating health in its social and relational dimensions. I then engage with the field of global health, arguing that an expanded notion of efficacy and work may, in turn, improve the delivery of biomedical care. It is my hope that this project cultivates awareness of how definitions of efficacy frame the lived experience and practice of medicine.

This work is dedicated to the people of Kuwdé.

Contents

ABSTRACT	I
DEDICATION	II
ACKNOWLEDGEMENTS	V
INTRODUCTION	
Alafia: The Business of a Village.....	1
Positioning and Framing	4
Methodology	7
A Word on Terminology.....	9
Situating: An Ethnographic Background of Kuwdé	12
Entering the Conversation: A Literature Review.....	13
Reworking Efficacy.....	19
CHAPTER 1: EMBODIMENT	
Kabre Philosophy of Body, Disease Categorization, and Explanatory Models	21
Kabre Ethnoanatomy: Beyond the Clinical Gaze.....	21
Beyond the Individual: The Kabre Body as Relational and Spiritual Subject	27
Why My Body? Why Me? Causation and the Domaining of Treatments in Kabre Medicine ...	35
CHAPTER 2: RELATIONALITY	
The House Medical System as Relational Practice	39
HMS: Mapping a Relationally Organized Medicine	40
Giving Thanks to the Ancestry: Negotiating Relations with the Deceased	48
Outside the Village: HMS and Regional Relationships Why My Body? Why Me?	50
Performing Relational Medicine	52
CHAPTER 3: POWER & BIOPOWER	
Reading Foucault in Northern Togo	55
The Management of Populations	57
Normative Coercion.....	59
Power and (Remedy) Knowledge.....	60
Tertiary Spatialization and the HMS	63
Ancestral Remedies as Heterochronies	65
Implications for Efficacy	66
CHAPTER 4: COHABITATION	
Local Medical and Biomedical Confrontations and Negotiations in Northern Togo	67
Global Health and Efficacy: A Discourse of Metrics	68
Collaboration or Co-optation?	71
Global Discourse, Local Realities: On the Ground in Northern Togo	75

CONCLUSION	83
Spoken and Unspoken: A Return to “Work”	83
(Un)Justifications	84
REFERENCES	87

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INTRODUCTION

Alafia: The Business of a Village

Even at the earliest hours in Kuwdé, you are bound to encounter someone on the network of paths linking the homesteads of this mountain village in Northern Togo. People who cross paths greet with a series of questions and answers. The interchange can be as short as a few seconds, or as long as several minutes. Beginning with a predictable structure, it spirals into nuance. It picks up rhythm and tempo, adding a musical quality to the already lyrical Kabre language. Almost like a dance, the lead shifts; the questioner becomes the respondent. Engagement in this exchange signifies local intimacy. Indeed, it took me several weeks to keep in step without fumbling and faltering.

Yet more intriguing than this iterative ritual, or even the questions posed, are the answers given in response. For as diverse as the questions may be, a single word often suffices: *alafia*. *Alafia*, a Kabre word probably derived from Hausa¹, means “health” or “well-being.” Here is a rough translation of what one might consider the core of a Kabre greeting exchange, in English:

“You have come?”

Eh (Yes).

You and the morning/sun/evening/dark (time of day-dependent)?

¹ Alafia is also a Yoruba word, likely also with Hausa and Arabic roots.

² I acquiesce that proving the physiological efficacy (biomedical mechanisms, etc.) of Kabre medicines is

Alafia-we (Health is).

In your work?

Alafia-we (Health is).

And the home?

Alafia-we (Health is).

In the market?

Alafia-we (Health is).

In the field?

Alafia-we (Health is).

And the family?

Alafia-we (Health is).”

If language reflects culture, then this exchange holds telling clues to the centrality of health for the Kabre and to the multiple ways in which it is conceived. More than a placeholder or utterance, *alafia* becomes the answer to a myriad of personal and community-wide questions, a subject of public concern. Its presence quiets worries; its absence raises discord. Health, in Kuwdé, is the business of the village.

I began to realize that this metaphor – health as the business of a village – asserted its presence in more ways than one. I became interested in how this notion of health as a community concern played out, particularly in the local medical system. My interviews and discussions revealed an intricate network of medicines purposefully distributed among houses in the village of Kuwdé. Born into this “house medical

system,” Kabre individuals are naturalized within a social fabric; remedies become yet another way of orienting oneself to kin and clan. The act of health seeking puts bodies into relationship with houses, community members, and ancestors. The association of certain houses with their respective remedies entwines with local knowledge and history. Within this democratized form of medicine, as the healer Kouwénam put it, “everyone is a healer.”

I hadn’t always intended to study this topic. I had arrived in Kuwdé with a foggy, largely academic notion of “traditional medicine.” Along with a suitcase and small backpack, I had brought with me a roughly defined research question to Togo, more affiliated with the study of Global Health than with anthropology. I initially intended to focus on the relationship between the Western biomedical clinic in Kuwdé – the *case de santé* (“house of health”) – and the Kabre “traditional” medical system. I hoped to identify potential areas of collaboration and cross-pollination between the two. Subjects like these tend to captivate global health research, particularly driven by recent international interest in Complementary and Alternative Medicine (CAM). I saw my own fieldwork as a contribution to this discussion, focusing specifically on a region of Togo never before studied through this lens.

Yet just as I felt initially disoriented – even paralyzed – by the Kabre greeting exchange, I quickly realized I had little idea what “traditional medicine” meant in the context of Kuwdé. Even supposing that such a system existed as a singular entity proved problematic. In my undergraduate coursework at Duke I studied several examples of “traditional” – or indigenous – medicine: Ayurveda in India, Akan medicine in Ghana,

and Traditional Chinese Medicine. Studying these systems as a whole, I attributed to them a body of cogent philosophies, characteristics, and practices. But simply comparing or analogizing any of these to Kabre medicine seemed presumptuous, even antagonistic, especially when the “system” I sought to discover revealed itself as multimodal, layered, and unbounded. This raised cognitive dissonance for me.

After an unsettling period of refocusing, reframing, and shifting, my imperative slowly came into focus. As I spent time to document and inquire into the distribution of local remedies, a much more intricate system emerged. I soon discovered the system extended far beyond remedies and their applications, into the realm of relationships between people, histories, and futures. My fieldwork, I decided, would situate itself at a different level of analysis: I would examine the house medical system of Kuwdé – fixating on *alafia* before translating into other epistemologies of “health.”

Positioning and Framing

When considering the local, indigenous, “traditional” healing practices of non-Western societies, Euro-Americans often ask whether or not they are efficacious – “do they work?” (Kirmayer 2004: 42). This question captivates the imagination and interest of those rooted in the biomedical tradition. Research into ethnomedicine aims to test the biological efficacy of certain herbal treatments, and interest in cross-systems integration drives research of drug-herb interactions. But from a biomedical perspective, our conception of work tends to be narrowly defined. Are they efficacious? Do they heal? Do they *work*? We seek to assign a value of worth based on whether

treatments cure or ameliorate the physical symptoms of disease and sickness. But just as medicine is an intensely context-specific, culturally embedded practice, the term “work” – and the way that we conceive of it – begs greater nuance. Asking “what, how, and why” a practice works requires a simultaneous exploration of what Laurence Kirmayer calls “basic or anterior questions”: “what it *means* for something ‘to work’, what it is supposed to be working *on*, and toward *what end*” (Kirmayer 2004: 46). Work, in this sense, is inextricably linked to power, meaning, and context.

My thesis will challenge and expand the ways in which we might think about the “work” performed by a so-called “traditional” medical system. Applying the question of “work” to the Kabre medical system of Northern Togo, I will show that a medical system does social, relational, and political work as well as physiological “work.”² That is, it not only knits together homesteads and lineages through a precisely articulated division of medical knowledge and practice, but also provides relief – bodily and relationally – in the face of illness.

Two theoretical orientations within medical anthropology tether my argument. The first, embodiment, focuses on the local experience of the body in all its physical, social, and spiritual dimensions. Such local (often non-Western) epistemologies are often thought of as contrasting with the “Universal body” posited by Western biomedicine (Livingstone 2010: 128). For the Kabre, relationships are integral to

² I acquiesce that proving the physiological efficacy (biomedical mechanisms, etc.) of Kabre medicines is outside the purview of my research and knowledge, and thus exists outside the scope this thesis. However, I caveat the need to “prove” the physiological work of Kabre local medicine in curing disease. Because this herbal-based system has been around for hundreds of years, because people in Northern Togo *do* overcome disease and illness to generally live long lives, we can assume its physiological work is efficacious to some undefined degree.

identity. A person's body both is and isn't her own, for it is in constant relationship with other humans, affected by spirits, and defined by ancestral history. Kabre medicine reflects such expansive and multi-modal notions of the body and its boundaries. As such, it responds to a particularly Kabre philosophy of the body and disease categorization.

The second orientation envisions medical practice within a larger political-economic context of what Michel Foucault terms "biopower" (Foucault 1976, Adams 1992: 149). Biopower sees medicine as a system of beliefs (spiritual-religious), a system of exchange (of both bodies and of treatments), and a system of power (political and ideological). Following this lead, I will consider how the purposeful distribution of medicines among houses in Kuwdé orients the individual to her community role and clan identity through health and disease. Usually applied in a Western biomedical context, Foucault's notion of biopower will be employed to the Kabre medical system.

My thesis exists among and between these two orientations. I argue that the house medical system of Kuwdé acts as a conductor, vessel, and vein, a passageway through which embodiment and biopower flow in both directions. The system is much like a synapse. While hard-wired mechanisms for distribution of remedies exist, they are hardly static. Plastic and adaptive in nature, they modulate and shift in response to the inputs of modernity, new disease, global health-related discourse, and other distinct networks (ie. biomedicine). In this flux, local understanding of health and illness – both of the individual body and of the community – are interpellated.

Methodology

The fieldwork for this thesis was carried out during the summer of 2011, from the months of June to August, and for two weeks in December 2012, in Kuwdé, Togo. While in Kuwdé, I lived in the homestead of Kouwénam and Tikénawe, along with their daughters Essocolo, Asia, Bienvenue, and Elli, and their son, Gros. In addition to conducting my own independent research, I attempted to integrate myself with the village of Kuwdé as best I could, attending ceremonies and funerals, brewing sorghum beer and selling it in the marketplace along with other Kabre women, and helping the local biomedical clinic deliver public health messages about mosquito net use, hygiene, and prenatal checkups for expecting mothers.

Nearly thirty semi-structured interviews with local Kabre healers, along with informal discussions with community members and a two-day collaborative conference between biomedical and traditional healers, inform this work. Field notes were either handwritten or tape-recorded and transcribed. I returned to Kuwdé nearly a year and a half after I first left, predominantly in order to confirm my initial understandings of the local medical system. The return also allowed a chance to pose questions previously off my radar, questions that arose from months of ruminating, poring over fieldnotes, and writing. As a fieldworker, returning to one's fieldsite poses a great risk; there always exists the chance you may discover that you had completely misinterpreted or misrepresented your subjects and topic of study. While my return interviews expanded and enhanced my understanding of medical beliefs and practices in Kuwdé, I was also

struck – and relieved – to find that my cursory interpretations were largely affirmed, even resoundingly echoed, by follow-up conversations.

Of course, my observations and interactions with local medicine in the village were not limited to interview sessions, discussions, or the conference. Perhaps a testament to the liquidity and proliferation of the system in everyday Kabre life, I observed the application of local remedies multiple times outside my interviews. For instance, when Gros returned from laboring in Benin with a cut on his foot, Tikénawe applied a leaf-based paste to his wound before wrapping it in cloth. Sure enough, the wound healed without a visit to the mountain’s biomedical clinic.

Such is not to imply that the biomedical clinic in Kuwdé, the *case de santé*, is not useful and frequented by locals, in any regard. The clinic inhabits its own niche, which could constitute the subject of an entirely other research project. During my first few weeks in Kuwdé, I worked to calculate a year’s worth of data from the clinic’s family health insurance program, which currently insures nearly 20 families in this 300-person community. I also conducted several interviews with the two *case de santé* staff: Basile, the clinic’s director, and Odile, the midwife. Their insight helped me gauge the extent of coexistence, and even cross-pollination, between the local and biomedical systems.³ As mentioned, these conversations could have informed a thesis focused entirely on the interaction *between* these medical systems and ideologies. However, I invoke them here insofar as they relate to the Kabre house medical system, or in instances where they provide a contrast to theories of the body and disease causation.

³ While practitioners of biomedicine themselves, both Odile and Basile reported using local treatments for various conditions in their homestead. This is yet another testament to the ubiquity of the local system.

I conducted my interviews with the help of two interpreters – Jespér and Georges. Without them, this work would have proved impossible, as I had a rather cursory knowledge of French and an even more limited familiarity with Kabre. Jespér is a local Kabre from Fárende, Kuwdé’s neighbor village located in the plains. As a young man, he left the villages for nine years to get educated in Paris, a rarity for Kabre. One day, for reasons little known to locals, he mysteriously returned to the villages, where he has remained since. He is a philosophe and scholar, fluent in French and competent in English and Spanish, but also an enjoyer of drink, and widely known as such in both Kuwdé and Fárende. Jespér’s father was an eminent Kabre ethnographer, who published several works on Kabre language and philosophy. Also, Jespér himself is a healer; he has knowledge of specific herbal remedies that he uses to treat maladies.

Like Jespér, Georges is Kabre, but he was raised in Togo’s Southern capital, Lomé. Therefore, he was not local to Kuwdé; he came North to the villages to assist us in translation during our stay. While he speaks Kabre well, French and Ewe are his primary languages. He also speaks decent English, learned while he worked as a translator for English doctors aboard the Mercy Corps ships.

The process of translation is fraught with complication, especially in ethnographic research. Integral components get lost or misconstrued, even among the most skilled of interpreters, due to inherent differences of syntax, idiom, and expression of meaning. The production of this work, from its inception to its current state, was a dance of three languages: Kabre, West African French, and English. While many of the younger village members spoke French, learned in primary or middle school or at the

lycée (high school), most older village members spoke only Kabre. Incidentally, most of the owners of house medicines were the eldest members of each homestead. As such, Jespér and Georges often translated my questions from French to Kabre, and their responses from Kabre back into French, sometimes with English interjections. I, then, would use my rather cursory (but working) knowledge of French to translate back into English. Often, my field notes appeared a jumbled *mélange* of Kabre, French, and English words. To address the limitations and borders of my own interpretations, I employ a first-person narrative. I do so to acknowledge the dissonance and disjuncture – and the inherently subjective nature – of the interviewing and interpreting processes.

A Word on Terminology

Linguistic variability and nuance do not only relate to the politics of translation; the language we use to speak about or depict culture itself proves delicate. Each word carries with it particular baggage. A litany of terms has emerged to define or classify medical systems *other* than Western biomedicine, including “traditional,” “indigenous,” “vernacular,” “ethno-,” and “folk.” One cannot underestimate the power of the current moment in influencing this discourse. For instance, centuries’ worth of herbal remedies, acupuncture, massage, and dietary practice, among others, have been synthesized and systematized into the practice of “*Traditional Chinese Medicine*,” or TCM. The World Health Organization officially recognizes TCM as a form of Complementary and Alternative Medicine (CAM), and the practice is taught side-by-side with Western biomedicine in many Chinese teaching hospitals and medical schools. Thus, the use of

“traditional medicine” to describe non-Western systems has quickly become a mainstay in global health discourse. While many works of medical anthropology also employ the term, there also exists a critical sensibility around use of the term “traditional,” to what scholars call its Orientalist implications (Said 1978).

As I quickly found in my own research, words and classifications impose restricting, if not obfuscating, borders – along with their own Orientalist leanings. This is especially problematic when the subject of study itself is rather amorphous. Indeed, as Arthur Kleinman notes, “Indigenous healing...even in one local social setting, is a variety of things, not one thing” (Kleinman 1984: 139). The term “traditional” in particular can imply a sort of time-bound state. Traditions are seemingly static relics; we tend to derive a sense of nostalgia from their dependability. As it entertains romanticized notions of the old and rooted, “tradition” juxtaposes “modernity.” While many of the remedies in Kuwdé have existed for centuries, new medicines also constantly emerge in response to both physical and bio-political demands. I aim to avoid such binaries (old vs. new, traditional vs. modern), searching for terminology that encapsulates traits of modernity within long-embedded practice. While aware it is no panacea, I have landed on the term “local medicine.” I employ “local” to indicate a sense of origin. Not just academic, it is a term salient in popular culture at the moment (“local food,” “local business,” etc.), often used to contrast the external, outsourced, or imported. This language of origin will gain greater relevance when I speak of encounters between biomedicine and local Kabre medicine. My fieldwork and thesis fixates on one particular shade of local Kabre medicine: what I term the “house medical system” (hereafter abbreviated as HMS). This

term is one derived from the Kabre language itself. Those who treat illness are referred to as “*dera koreto*” – which translates directly to “house medicine person.” Thus, “house medical system” carries local significance.

Situating: An Ethnographic Background of Kuwdé

Northern Togo is a mountainous region, with villages sprawled across hillsides and sorghum, yam, and cornfields meticulously terraced into rocky terrain. Atop Kuwdé Mountain sits its namesake, the 300-person village of Kuwdé. Homesteads consist of not only nuclear families, but also clusters of kin with common lineage. A subsistence farming community, the village is closely tied to the cyclical production of crops and the passing of the dry and wet seasons. Production, in Kuwdé, relies on a gendered division of labor: men cultivate collectively in cooperative workgroups (*haja*) while women cook, tend the homestead, brew *sulum* (sorghum beer, the fuel and sustenance of Kabre labor), and make products for sale in the markets. While divided, these roles simultaneously complement; both depend on the other to subsist. Such dependence and complementarity begets a sense of relationality, modulating experiences of the body with regard to the social in addition to the physical. A complex ceremonial system with intricate performative ritual resides at the center of Kabre culture. Kabre navigate relations between each other, the land, the spirits, the ancestors, in addition to disease and the body. Indeed, these spheres often integrate and intersect, as this thesis will explore.

While rural, Kuwdé is not insulated. There exists a dynamic diaspora between the North and South of Togo, along with fluid labor-driven migration to Nigeria and Benin. Diaspora and migration also link Kuwdé to a global that is constantly re-appropriated within the local (Piot 1999). Medicine is no exception. As with much of the continent of Africa, biomedicine arrived in Togo during the early colonial period. In Kuwdé, biomedicine is practiced in the *case de santé*, the lowest-funded type of clinic in the tier of Togolese state-funded health clinics. The case de santé is a birthing clinic and pharmacy of sorts, staffed by a director and midwife. Kabre can visit the clinic to receive medications for symptoms, although formal diagnoses are deferred to the larger *Centre Médico Social (CMS)* in neighboring Farendé, or to the hospital in the Northern regional capital of Kara. In addition to clinics and hospitals, multiple NGOs distribute medications throughout Togo, following pre-determined guidelines for annual quotas. Kabre do not see the *case de santé* and the house healing system, or any iteration of local healing for that matter, as antagonistic. Most Kabre employ the practices of both, depending on their health circumstances. This complex relationship between biomedical epistemology and local healing will be touched upon in Chapter 4 as it relates to discussions of power and definitions of efficacy.

Entering the Conversation: A Literature Review

The medical systems of non-Western cultures caught the eye of anthropologists early on and generated some brilliant albeit intensely local ethnographies. In these studies, Andrew Strathern notes, “Anthropologists tended to describe small-scale,

isolated cultures as independent units without systematically setting these into a broader historical context” (Strathern 1999: 213). Taken as insulated and relatively static, these systems were analyzed through the lens of the symbolic and the structural. Thus, the French anthropologist Claude Lévi-Strauss drew attention to the role of symbols in crafting healing systems of local significance and belief. And the British anthropologist E.E. Evans-Pritchard’s theories of witchcraft heightened awareness of social and relational explanations for the misfortunes of disease and illness.

As local medical systems entered the sphere of discourse with biomedicine, new comparisons and methods of evaluation emerged. Along with them came the challenges of resisting the currents of Orientalizing binaries. Early medical ethnographies often cast local medical systems as “fashionable” yet distinctly “other” subjects; “social development literature of the past” posited indigenous healing as contrapuntal to Western biomedicine (Singer 1989: 1199, Kleinman 1984: 139). As Margaret Lock notes, “By far the majority of anthropologists had been content to research only ‘traditional’ medicine on the assumption that biomedicine, being grounded in science, was of an entirely different order” (Lock 2010: 59). Within this paradigm, biomedicine enjoyed – and in many circles still continues to enjoy – a “critical immunity,” shielded from critique by the assumed scientific impenetrability of Western practice. This ideology yielded both medical and social scientific research that translated “devils into parasites...jealousies as a way of talking about social inequalities...angry ancestors as disturbances in the psyche” (Langwick 2011: 8). Langwick’s observation highlights the overwhelming tendency of slotting local and traditional accounts into Western

biomedical categories. Yet the politics of such translation also shielded traditional medicine from its own autonomy, limiting the extent to which local practice could work *independently of* biomedicine.

Margaret Lock credits medical anthropologist Allan Young with inspiring a shift that started to envision local medical systems symmetrically to biomedicine. In his writings during the 1980s, Young emphasized the need to consider medical systems as knowledge practices, produced by their social, historical, and political contexts. With this “understanding of how medical facts are predetermined by the processes through which they are ... produced,” the task of comparative medical anthropologies became to “critically examine the *social conditions* of knowledge production” (Lock 2010: 59, emphasis added). Such symmetry of analysis freed the study of local medical systems, no longer defined solely by their contrast in the shadow of biomedicine. Just as biomedical knowledge emerged from a long history of Western thought, local medical systems, too, could provide insight to their cognitive and social origins.

The emergence of the school of Critical Medical Anthropology (CMA) in the 1990s brought a new emphasis to the role of political economy and power structures in producing medical systems (Strathern 1999: 214). This direction echoes Foucaultian notions of biopower, seeing medical systems as instruments of the state and positing the individual body within a controlled population (Foucault 1976). CMA’s project became to “bring medical anthropology firmly into the sphere of contemporary global relevance” (Strathern 1999:218). Fast-forwarding to the current moment, medical anthropology finds “global relevance” by engaging with the field of global health.

Increasingly, research on medical systems within this field trend toward the goal of informing healthcare practices and policies in broad global contexts. This trend is evidenced by the WHO's funding of collaborative initiatives between "traditional medicine" and "biomedicine." Researchers in Complementary and Alternative Medicine emphasize strategies for the adaptation and re-appropriation of biomedicine in non-Western settings. Furthermore, both the World Bank and WHO have voiced support of pharmaceutical research and drug development based upon herbal remedies of traditional healers. Such initiatives are political and economic as much as they are health-driven, guided by transnational institutions, "neoliberal restructuring, and the insistence of international financial organizations that the poorest of countries produce their way out of poverty." These supranational, large-scale interests enter local medical practices into global exchange systems (Lock and Nguyen, 65).

While in the subsistence farming community of Kuwdé, Togo, these currents of transnationalism and global political economy may seem a far cry, this discussion frames the risks, relevance, value, and future of research into local medical systems. It also reminds us of the inarguable presence of exchange, politics, power, and commerce – in addition to health, disease, culture, spirituality, and relationality – surrounding both "biomedical" and "traditional" medical practice. In Kuwdé, the interaction between biomedicine and the house medical system (HMS) is an on-the-ground reality, as healers refer their patients to the local clinics for blood tests and X-rays and clinic directors take their children to local healers when they fall sick with certain ills.

In the wake of this global-medicalization, previously insulated local notions of health, the body, and disease are constantly renegotiated and reconceptualized. While the lens of CMA and political economics enhances our understanding of global interests and attitudes towards traditional medical practice, it does, as Gaines reminds us, “tend to downplay the agency of people themselves and their ability to create their own meanings from, and solutions to, the problems of sickness” (Nichter 1992: 214). Furthermore, as Scheper-Hughes and Lock argue, over-emphasis on the political-economic influences on healing systems ““depersonalize(s) the subject matter...neglecting the particular...content of illness, suffering, and healing as lived” (Singer 1989: 1199). Confronted by such depersonalization and downplay of local meaning, we turn to the theory of embodiment.

Embodiment, within medical anthropology, attempts to circumnavigate this roadblock by placing the body at the center, studying what Scheper-Hughes calls “medicine’s *regard* – its focused and sustained gaze on (or inside) the body” (Scheper-Hughes 1994: 230). Following Arthur Kleinman’s identification of multiply layered and locally constructed understandings of sickness, disease and illness, Scheper-Hughes defines not one but three “bodies” of interest: “the representational *body social*; the controlling, bio-power forces of the *body politic*; and...attribution of meanings to the individual and existential *body personal*” (Scheper-Hughes 1994: 231). This multivalent analysis of the body provides a useful optic, one I will employ in contrast to the singular “Universal body” of biomedicine.

Paramount among cross-cultural studies of medical systems is the question of efficacy (Nichter 1992, Kirmayer 2004, Waldram 2000). This question tends to problematically adhere to a narrow conception of what is “efficacious” and what is not; whereas in reality “what counts as a good outcome may range from change in a discrete behaviour...or improved ‘quality of life’ to the restoration of harmony between body, social order, and the cosmos” (Kirmayer 2004: 42). A refocusing of ethnomedical study from strictly conceived “efficacy” to situated “meaning” allows anthropologists to probe at the multiple ways a system can heal – physically, socially, spiritually, and relationally. Kirmayer calls this the “triumph of ideology over experience” (Kirmayer 2004: 43). According to Kirmayer, the allure of healing systems – both biomedical *and* local – derives primarily from their operation within a larger set of cultural ideologies, values, and meaning. My stance is that we can better explain efficacy by a renegotiation of embodiment within power studies, at both the local and global levels. Like Waldram, I argue for a more fluid conception of efficacy that allows for multiple notions of “meaning” (Waldram 2000).

The debate here within the study of local medical systems is one endemic of anthropology on a larger scale: how to reconcile the individual (body) and both the local and global contexts in which it exists (culture)? Furthermore, how do these lenses, dually, construct notions of health, social identity, and the body? And perhaps most relevantly, how do we evaluate the efficacy of systems operating on paradigms far different than those of biomedicine? To answer, or at least address, these questions requires an integrated consideration of embodiment, symbolism, and etiology alongside

power, exchange, and the maintenance of sociopolitical order. Here, the Kabre house medical system enters this discussion.

Reworking Efficacy

My thesis seeks to expand constrained prevailing views of medical efficacy. Using Kabre medicine as a lens, I challenge fixed notions of work, the body, tradition, medicine, and health. I aim to move from a conception of health solely as biological-pathway-to-biological-impact, to situating health in its social and relational dimensions. I probe the freighted social relationships between local medical practice and global health, and between the Kabre house medical system and biomedicine. Finally, I argue that an expanded notion of efficacy, informed by local practice, may improve global health work. The critical issue remains cultivating awareness of how definitions of efficacy frame the lived experience and practice of medicine in Northern Togo, and in turn, of health.

To advance my argument, I use a scaling of analysis, from individual body to the cross-disciplinary field of global health. Chapter 1 starts with the body, the most basic (yet arguably also most complex) unit of interaction with the external world. By focusing on local philosophy of bodily experience, I introduce the Kabre body as distinct from a biomedically-assumed “Universal body.” Chapter 2 moves to relationships *between* bodies. This chapter explores the work of one particular shade of Kabre medicine – the house medical system (HMS) – as a relations-based practice knitting together people and villages in Northern Togo. Chapter 3 serves as a bridge between relationality and

biomedicine, considering the power dynamics within and surrounding the HMS. Chapter 4 reads the HMS in a wider context of “global interconnections,” as it confronts global health discourse of collaboration and pluralism, probing what happens on-the-ground when their spheres intersect.

CHAPTER 1: EMBODIMENT

Kabre Philosophy of Body, Disease Categorization, and Explanatory Models

At their core, medical systems come into existence to address and treat the body. This lends the illusion of simplicity. But the immense variability of medical systems indicates immense variability in the meaning, understanding, and visceral experience of the “body.” The house medical system native to Kuwdé emerged in response to, and as a product of, a uniquely Kabre philosophy of the body, its boundaries, and its susceptibility to disease. As such, examining the work of Kabre medicine necessitates identifying what bodies – and illnesses – it emerged to work *on*. Claiming to decipher a culture’s understanding of the body is an immense undertaking. This section provides a brief and partial introduction to the ways in which the Kabre conceptualize the body. An expansion of the paradigm for health beyond strictly Western biological definitions of the body better equips us to explore the types of work performed by the house medical system within Kabre culture.

Kabre Ethnoanatomy:⁴ Beyond the Clinical Gaze

I, for instance, have never had the opportunity to see a real gene under an electron microscope. And even should I have had the opportunity I would be placing a certain degree of faith in the power of the microscope in showing me something I could not in fact see with my own unaided eyes. My faith in the existence of genes, however, is no less important or real than certain perceptions ... about the human body.

⁴ This term is borrowed from Richard Alan Swanson, referring to the cultural construction of anatomy based upon differential organizational systems for the human body (Swanson 1985: 30).

Swanson's remarks remind us of the power of the lens for both medicine and anthropology. The lens of the electron microscope enables us to see and envision cellular and molecular forces at work invisible to the naked eye and far from the reaches of human imagination. Likewise, the lens provided to us by our own culturally crafted conceptions of our surroundings and ourselves influences how we see and experience our physicality. To assess the efficacy of medical systems in treating the "body," we must first identify – and gaze through – the particular lens through which that body sees and lives.

In biomedicine, we often think of the body proper as a physical container of a more amorphous and abstract self. Margaret Lock explains:

With its assumption of a 'body proper' given wholly by nature, biomedicine is unique. Compared with other medical traditions biomedical explanations are, comparatively speaking, reductionistic and focused primarily on the detection of named entities such as viruses, genes, biomarkers, or other signs internal to the body thought to be directly implicated in malfunction. [Lock and Nguyen, 2010: 61]

Scheper-Hughes posits this "clinical gaze" of biomedicine: "Whereas biomedicine presupposes a universal, ahistorical subject, medical anthropologists are confronted with...bodies that refuse to conform (or submit) to presumably universal categories and concepts of disease, distress, and medical efficacy" (Scheper-Hughes 1994: 239). A culture's conceptualization of the body and its borders thus produces differential experiences. The body becomes a stage of sorts, on which these relationships are negotiated. But the body is not *just* a stage; it is also an actor negotiating these

relationships. For as Scheper-Hughes emphasizes, “Sickness is more than just an unfortunate brush with nature...more than something that “just happens” to people. Sickness is something that humans do in uniquely original and creative ways” (Scheper-Hughes 1994: 232). In this chapter, we employ an expanded appreciation for the ways in which the body is both inscribed upon and inscribing – and how disease becomes not a passive experience but an active assertion of identity, relationality, and power.

Generally speaking, the Kabre body cohabits naturalistic, spiritual, and relational space. Although the Kabre concept of the body is, on one level, corporeal and physical, it also consists of invisible entities. My introduction to this philosophy-of-being occurred under a shaded structure in the courtyard of a Farendé homestead. This frond-sheathed refuge proved an ideal interview site, and on a sweltering mid-July afternoon the healer Jespér lead me through his description of the Kabre body. “The Kabre person is composed of four parts,” Jespér explained, “the body, the soul, the star, and the *warito*.” The physical body is the only part visible to the human eye. However, as Jespér noted, “alone, the body is useless; the body dies.” “Death also results from a departure of the soul,” he continued. The star refers to the belief that “every person is also a star in the universe,” placing the body in a universal context. The *warito*, which will be examined subsequently in greater detail, refers to one’s “shadow person.”

Jespér qualifies the interrelation and interdependence between these four constituent parts: “The four are interconnected, always, elemental. A good relationship between them means health. You miss one, and you are sick, or dead. But some sicknesses strike only one (part).” Rather than compartmentalized into units or organs,

the Kabre body is multiply extended. Yet such multiplicity is not unique to the Kabre. The Gourmantché ethnic group, close neighbors⁵ of the Kabre in the Upper Volta region of Northern Togo and Southern Burkina Faso, identify “six attributes” that compose a singular human being (Swanson 1985: 93). As Swanson notes, “Man is not necessarily the unity we might conceive him to be” (Swanson 1985: 30). As such, ethnoanatomy, the distinct representation of the body within a culture’s own purview, becomes an essential tool for understanding local medical practice.

The Kabre notion of *warito*, in particular, epitomizes the unseen qualities inherent to the self. *Warito*, which translates literally to “behind person” or “shadow person,” is just that – a reflection of one’s self; a double. “Each *warito* is unique; it is like DNA, or a fingerprint,” Jespér explained. At first, the significance of this analogy eluded me. It seemed a perfectly apt way to depict the “uniqueness” of the *warito*, but it was not until later that I realized: Jespér had used a distinctly biomedical concept – DNA – to illustrate a local philosophy. His cunning turn challenges the notion that the two occupy uninhabitable or mutually exclusive spheres, a concept which will be expanded and emphasized in the latter portion of this thesis.

The Gourmantché theory of the human being parallels the *warito*: “Each nilo ‘human being’ is really two niba ‘human beings’ ... one of these beings is the *naano* ... it is the life without which the body would soon be dead ...” (Swanson 1985: 97). Equilibrium and balance in life requires establishing a relationship with one’s double. For the *warito*, as Jespér notes, “you have to know him/her, you meet him/her to find

⁵ Linguistically and culturally, the Gourmantché and Kabre are quite closely related.

out what he/she wants.” As Swanson describes, “the presence of the *naano* is thus equated with complete and normal control of one’s faculties” (Swanson 1985: 97). This unity – of the body with its double – begets stability and normalcy, which are often equated with health and wellbeing.

It follows, then, that the Kabre define health by a sound and intimate knowledge of one’s *warito*. As a corollary, disease often indicates lack of adherence to the *warito*. Like the Kabre, the Gourmantché describe death or illness as alienation or detachment of the *naano* from the body: “...when you are about to die (*naano*) will be the first to come out and run away” (Swanson 1985: 96). Kabre local medicine reflects this belief; in the case of illness, an individual must consult their *warito* in order to learn the appropriate steps to restore health. Often, a diviner, a healer with clairvoyant connection to the spirit world, must facilitate this consultation. Remedies incorporate these idiosyncrasies; the diviner heeds the needs of the *warito* by tweaking and individualizing treatment regimens.

The *warito* does not exist in solely the healing paradigm. Outside each homestead, literally embedded in the soil, sit tiny clay pots built to house each *warito*. The pots themselves reflect the distinction of gender; the male pot features punctured holes, while the female pot is smooth and solid. The *warito* thus resides in the physical environment of the Kabre, something their body passes as they exit and enter the homestead each day. After death, the *warito* become ancestors, brought back to their homestead of origin.

On a related note, and to be further expanded in Chapter 2 when discussing the relational and clan dimensions of Kuwdé, gender is not a fixed biological category for the Kabre. Whereas often posited as a naturalized feature of the “Universal body,” gender for the Kabre is actively created. Rather than establishing one’s sex upon birth, a Kabre child enters the world androgynous. Through a series of performances and initiation rites recognized and witnessed by the village, the person is created through their actions, coming to inhabit their respective gender (Piot 1999). Dominique Zahan echoes this notion of *becoming*, versus inherently *being*, in his study of religion, spirituality, and religious thought in several “traditional” African societies (Zahan 1981). The Kabre construction of gender illustrates one of many instances in which the social activity of the body prevails over biological activity.

These multiple understandings of the body as an individual entity and a system of entwined parts – material and spiritual – paint a complex picture. While all of Kabre body philosophy cannot be distilled into Jesper’s categorizations, they do provide an apt sketch of the ways in which the Kabre body is seen as compartmentalized, but also whole. The unseen components and qualities of the person are constantly invoked through sacrifice, divination, and communication with spirits and ancestors. Codependence between parts – “a good relationship between them” – yields equilibrium understood and experienced as health. Kabre healing “works” to knit together not only this bodily multiplicity but also, as we will subsequently see, people and bodies relationally, as a community.

Beyond the Individual: The Kabre Body as Relational and Spiritual Subject

“Persons here (in Kuwdé) do not ‘have’ relations; they ‘are’ relations.”

– Charles Piot, Remotely Global (Piot 1999: 18)

Bodies cohabit space. They produce relationships that in turn act on and reproduce those bodies themselves. In embodiment literature, an expanded definition of “self” and “body” hinges on this transubstantiality. As Laura Hengehold remarks:

The emotional and social self is ‘transindividual’ or imperfectly separate from other beings...it has an invisible dimension and relationships with invisible entities; indeed, *relationships* may determine someone’s selfhood – and their flourishing or sickness – more than their *visible, tangible body*. [Hengehold 2009: 8, emphasis added]

While equilibrium among the individual’s multiple constituents determines wellness for the Kabre, relationships among and between people also influence health and disease. This notion of relationality mirrors the subsistence farming practice central to Kabre lifestyle. Kabre farm collectively, in *haja* (work groups) that rotate to each man’s field. Each man’s livelihood quite literally depends on the other. Yet within this cooperative structure, Kabre also devise competitive motivational games to see who can harvest their row of crops fastest. They reach agreement to define the “best” cultivators in the community.⁶ This interplay of individualism and collectivity defies a stark dichotomy. In this sense, the basic act of food production mirrors the production and maintenance of health.

The subject of relational health and healing taps into a larger discourse of disease as a social operant. Naomi Adelson observes a concept of socially constructed

⁶ For instance, Sandi is widely considered the “best cultivator” in Kuwdé, a legend for his skill.

health explained by the Whapmagoostui Cree of northern Quebec as “*miyupimaatisiium*,” or “being-alive-well.” To the Cree, wellness stems from “the relationship among individuals and their social, spiritual, and natural worlds” – beyond the confines of the individual body (Lock and Nguyen, 81). In her ethnography of the Tibetan Sherpa, Vincanne Adams notes: “Failing to sustain a balance between the extremes of a continuum between self and other caused health disorders” (Adams: 153). Scheper-Hughes: “Pain, disability, and other forms of human suffering are habituated bodily expressions of dynamic social relations.” (Scheper-Hughes 1994: 232) In the case of the Kabre, many diseases are believed to have social origins – physical manifestations of failed or troubled relationships, indebtedness, and ill will – all of which affect the material body.

Relationality, for the Kabre, manifests in three main arenas: interpersonal, with the spirits, and with the ancestry. In the following sections, I explore each of these dimensions. An examination of the illness *kotong susoko* sheds insight into interpersonally produced pathologies within community relations. Relations with the spirit world are rampant, best exemplified by Kabre explanatory model of witchcraft, and invoked by the house remedy for snakebite, among many others. Snakebite also illustrates how natural occurrences may carry spiritual undertones. Finally, I discuss relations with ancestry as the foundation of house system herbal knowledge. The notion of balance runs throughout – this time not in regard to the constituent parts of the “self,” but among the multiple relationships the Kabre navigate. By investigating the

multiple dimensions of Kabre relationality, we see the ways the HMS addresses and distinguishes among these, a form of social work unto itself.

Kotong Susoko: A Case Study on the Kabre Body as a Social-Relational Subject

“One can invite this malady.”

– healer Pascal Kei, speaking of *kotong susoko*.

One disease, referred to by the Kabre as *kotong susoko*, or “bigness disease,” is understood in purely relational terms.⁷ The disease exhibits itself as gross swelling of limbs and appendages. Biomedically, the swelling may indicate of kidney or liver failure, a possible form of hydropsy, according to François, the biomedically-trained *assistant medical*⁸ at the CMS Farénde. But for the Kabre, *kotong susoko* has an intensely interpersonal causation. A scarlet letter of sorts, the swelling indicates a poisoned relationship among either friends or family. The physical manifestation – being grossly enlarged – serves a source of social stigmatization, one the sufferer would be ashamed to bear. Though the village members I spoke with attributed various causes—two families refusing to speak, a wife’s refusal of her husband’s sex, a husband’s rejection of his wife’s *moto*⁹ — all scenarios involved disruption of village social order and Kabre

⁷ The implications of understanding a condition with undeniably visible physical manifestations raised some cognitive dissonance for me as an ethnographer, particularly in my conversations with François. I will return to and expand upon this dissonance in Chapter 4, when I discuss the interplay between local and biomedical disease epistemologies.

⁸ François is perhaps the most knowledgeable practitioner and thoroughly trained biomedical practitioner in the Farendé-Kuwdé-Tchikawa region. A Kabre himself, he was raised within the HMS before he received training in biomedical diagnosis.

⁹ *Moto*, a cornmeal porridge, is a staple of Kabre diet in the rainy season. Here, rejection of *moto* is also read to be refusal of a wife’s sex, as symbolic correlation exists between fertility and female food production in Kuwdé (Piot 1999).

gender roles. These disputes are not to be confused with misunderstandings or lapses of judgment. According to Pascal Kei, *kotong susoko* results from “*willfully* resisting good social conduct—when you know better, but choose to act otherwise.”

Interpersonal refusals and rejections are somaticized and embodied in other local medicine contexts, manifesting in physical disease. Scheper-Hughes terms this phenomenon “illness as resistance”: “whatever else illness is...an unfortunate brush with nature, a fall from grace, a social rupture, an economic contradiction—it is also, at times, an act of refusal.” (Scheper-Hughes 1994: 238). The refusal that spawns *kotong susoko* is echoed and paralleled, in many senses, by *nervos* among the “Nordestino” sugarcane farmers of northeast Brazil. “It is...a way of communicating a state of affairs where one moves back and forth between an acceptance of the situation as normal, or expectable, and an awareness of the real state of emergency” (Scheper-Hughes, 237).

Yet Scheper-Hughes’ ethnography interprets the expression of illness as a political critique, a “body-praxis” revolt against bourgeois exploitation of working class bodies. How, then, does such rebellion apply to the context of Kuwdé as a village community? What implications does it hold for community structure, expectations, norms, and power dynamics? As Piot explains, relationships among the Kabre are based upon hierarchies of exchange and of debt (Piot 1993: 362). Contrary to early Africanist schools of thought that painted romanticized images of egalitarian ethnic groups, hierarchy is actually actively sought and maintained. So, disease explanation becomes a way to remind individuals of their roles within this hierarchy; physical swelling indicates deviation and imbalance among these relationships. We will see in Chapter 2 how this

hierarchy gets extended to the village and community level. Furthermore, and unlike many diseases that seem to operate “invisibly” within the body, swelling is extremely visible, hyper-present, and noticeable even with the most fleeting of glances. It makes sense, then, that such a publically visible malady should be linked to exposing publically relevant rejection of social mores.

One of my more embarrassing fieldwork faux pas actually elucidated another striking relational implication of the disease. By word of mouth from another healer, I was told to speak to Abalo Jean, who purportedly owned a house remedy for *kotong susoko*. About ten minutes into the interview, after looks of confusion plagued the faces of both interviewer and interviewee, it became apparent that Abalo Jean did not, in fact, treat *kotong susoko*. However, he mentioned, he did know a house healer in Farendé who treats *children with kotong susoko*. “*Kotong susoko* can also result from denying sex from one’s partner; the partners’ child can fall ill with this malady,” he explained. That is, if the dispute occurs between spouses but neither spouse experiences the physical swelling, their child may swell in their stead. What was more, Abalo Jean planned to visit this homestead the following morning, seeking treatment for his own child’s swollen limbs.¹⁰

The transitive nature of physical symptoms – past those directly involved and into those proximally related – indicates the social vulnerability of the body, bearing the physical repercussions of another’s actions. That is, social consequences for the dishonesty of one can span beyond the body of the individual, harming another. The

fact that *kotong susoko* can strike the child furthers the extent to which the disease threatens Kabre reproduction and life cycle. Revolt against the family, a husband's refusal of the wife's *moto* or sex, or rejection of amity among fellow Kabre unravels the social threads of the village. The risk of disease and bodily vulnerability thus leverages a warning against these social and relational transgressions.

Once incited, one cannot avoid the physical sickness of *kotong susoko* unless the aggressor admits to wrongdoing. Prevention of the malady requires timely repentance and pardon. Confession and reparation of relationships enables health, saving the body from this "very grave disease." If repentance is performed in time, as several healers told me, one can even avoid the physical effects of the disease altogether. This suggests a latency period¹¹ between the time a social rejection is committed and the physically visible deterioration of the body.

Confession as a therapeutic tool is not unique to Kabre medical epistemology; the practice is widely employed even in biomedical environments as a means of empowerment and a symbolic step in the healing process. In the case of the HIV/AIDS epidemic across Africa, international human rights groups during the late 1990s worked to encourage people living with HIV to "come out" about their condition. This confession of illness produced social vulnerabilities – chastising remarks, blame, even violence and familial estrangement. Yet with time, the process became equated with a "first step" towards empowering health-seeking behavior (Lock and Nguyen 2010: 298).

¹¹ Latency periods are also evident in Kabre gift-giving practices. Piot interprets the time between when a gift is given and the favor returned as a debt that produces relationships between Kabre (Piot 1999).

Thus, making public the intimacies and struggles of one's own body catalyzes healing in many medical cultures.

Snakebite: The Kabre Body in Relation to the Spirits

If you've been witched, you become estranged from your warito. The warito is held captive, guarded by the spirit *aluka's* dogs. You must sacrifice a dog, and pour its blood over your head. When the spirit sees the blood, it will flee. Then, your warito is free to return to you.

- Kouwénam, House Healer¹²

Those grounded in the tradition of biomedicine would likely describe a snakebite as a natural occurrence –perhaps the snake's defense mechanism in response to threat, or as a means of fulfilling metabolic demands. Unfortunate for the prey, indeed, but strictly driven by biology and the food chain. But for the Kabre, snakebite occurs from one of two possible scenarios: (1) a natural coincidence, similar to the biomedical line of thought above, or (2) sent by a witch. Furthermore, according to Sam, the house healer with the snakebite remedy, the prevalence of snakebites each year depends on the quality of relationships within the village. However in this scenario, unlike that of *kotong susoko*, the relationships in question are not interpersonal, but with the spirits. In the sacred forest of Kuwdé, there exists a fetish¹³ for the snake. If a village member commits witchcraft or sin at this site, Sam notes, "there will be many snakebites that year...five to ten." In the absence of such violation, fewer bites occur. Bodily health

¹² Kouwénam's quote paints the warito as the arbiter between physical and spiritual worlds, held for ransom by acts of witchcraft.

¹³ Altar

results from spiritual deference, compelling the Kabre to maintain and practice respect for the spirit world.

While Sam will treat the physical pain of the bite and attempt to prevent the venom from poisoning the victim, he also sends the individual to a diviner. The diviner aims to discern the reason *why* the snakebite occurred. Was the snake itself sent by a “witch,” a jealous community member wishing misfortune toward the victim? Or, was the bite a mere natural coincidence, with no further significance? To establish the reasoning behind the bite, the diviner asks: “Are you clairvoyant¹⁴?” This crucial question gets posed even before the victim receives treatment. Whereas a biomedical healthcare setting may prioritize removing the contaminant – venom – before all else, for the Kabre the most urgent plan of action is to first identify causation. “If the victim lies, he will die. If he confesses, he lives,” explained Sam. His answer indicates the role the victim himself plays in determining his own fate. Death and life are not only tempered by the spread of poison through the bloodstream, but also by the victim’s willingness to expose the truth. Furthermore, the significance lies not in the wrongdoings of the past, but in an honest confession. Much like *kotong susoko*, admission of wrongdoing (cf. repentance) alleviates the gravity of the situation, even meaning the difference between life and death. Such reinforces social expectations of honesty and transparency.

Ancestry and the Body

¹⁴ By clairvoyant, the diviner likely means capable of performing witchcraft: a “witch” or sorcerer.

Much as the spirit world tempers and mediates the Kabre body, the ancestral world similarly influences the equilibrium. Ancestors, for the Kabre, are family members who have passed away. Unlike the spirits, ancestors are believed to inhabit the homestead long after their passing, living alongside their progeny. Though not physically present, their existence continues through relationships to the living. Many, if not all, house medicine remedies find their roots in ancestral knowledge, passed on through generations. Sacrifices and payments to the ancestors, detailed subsequently, thank ancestors for protecting and guarding the health of the individual. Forgetting to deliver due gratitude—or perhaps more gravely, doing so incorrectly—could incite further illness. Indeed, this issue became apparent in my own fieldwork process. During a discussion with the *haja*¹⁵ shortly after my arrival, I vocalized my interest in learning about local remedies in Kuwdé. One worker replied, “We want to bring you our herbs, but in order to do this, we must have to ask permission from our ancestors. If you take an herb when someone isn’t sick, someone will get sick.” His remark indicated a sense of indebtedness and vulnerability of an individual’s health at the hands of the ancestors. Caring for ones’ body implicitly involves caring for and respecting ones’ ancestral antecedents; the two worlds are thus interlinked.

Why My Body? Why Me? Causation and the Domaining of Treatments in Kabre Medicine

¹⁵ Male group of cultivators

The question of “why,” placed in the context of bodies and disease, is at its fundament central to *any* system of medicine. “Why this disease, why this person, why now...” We ask in hopes that discovering the cause may lead us to some resolution, or, ideally, toward health. Biomedicine defers this answer to science. Spoken in the parlance of pathogens and antigens, the explanation is depersonalized, translated into a language that is not of the masses, but instead of the highly trained and specifically educated. Local medical systems seek their own, arguably more proletarian, answer to the question of causation. In Kuwdé, as in many West African societies, the Kabre look toward “witching” to explain *why* a disease would strike, establishing causation and responsibility. Evans-Pritchard’s seminal text on witchcraft among the Azande linked witchcraft to questions of causation, jealousy, circumstance, and coincidence (Evans-Pritchard 1937). And as Scheper-Hughes notes, “witchcraft and sorcery accusations and illnesses are invoked in many parts of the world to correct ailing social relationships” (Scheper-Hughes, 233). For the Kabre, witchcraft domesticates the mystery of causation, placing it within a social domain. In relation to medicine and the body, the explanatory model of witchcraft provides answers that biomedicine can’t, navigating the limits of science.

In Togo during December 2012, I witnessed the invocation of witchcraft in the face of illness right in my own host family’s homestead. Kouwénam’s daughter, Elli, a bright 11-year-old with a usually sunny and cheerful demeanor, began to exhibit troublesome symptoms several months before my arrival. She had trouble walking – her balance was off, and often she would stumble, fall, or limp. At times, according to her

mother Tikénawe, she had trouble producing language; it appeared nonsensical or broken although she could still comprehend the words of others. On several instances, I saw her hands and limbs tremble erratically; often she would fiddle to mask it. Due to her symptoms, she was not attending school – a shame as she was one of the best-performing students in her year. Kouwénam first took Ellie to a biomedical hospital in the village of Pagouda to run tests and analyses. After blood tests returned normal, Kouwénam took Elli to several *charlatans* (diviners) in Sokodé, Farendé, and Tchikawa. In each case, they heard the same message: “someone wants to do her in.” The message held undeniable allusions to witchcraft and spiritual enmity. But what is more, the mal-intent of the spiritual work, according to the diviners, was *not* due to Elli’s wrongdoing. Rather, they told Kouwénam that several people were jealous of him, and hurt Elli in his stead. Elli bore the physical brunt of Kouwénam’s relations. This scenario epitomizes the Kabre philosophy that one’s bodily boundaries – the consequence of their being – is not constrained to the physical self. They extend to one’s progeny, one’s life force. This extension is not one-way; Kouwénam attributed some of his own physical malaise to the fact that he carried his daughter from village to village to seek help, emerging empty-handed and fraught with the message of witchcraft. I posed the question to Kouwénam: “If you take Elli to a biomedical doctor and she recovers fully, could the disease still be spiritual, or related to witchcraft?” Kouwénam answered, “Yes, the *cause* could still be spiritual.” His emphasis implied that causation – and its lingering spiritual effects – might stand apart from the physical manifestation of the disease. Such

implies that a biomedical treatment may not heal the underlying spiritual discord, indicating only a partial sort of healing for the Kabre.

Such is not to say that the Kabre attribute *all* ills to witchcraft. Still, as in Elli's case, the distinction in practice often defies strict delineation. While slippage between the natural and spiritual lies inherent to Kabre etiology, Kabre medicine relegates these questions to certain systems. In fact, most Kabre I spoke to took care to distinguish whether they sought the care of a *guérisseur*¹⁶ or a *charlatan*¹⁷ in certain medical cases. In my conversations with Jespér, Kérékou, and Henri, all indicated a "line in the sand" drawn between the house medical system and divinatory or witchcraft healing methods, which are often lumped into the domain of the *charlatan*. The HMS, by contrast, is based upon relationships – between people, villages, and histories. While the subject of witchcraft and divinatory healing practice in Northern Togo is extensive and telling in its own right, I bracket it here, as it is largely peripheral to the object of this thesis.¹⁸ Henceforth, the HMS will serve as our unit of analysis. Having explored the multifarious ways in which the Kabre body is locally experienced and constructed, we are now ready to inquire how the HMS works on Kabre bodies – in both material and social ways.

¹⁶ Healer; one who treats an ill person without clairvoyant communication with spirits.

¹⁷ The term "charlatan" in this context connotes spiritual healer, one with clairvoyant communication into the spirit world. It does not, for the Kabre, carry the negative connotation held in many Euroamerican circles (ie. Swindler, quack, or fraud).

¹⁸ This bracketing does not entirely exclude the spiritual; as will become evident, the relational and natural are shot through with spiritual invocation.

CHAPTER 2: RELATIONALITY

The House Medical System as Relational Practice

On a walking tour of several house medicinal plants surrounding the village, Kérékou, a healer and *chef du quartier*¹⁹ of Kuwdé, noted, “Three things grow here. Crops, trees, and medicines.” “We do not cultivate medicine,” he added with emphasis. For a community of some of the most skilled and able-bodied cultivators in Togo, it may come as a surprise that remedies, unlike crops, aren’t grown for subsistence. These “wild” plants are also distinguished from weeds, which the Kabre meticulously remove by hand from their fields. The land is, in essence, a verdant pharmacopeia.²⁰ That medicines grow uncontained and “wild” is a symbol of their potency, especially in a community of cultivators.

Just as the Kabre orient to the land as a garden of medicines, they are similarly oriented to which houses in the village cure which ills. Ask any member of Kuwdé which house medicines belong to which houses, and with little hesitation for recall they will quickly generate a list. For instance, members will say: “If you have swollen glands or difficulty swallowing, you must visit the house of Sandi for his medicine; if you are struck by *le maladie rouge*²¹ you go to the house of Pikam. If you have come into contact with a corpse, you go to Kouwènam’s.” Familiarity of the location and distribution of certain

¹⁹ Chief of a cluster of homesteads within the village of Kuwdé

²⁰ Yet the herbs invoked in house medicine treatments aren’t all available in the immediate vicinity of the village. As in the case of Tikénawe, many specialists and their families travel several kilometers to procure certain plants specific to a remedy.

²¹ Redness/rash on the skin

remedies within Kuwdé seems as naturalized as the network of paths connecting homesteads.

The house medical system (HMS) is structurally and functionally organized based upon Kabre principles of relationality and complementarity, such that it performs social-relational work at the regional, village, and family levels. The act of health-seeking within this system orients the health-seeker to their relative place within the village, the family, and the ancestral lineage. This social orientation forms the identity of a patient's body within the context of village community. Furthermore, the delegation and passing-on of medicines also requires Kabre to actively negotiate their relationships and comportment within the family. Embedded within, remedy payment practices illustrate a negotiation of relationships not only with the healer (who provides the medicine) but also with the ancestors, from whom the remedy knowledge originates. As such, falling ill is not an anomaly experienced by bodies in isolation, but an experience tightly interwoven with social life. By seeking a return to health, the Kabre person must navigate and negotiate relationships with both their own bodies and with other Kabre.

HMS: Mapping a Relationally Organized Medicine

Hardly arbitrary, the specific pairing of house with medicine is precisely articulated, with emphasis on complementarity between parts. Fundamentally, this distribution follows the clan and gender hierarchies of Kuwdé.

Village and House Hierarchies

When I asked my subjects to recount a list of house medicine distributions among the village, I was repeatedly struck by the way in which a certain few remedies and houses always came first. The remedies for more grave illnesses (ie. infertility, *kotong susoko*, snakebite, etc.) get assigned to more ceremonially significant houses. This purposeful and articulate assignment reflects and reproduces village hierarchy. Though access to the treatment system may be available to all, specific knowledge of how to invoke and apply a treatment remains intensely secret, the property of its particular homestead.

Whereas *charlatans* Hamidou and Kérékou said that their remedy knowledge could be given to someone outside the family, house healers keep remedies strictly within the family. Such domaining gestures to Kabre deference to houses and families as entities. As Kouwénam explained to me, “The family *owns* the medicine. And one person within the family has the *right* to treat with it.” An HMS medicine will not work correctly if, for instance, someone outside of the house tries to treat someone with it. Attempting to do so could have disastrous consequences; according to Henri, “it can create spiritual...even physical...side effects.” Fear of such side effects and consequences presumably keeps remedies within the domain of their “house.” Furthermore, each healer I spoke with resoundingly echoed one central feature of the HMS: “the father passes the remedy to his son.”²² As Jespér explained, “The child who receives the medical knowledge is *chosen*. He is normally the most curious child in the house, but

²² Some remedies are passed to female members of the homestead; this is at the father’s discretion. Indeed, Tikénawe learned several medicines from her father which she currently uses.

also the most respectful.” Jespér emphasized *respect* when asked how the child inheritor gets selected. Respect for the healer role reinforces the importance of reverence to one’s father/ancestor, rewarding the good behavior of progeny.

While intensely hierarchical in many respects, the diffuse distribution of medicines among houses in Kuwdé also operates on principles of complementarity. The very fact that medicines are distributed in the first place, rather than concentrated in one or two key homesteads, is telling. As Kouwénam informed me, “Each house carries, at most, two to three house medicines.” This principle harkens the notion of health as the business of the village; the whole (village) is necessary to heal the part (individual’s body). Furthermore, to treat the *entire* body relies upon a concerted effort from multiple houses that make up the village.

This phenomenon of attaching remedies to houses based on their hierarchical and relational importance raises a paradox. Are remedies merely slotted in to a pre-existing clan system? Or does having certain types of disease assigned to certain houses boost the significance of those houses? Chapter 3 will more thoroughly tease apart the power dynamics at work within this system. For now, the answer exists perhaps somewhere between these two questions, with a circular and self-iterative basis. While the relative significance of homesteads within Kuwdé depends on forces outside health and medicine (ancestral histories, etc.), the house medical system continually produces and reiterates relationships of hierarchy and complementarity within the village.

Gendered Relations

The village of Kuwdé is divided into two gendered clans – the male and the female. “Male” and “female,” in this context, do *not* refer to sexual gender; both clans consist of male *and* female members.²³ Rather, this division is a cultural one tied to ancestral and spiritual histories. By virtue of their attachment with specific houses, diseases and medicines themselves also get assigned positions within the Kabre gendered clan system. Two remedies in particular reinforce the gendered identity of their homestead within the village: the treatments for infertility and snakebite, which rest in key houses of the female and male clans, respectively. In the process of seeking remedies, the Kabre are implicitly interpellated within the gendered organization of the village. In this sense, the house system of medicines works to reflect and echo house identity within the gendered clan system. Furthermore, the remedies themselves directly (and more materially) invoke the sick person’s body in a way that enacts and defines gender.

Infertility

Perhaps the gravest of bodily ills within Kabre culture is the inability to conceive and produce a child. The production of life vitally perpetuates the house and clan. Couples unable to birth a child are considered ill with *kokode kotong*, or “disease of the womb.” They seek to reverse their infertility by visiting the homestead of Pokare, one of the highest two houses within the female clan. According to the healer Pokare, infertility, or *kokode kotong* strikes a couple, not solely the husband or the wife. This

²³ As explained in Chapter 1, gender for the Kabre is a performed, rather than naturalized, category.

dualistic notion of disease sharing, as a product between two people—not unlike offspring—is inherently reflected in the house medicine treatment itself. A translated account from Pokare:

The woman comes in the middle of the night to get the medication. The medicine has two parts. She drinks the first medicine. Then, she covers her skin with the second. The woman covers herself with a *pagne*²⁴ and stands over an open fire. The fire, along with the medication, goes into her body. The next day, she and her husband drink the first medication again. If the treatment does not work, the couple is truly infertile. Or, the *warito* may accept or refuse treatment.

- Pokare

The remedy itself is ripe with symbols of reproduction. By standing over the fire, the medicine enters “into her body;” the mechanism for the medicine’s delivery alludes to insemination. If upon visiting Pokare the female regains her fertility and successfully gives birth, Pokare, rather than the woman’s husband, is considered “father” of those children. They even call him “father” by name. Such a practice harkens the extended philosophy of person and body discussed in Chapter 1. Births, like bodies, are relational phenomena, rather than strictly biological. With a laugh, half jokingly but with an undertone of seriousness, Pokare remarked upon the fact that he had “so many...hundreds of children” throughout Kuwdé, Farendé, and other surrounding villages. Read in the context of the medicine’s delivery ritual, it is as if Pokare himself, or as a vessel of the gendered power of his house, acts to inseminate the female. By restoring her capacity for childbirth, he is dually restoring her ability to become a productive member of Kuwdé, actively populating the village. Reference to Pokare as

²⁴ Cloth skirt worn by females throughout Togo.

“father” hails, in an Althusserian sense, not only the medicine, but also the house itself, affirming its potency in the female clan.

Pokare’s account provides its own reference to work (“If the treatment does not *work*, the couple is truly infertile”). Yet work here is defined by its antonym: the continuation of the ill (infertility). By “working,” Pokare’s remedy is restoring gender to the bodies of both the man and the woman: their ability to produce offspring. Why is it necessary for gender identities to be reinforced by Pokare’s treatment? And why is such careful attention given to the performance involved in applying the remedy? According to Piot, there exists a “power and efficacy” to Kabre public ritual, such that “through ritual, identities and relationships are made known, ‘visible,’ and thus real, to others” (Piot 1999: 77). Gender, for the Kabre, is repeatedly performed and asserted; its biological evidence alone does not suffice. Remedies within the HMS, like Pokare’s infertility medicine, act on bodies that must assert their gender through activity; the very act of taking a HMS medicine mirrors and facilitates such an assertion.

Snakebite

As mentioned in Chapter 1, the house of Sam, head of the male clan, holds remedial knowledge for the treatment of snakebite. Though not explicitly stated by those whom I spoke with, one could infer that the entrustment of the snakebite remedy to Sam’s house was no coincidence. Snakebite happens to men more than women – when men are cultivating in the fields – to say nothing about the way in which snakes are phallic symbols in Kabre culture and folklore. Thus it follows that the power of the male clan must be invoked in order to expel poison and heal. The ceremonial payment

structure, where the victim of snakebite gives thanks for the medicine, also invokes gendered performance. Sam outlines a facet of this payment:

You must cut the outside toe of a female chicken, take the blood, and put it on the foye where the woman cooks. If the bitten person is truly good, the chicken will live a long life and give many eggs.

The invocation of the female – the female chicken, blood, the act of cooking, and the production of eggs – is itself rich with symbols of fertility. By performing this rite, the snakebite victim makes publically known the restoration of wellness and return to production.

In addition to successfully expelling the venom and healing the bite itself, Sam described a second effect of the remedy: “the snake (that bit) will die if you place the medicine on the bite.” This added dimension exemplifies the symbolic power of the healing ritual. Indeed, the snake’s death is more symbolically understood than physically enacted. More often than not the snake’s physical carcass never gets recovered, assumed to have died in the brush. This requires a dimension of belief in the healing process; a Kabre entrusts a certain measure of belief in the power of the male clan – and Sam’s remedy – to affect something they may visibly “see.” In “The Sorcerer and His Magic,” Lévi-Strauss illustrates the centrality of *belief* in symbolic healing, outlining three essential and complementary conditions:

First, the sorcerer’s belief in the effectiveness of his techniques; second, the patient’s or victim’s belief in the sorcerer’s power; and, finally, the faith and expectations of the group, which constantly act as a sort of gravitational field within which the relationship between sorcerer and bewitched is located and defined.²⁵

²⁵ In this context, “sorcerer” is taken to mean healer and “bewitched” to mean the ill or sick person.

Here, we see effectiveness and work of the sorcerer's magic (read: healing) centrally linked to a sense of group faith. By seeking a restoration to health from Sam's house, the victim is dually endorsing and vesting their belief in the potency of the male clan to heal snakebite. Indeed, belief is an integral element of the social. This facet of Sam's remedy reiterates that health and illness, for the Kabre, are things that occur between—rather than just within—people and bodies.

Other Gendered Remedies

While the remedies for infertility and snakebite provide prime examples for the gendered allocation of medicines to Kabre homesteads, gendered placement of house medicines extends further. In addition to infertility, Pokare's house also treats a serious malady that strikes children, characterized by episodes of seizing and referred to as *sumura kotong*, or "bird disease." As child rearing in Kuwdé primarily falls within the domain of the mother, or related females, it seems logical that the remedy would reside in a female clan house.

The homestead of Kouwénam, another important house within the female clan, owns the remedy *hilum kori*, or "wind medicine." According to Kouwénam, *hilum kori* treats a Kabre illness that strikes those who take care of the ill:

The wind carries the stench of the ill person's body, and you cannot hold your stomach. You cannot eat well; you have no appetite, you have intestinal discomfort, indigestion, vomiting, and nausea. This remedy gives you back your appetite.

-Kouwénam

In Kabre culture, the women are entrusted with the role of caring for cadavers, or drying bodies. Like *sumura kori*, *hilum kori* provides another instance incurred by those implicated in caregiving, the female, and thus must only reside in a female clan house.

Giving Thanks to the Ancestry: Negotiating Relations with the Deceased

As opposed to a commoditized pay-for-service system like we observe in biomedicine, money is not the central form of payment in the HMS. Instead, payment closely mirrors Kabre ceremonial ritual, with nonmonetary forms such as animal sacrifice and *sulum*²⁶. HMS payment schemes are carefully articulated. Just as each remedy is unique – with its own specific herbal and performative constituents – so is each payment. Remedies commonly involved animal sacrifice. Each healer carefully specified the animal type pertaining to their medicine (chicken, hen, pintade, goat). The healer would also identify the animal's appropriate color (red, black, or white). Or, they would identify the number of *sulum* calabashes (often one for the sick person and one for the healer). In the rare cases in which healers do accept money as payment for a remedy, this is often only in order for the healer to purchase the necessary ceremonial objects or the requisite number of *sulum* calabashes.

Whereas in biomedical practice we assume that we pay for the practice itself – as delivered by the practitioner – payment within the HMS targets a decidedly different benefactor. Rather than directed toward the healer, the payment acts as a symbolic gratitude to the ancestor (deceased Kabre) from whom the remedy itself originated.

²⁶ Kabre beer, a common ceremonial drink

Such symbolic gratitude, detached from monetization, echoes what Piot observes in other forms of Kabre exchange: “(the) monetary nature of the gift defeated the whole aim of...sacrifices...spirits would simply ignore them. ‘The powerful spirits need to see an effort, a display of will/desire from the members of the community’” (Piot 1999: 150). While money is a coveted – and often rare – object in Kuwdé, the context of the HMS limits its work and efficacy. Currency does not suffice to express community will or desire.

Furthermore, whereas upfront payment usually comes as a prerequisite for biomedical care, payment in the HMS generally occurs *after* a treatment “works” or is deemed efficacious. In fact, Jespér called healers who demand payment upfront, “kooks, not true healers,” implying that they would use the money themselves instead of for the ancestor. However, some healers adapt their practices, particularly in the wake of increasing usage of biomedicine²⁷. For instance, Pokare has recently begun to demand upfront payment for his services. He decided to coerce payment after several instances in which people failed to pay, and he was forced to purchase the requisite sacrificial items with his own money. In fact, Pokare now refuses to treat those who have not paid; he cites this as an ultimate sign of disrespect for the remedy. Pokare thus illustrates how some healers adapt long standing “traditional” payment practices to changing “modern” fiscal demands; there exists no hard-and-fast rule by which all healers abide.

²⁷ I will further explore this theme in Chapter 4.

Whether upfront or after the fact, payment within the HMS offers a way for Kabre – both patient and healer – to negotiate their ongoing relationships with the deceased, yet still metaphysically present, ancestry. In a similar vein, Kabre always symbolically toss the final dregs of their *sulum* on the floor of the homestead, a gesture to feeding the ancestor. By “sharing” a drink between healer, sick person, and ancestor, their bodies and identities are marked as linked. The healers Kérékou, Kouwénam, Jespér, and Pokare all heartily emphasized that failure to deliver proper payment for a house medicine would, in turn, result in the failure of that medicine. In this sense, the payment schemes of the HMS serve as a socialization tactic, imbuing the importance of maintaining good relations with the spirits and ancestors. It is also, arguably, a way in which the Kabre defy or reject the commodification of their medical system, which I expand upon in Chapters 3 and 4.

Outside the Village: The HMS and Regional Relationships

While most of the interviews and observations informing this fieldwork took place in the village of Kuwdé, the house medical system itself (as a system of distribution and organization of remedies among houses) spreads beyond the confines of a single village. Indeed, the tendency to divide geographic space into neatly contained units remains a legacy of colonial times. Just as Kabre kinship structures and histories in Northern Togo span villages, the HMS echoes, extends, and reasserts itself across these imaginary borders.

Sam's snakebite medicine provides one example of this phenomenon. Unlike most house medicines, the remedy for snakebite did not originate in Kuwdé. Rather, Sam's older brother, Kokou, learned the medicine from a friend's father while in high school in nearby Ketao. Kokou then brought the remedy back to Kuwdé and into the homestead, where it became the domain of his family and his own father. It is significant that Kokou was entrusted the remedy by a close friend rather than an informal acquaintance. According to the guerrisseur and diviner Kérékou, "knowledge of the remedy rests in the house, but *can* be disseminated if someone demands or requires it. Still, the healer has discretion as to whom he teaches. That person then must return to thank and pay him." This phenomenon of medicines *moving* between villages and people as forms of knowledge practice illustrates the fluidity and translocal nature of the house medical system, and of life more generally among villages in Northern Togo. Just as people and goods move between villages, so do medicines. Villages as social structures do not operate in strict isolation; Kabre medical systems do not, either.

On another level, the HMS mirrors the power dynamics and hierarchies of the mountains and plains villages, steeped in histories of migration and resettlement. Neighboring villages (Faren, Farende, Kawa, Tchikawa...)²⁸ have their own remedies scattered among houses. These other house medical systems are not mere carbon copies of one another, nor mutually exclusive. According to Jespér, Faren has some

²⁸ In the region of Northern Togo where the Kabre originate, the mountain villages (Faren, Kuwdé, Wasilao, Asiri) are considered the original communities. In search of soil less rocky and friendlier to widespread cultivation yields, some Kabre spilled down from the mountains into the plains over centuries. While now recognized as villages in their own right, these plains villages (Farende, Tchikawa, Kawa) still defer to the original mountain villages as the seat of tradition for ceremonies, burials, and other rituals.

remedies that Kuwdé doesn't, and vice versa. Thus, someone who is sick in Kuwdé will travel to Faren or Wasilao to seek a remedy that cannot be found in her own village. If a house becomes empty (by circumstances of death or marriage), the Kabre will look around the villages for another house closely related, to which the medicine would then be transplanted. In this sense, the geographic distribution of HMS remedies among the mountains and plains of Northern Togo reinforces the relationships between and among not only Kabre people and houses, but villages too.

Performing Relational Medicine

One morning, upon waking, I walked into the homestead courtyard to see Tikénawe tending to a large pot on the hearth. When I asked what she was cooking, she responded that it was not food, but a medicine intended to treat her infant granddaughter Clementine's skin rash. The courtyard and kitchen are centrally and publically placed, visible to all and often a site of gathering for visitors. Tikénawe's public preparation of a house remedy can be read as a sort of performance, and an indication of the ways in which house medicine is domesticated and proletarianized. As further evidenced by Pokare and Sam's careful specifications of remedy preparation and application rituals, healing is a performed activity. Performed activities are inherently social activities. As such, production of medicines in Kuwdé does not always happen behind closed doors.

If performance is indeed central to the production of Kabre bodies and relationships, then we must inquire whether the HMS itself enacts performance. As remarked upon in Chapter 1, entwined relations blur the boundaries between physical

Kabre bodies; the acts of one person can have visceral consequences on kin or neighbors. The *kotong susoko* funeral ceremony perhaps most resoundingly exemplifies health as the business of a village. Part of the HMS, it illustrates centrality of performance to the work of local Kabre medicine. Consider Pascal Kei's account of the ceremony:

If someone dies of *kotong susoko*, a special ceremony occurs. This funeral must take place on a Wednesday, no more than three weeks after the death. The dead, naked body is placed on (a stretcher of leaves). It is not placed in a coffin. The corpse enters the homestead over the wall, not through the entrance of the homestead like a traditional burial. The body is then taken to a separate grave; it does not go to rest in the houses' tomb with the other ancestors. That is because this is a very shameful event. Even if you are wealthy and have a lot of money, it does not matter. This is not an honorable death. After the death, you must put all the (dead person's) belongings in the middle of the homestead and burn it. Even their money, even their children's belongings.

Pascal goes on to describe the roles of those who attend the ceremony, which usually consists of the entire village:

Before people come to observe, the ceremony leader or healer will retrieve the herbal product. The product (remedy) goes into the *sulum*, and everyone who attends must drink it, for protection. There is no dancing, no joy; this is a diabolical and shameful malady.

I had heard word of this preventive performance – the treatment of all those in the community upon a death from *kotong susoko* – from Kouwénam weeks earlier:

If someone dies of *kotong susoko*, everyone in the community gets treated. You drink the remedy from *sulum* on the day of the funeral; there are two calabashes – one for the men and one for the women. When people return from the burial, they cleanse their bodies by putting the remedy on their chests and backs.

- Kouwénam

Bokota Germain, whose house performs these funeral ceremonies, added, “the whole *quartier* (neighborhood) should attend the ceremony, to ensure that they avoid the

malady and prevent it from continuing.” Thus, this protective remedy functions *trimodally*: through ingestion (internal), washing (external), *and* collective application (communal). In this sense, the body is protected both inside and out. But perhaps more notably, the village *shares* in this collective action, a necessary stipulation presumably crucial to the remedy’s effectiveness. This illustrates the extent to which Kabre medicine treats *both* the individual and the community. The imperative – that full protection and absolution of the illness requires the presence of all neighbors – dimensionalizes the community-focused nature of this performance.

Performativity at an individual and systemic level thus resides at the core of HMS work. The performance of medicine continues to serve a useful optic as we move into Chapter 3, particularly when we discuss medical practice as a disciplinary technique. Indeed, as iterated earlier, performance as a social activity also functions as a method of socialization, nested in dynamics of power.

CHAPTER 3: POWER & BIOPOWER

Reading Foucault in Northern Togo

Invoking the theory of biopower to analyze a “traditional” African healing practice may initially seem counterintuitive. Michel Foucault coined the term “biopower” in reference to a decidedly Eurocentric historical shift from the 17th to 18th centuries, in which the biological moved from the purview of the sovereign to the object of State control (Foucault 1976: 240). Along with this shift in governmentality, power transformed from the sovereign’s “old right – to take life or let live” to the State’s “new right... to make live and let die” (Foucault 1976: 241) As such, biopower is (traditionally) tied to the discourse of “modern” or Western statecraft. In Kuwdé, as in much of Northern Togo, the state is more absent than present, and its provenance is only 100 years old. Furthermore, as the very title *The Birth of the Clinic* suggests, Foucault focused his analysis on a clinical space as a site of power through which doctors, patients, medicines, knowledge and pain move. In the House Medical System, the “clinic” is the entire village, the hallways of the hospital the pathways from homestead to homestead, the “doctors” and “patients” simultaneously neighbors and kin. Of course, this analogy between Foucault’s clinic and Kuwdé’s House Medical System hardly enables a one-to-one mapping. We must caveat the complete transposition of Foucauldian theory onto the HMS and honor the historical context from which it was birthed. Even so, if life, death, and health in Kuwdé are indeed the business of a village, as the HMS suggests, then the notion of biopower may not be as irrelevant as first glance suggests. In fact, Foucault’s theory of biopower provides a useful optic for the

unique sort of work performed by the HMS: the positioning of the “biological,” or individual yet relational, Kabre bodies within the tacit power of the village, all through the language of health and disease.

Why a discussion of power in the first place? As demonstrated in Chapter 2, relationality and hierarchy within the village subsist upon power dynamics. To speak about efficacy is also, inevitably, to speak about power. Laguerre even suggests, “the status of ... knowledge...relies *more* on questions of power than on standards of truth and effectiveness,” gesturing to the essence of power in constructing knowledge practices (Waldram 2000: 617, emphasis added). But perhaps most pertinent to the discussion at hand, one cannot extricate medical systems from the discourse of power. Indeed, the legacy of Foucault’s biopower vastly influenced subsequent work in health and medicine studies, often termed the ‘Foucault effect’ (Bunton & Petersen 1997: 1). Still, the direct application of his work to local medical systems remains limited.

This chapter advances the argument for expanding and rethinking the discourse of efficacy and traditional practice. Relegating biopower solely to Western political contexts and biomedicine perpetuates Euro-American medical discourse, a shade of medical paternalism or medical colonialism itself. That is, it propagates a relationship of inequality between the biomedical and local practice, often in masked ways. This limits our consideration of the work a local medical system may perform. This bracketing also promulgates the traditional/modern dichotomy that plagues many medical anthropology studies of local systems, the same Stacy Leigh Pigg grapples with in her ethnography of villagers’ beliefs in Nepal (Pigg 1996). In order to decouple and detangle

this dichotomy, we must push the boundaries of theory and discourse used to discuss power. Conversely, if we neglect to undertake this exercise, we risk widening the gulf between the biomedical and local.

Indeed, as Bunton and Peterson impart, “with Foucault, as with Marx and Nietzsche, the point is not simply to interpret his work but ‘to use it’ (Rajchman 1995)” (Bunton & Peterson 1997: 2). Here, Foucault offers us a lens into the Kabre HMS. Using this lens accords with Foucault’s own imperative to challenge the “for-grantedness” of the present moment. The assumed incompatibility of Western power dynamics in a primarily subsistence agriculturalist community like Kuwdé is overwhelmingly taken “for-granted.” In addition to calling into question the micropolitical ways in which the HMS exerts power within the village, we must also envision the HMS as an agent in macropolitical power dynamics. As such, this chapter interprets the House Medical System as an informal and improvisatory form of biopower. Situated in the current moment of Togolese statehood and transnationalism, I ask: How does the biopower exerted by the HMS allow a Kabre ethnicity to retain its integrity and assert its autonomy? What forms does power emerge from within the HMS? And how does it exert power – through what methods of socialization or normative coercion? What agents are invested in this power dynamic?

The Management of Populations

The central tenet of the historical shift in power, for Foucault, hinges on the governing of populations – from “mak(ing) die” to “mak(ing) live.” For Foucault, the population is the “natural object” of power, “with behaviors that must be observed and

protected.” (Hengehold 2009: 12). Medicine serves a fitting stage for population management, positing individual bodies in relation to their larger social superstructure: “medical knowledge mediates between the order of the body and the order of society” (Mol 2002: 60).

Whereas Chapters 1 and 2 explored the order of individual bodies within the scope of embodiment and relationality, here a Foucauldian focus on “populations” enables a deeper understanding of the ways in which the HMS governs a population of Kabre bodies. In this context, avoiding a discussion of French colonialism in West Africa would severely hinder our understanding of biopower. European colonialism not only divided the continent into countries, but also spawned the creation of “the village.” These villages materialized populations, forming administrative units from which the colony could extract labor and fiscal profit. Even the name “Kabre” was borne out of French colonial times; Kuwdé did not exist as a defined space before the arrival of colonialism in Northern Togo (Piot 1999). As such, the house medical system itself, organizationally and materially, did not exist before colonialism. This presents a quandary when we categorize HMS practice as “tradition” steeped in timeless “indigenous” practice. Historical context illustrates that Kabre did not exist outside the exercise of biopower in the colonial moment. Thus its application here is not only legitimate, but centrally relevant.

Within the HMS, all are complicit in producing the health of the community and life of populations. Managing populations not only refers to practices on the micropolitical village level, but also with respect to macropolitical regional and national

interests. We consider both levels of biopolitical “work” subsequently.

Normative Coercion

Biopower manages populations principally through normalization – that is, establishing the normal from the abnormal, or the healthy from the pathological. The maintenance of social order subsists upon this juxtaposition. For Foucault, the normalized “self” emerges – and gets continually produced – through “disciplinary technologies”:

Institutions are coercive in the sense that they discipline individuals and exercise forms of surveillance over everyday life in such a way that actions are both produced and constrained by them. However, (they) are not coercive in the violent or authoritarian sense because they are readily accepted as legitimate and normative at the everyday level. [Turner 1997: xiv]

The language used by healers to describe the roles of the ill within the HMS healing process directly reflects such rhetoric of self-discipline and normative coercion. According to Henri, “House remedies have many rules. The sick person must respect them. Healing demands concentration, an interest to be willing to work.” Storytelling and illness narratives, particularly descriptions of causation that implicate the social and metaphysical, position the body in terms of moral obligations, ethical codes, and values.

Still, built into the very framework of Kabre etiology, and iterated by the healers with whom I spoke, the ill person remains an agent. No authoritarian “coercion” obliges people to use the HMS; no mandate or decree exists. Some choose to visit the clinic before consulting an HMS healer, or perhaps even at the same time. This practical departure from rigid systemization lends the illusion of agency and also parallels the

nuances of normalization described by Foucault:

Foucault's doctors do not control. They neither oblige people to stay in bed and get better nor get up and go to work again. Instead, they set the standards of normality. [Mol 2002: 57]

For Foucault, "power" was a departure from sovereign kings throwing mandates on the masses from high atop their thrones. By contrast, its operation was far less obvious and apparent, even characterized by a measure of invisibility (Hengehold 2009). One of the more noticeable nuances is Foucault's emphasis on *action*. For Foucault, power was, "a mode of action that does not act directly and immediately on others. Instead, it acts upon their actions; an action upon an action, on possible or actual future or present actions" (Foucault 1994: 236). Whereas "making die" required a far more transparent and directly violent act on behalf of the sovereign, "(Foucault's) power relations...give the impression that the directed party chooses actions freely" (Hengehold 2009: 9) Action, navigation, and movement within the HMS is similarly constituted. The apparent agency of the sick person is maintained; they are not "required" by a healer to follow a remedy, although it is implied that they *should*. The most obvious implied consequences of not doing so are failure to return to health and unmended relationships. All the while, the relational work of the HMS, both positive and negative, exerts a quiet but present power.

Power and (Remedy) Knowledge

The popular adage "knowledge is power" perhaps found inspiration in Foucauldian theory. But for Foucault the relationship between knowledge and power is far more nuanced than such a causal statement implies. According to Turner, "Foucault

saw that power and knowledge were always inevitably and inextricably interconnected so that any extension of power involved an increase in knowledge and every elaboration of knowledge involved an increase in power” (Turner 1997: xiii). Owning or having in one’s domain medical knowledge of a particular treatment in the HMS is, then, both a manifestation of power and a boon to further power.

In Chapter 2, we drew attention to the entwined relationship between Kuwdé house/clan hierarchy and the purposeful assignment of medicines to particular houses. We raised the question of whether remedies are merely slotted into a pre-existing clan structure, or if the assignment of certain remedies to houses boosts their importance within the village. We now return to this question. Under Foucauldian analysis—and to speak the parlance of Victor Turner’s liminality—the answer lies “betwixt and between” (Turner 1967). The relationship between power and knowledge is (re)iterative. As commented throughout this work, the physical act of health seeking within the HMS continually reminds houses of their attachment to remedies, but also to their role, identity, and place. Hierarchy is performed every time someone in Kuwdé falls ill. For Kabre, there is nothing worse in a woman’s life than being unable to have children. When a woman seeks a cure for infertility from Pokare’s house, that house is *performing* its power and importance. If rank or power within Kuwdé was defined and asserted in merely abstract discourse, it would quickly be forgotten. The system perpetuates itself as long as people fall ill and continue to utilize it; house power is self-fulfilled circularly. One could even posit that disease *itself* produces hierarchy within the village.

To gauge the extent of this (re)iterative dynamic, Foucault studies the everyday

and seemingly mundane. As Bryan Turner remarks:

Foucault saw power as a relationship which was localized, dispersed, diffused, and typically disguised through the social system, operating at a micro, local, covert level through sets of specific practices...Power (for Foucault) is rather like a colour dye diffused through the entire social structure. (Turner 1997: xii).

Medical sociologists adopted his theory of dispersion and diffusion to envision medical power as embedded in daily practice, rather than an institutionalized and mandated set of operations (Turner 1997: xiii). With this approach in mind, the HMS serves a fitting stage to inquire into the micropolitics at work that position bodies and houses in village power relationships.

My conversations with several Kabre echoed this diffusion, embeddedness, even covertness. Upon my return to Kuwdé in December of 2012, I shared with Jespér my observations of the seemingly gendered distribution of medicines, along with the attachment of more grave illnesses with particularly powerful houses. I then asked him whether there exists a logic behind this pairing. He agreed that my observations implied a relationship between remedy type and gendered house identity, but to my question responded, "I am unsure." Kouwénam and Henri, when asked the same question, offered similar answers: "I have never thought of it that way." In the practice of fieldwork, "I am unsure" yields delicate ground for the anthropologist to tread. On the one hand, the anthropologist must take care not to superimpose or project meaning where it is not locally given. On the other, the *unknown* can indicate as much as the known or verbalized, a hand on the pulse of the "for-granted."

In this instance, Jespér's unfamiliarity with framing and positioning the system as such is telling. It echoes the very subtlety and disguise which Foucault terms as power.

The possible explanations for such unsuredness are myriad. It could simply be that the distribution is so taken-for-granted that it is not consciously known or remarked upon. Or, the intricacies of remedy-house pairings could be the domain of a select few powers-that-be (heads of clans, etc), such that the underlying logic may not be obvious to all. In any sense, this *unknowing* affirms the HMS power relations within the Foucauldian purview of biopower: not explicitly stated or obvious, it works in quiet and seemingly naturalized ways. Knowledge – and sometimes its apparent absence – becomes in this case not only a product but also a producer of power.

Tertiary Spatialization and the HMS

Although most Kabre do not explicitly articulate the practices of distribution and power within the HMS, such does not imply these practices are completely abstract and immaterial. Indeed, “medical knowledge...is material as well: a *discourse* that structures buildings, instruments, gestures” (Mol 2002: 61). Foucault’s notion of *tertiary spatialization* allows us to understand the social space in which medical knowledge operates and circulates. As Mahon explains, “(*tertiary spatialization*) is the locale where the micro-practices of the power axis are most clearly observed, where disease is inserted into social, political, and economic space...medical space ‘traverse’(s) and ‘wholly penetrate’(s) social space” (Mahon 1992: 46). *Tertiary spatialization* gives us a rubric for understanding the particular materiality of remedy distribution within the HMS:

Let us call *tertiary spatialization* all the gestures by which, in a given society, a disease is circumscribed, medically invested, isolated, divided up into closed,

privileged regions or distributed through cure centres, arranged in the most favorable way... the way in which a group, in order to protect itself, practices exclusions, establishes the forms of assistance, and reacts to poverty and to the fear of death. ... it is the locus of various dialectics: heterogeneous figures, time lags, political struggles, demands and utopias, economic constraints, social confrontations. [Foucault 1963: 16]

“Heterogeneous figures, time lags, political struggles, demands and utopias, economic constraints”...each speak directly to the Kabre House Medical System. *Heterogeneous figures*, in the sense that a healer is at the same time a cultivator, and a neighbor, as is the patient. *Time lags*, in the way which dead ancestors reassert their continued existence each time a healer invokes their remedial knowledge, defying strict laws of chronology. *Political struggles*, reflected in the Chef du Village’s effort to assemble an “Association of Healers”²⁹ as a professionalized establishment outside (and, presumably, above) the HMS. The harsh biological *demands* of one of the most disease-rife regions of the world; the elusive *utopia of alafia*. *Economic constraints* as healers grapple with altering HMS payment structures in the wake of more commercialized biomedicines. *Social confrontations* as relationships between husband and wife, or friend and neighbor, are called into question when the physical body swells (*kotong susoko*). Together, these dialectics constitute the tertiary spatialization of the HMS.

To contextualize the ways in which these play out on-the-ground in Kuwdé, the *kotong susoko* funeral ceremony serves a useful and concrete example. Detailed in Chapter 2 for its role in performing community health, this ceremony directly implicates social village values, imploring community members in Kuwdé to maintain good

²⁹ The Chef du Village’s “Association of Healers” will be explained and delved into further in Chapter 4.

relations and reminding them of their precarious vulnerability to social ills. “Exclusions” are made visible by passing the corpse over the wall of the homestead (instead of the entryway); the body (and person) is thus marked as dishonored and tainted. This metaphor of impurity is carried through by the requirement that burial-goers wash themselves with a remedy afterwards, freeing themselves from contaminants. By imbibing the remedy and sharing it with neighbors and kin, the group “protects itself,” as Foucault may imagine. In quite literal and visible ways, this HMS funeral ceremony circumscribes disease within Kuwdé social relations, rallying the community in a shared performance that acknowledges joint responsibility and vulnerability in the face of illness.

Ancestral Remedies as Heterochronies

Extending beyond Foucault’s theory of biopower, we also find that his study of space and temporality invokes parallels to the HMS. Foucault explored what he termed *heterotopias*: “cultural spaces” where individuals maintain, negotiate, and embody multiple identities “in materially significant ways” (Hengehold 2009: 11). He extends this theory of multiplicity to the temporal domain with a discussion of “heterochronies,” where “men arrive at a sort of absolute break with their traditional time” (Foucault 1986: 26). These heterochronies “bring together the perspectives of several temporalities or historical periods” (Hengehold 2009: 12). Such aberration from a strictly linear chronology of time embeds itself within the HMS and Kabre epistemology, namely through the invocation of ancestors in the healing process. Heterochronic analysis thus

widens the paradigm for efficacy, because if the Kabre envision temporality differently, this may provide challenges for a Western-imposed temporal structure within medical practice.

Implications for Efficacy

In his musings on the politics of “efficacy,” James Waldram poses a crucial question to our discussion:

If biomedicine has become inseparable from the state, as Kleinman asserts...then are medical anthropologists who examine the efficacy of traditional medical treatments through the use of biomedical concepts and measurements inadvertently serving the interests of the state and the biomedical system?
[Waldram 2000: 619]

Waldram’s question enforces the importance of an expanded notion of efficacy, one which originates outside a strictly biomedical paradigm. It also affirms the value of the theoretical exercise undertaken above. By acknowledging the ways in which a local system exerts its own sociopolitical power – we widen our conception the work it undertakes. Reading Foucault in Northern Togo becomes necessary in order to place the two – biomedicine and local medical practice – on equal footing. This prepares us for the subsequent chapter, at which these planes intersect.

CHAPTER 4: COHABITATION

Local Medical and Biomedical Confrontations and Negotiations in Northern Togo

Our discussion of the house medical system in Northern Togo is not merely an ethnographic case study of one local medical system operating in isolation, nor meant to be romanticized as a cultural artifact. It is also a stage on which a larger discussion circulates: how “traditional” healing practice gets continually appropriated and (re)defined in juxtaposition to the “modern” or biomedical. These questions are inevitable when biomedical clinics appear next to healer houses and people begin to navigate among and between systems, as in Kuwdé and increasingly throughout even the most remote regions of West Africa. A critique on the fixed notions of the work performed by medical systems would be incomplete without a consideration of larger-scale power dynamics through which they move. The task is now to widen the aperture, considering the work performed by the HMS as it interacts with state-delivered biomedical practices and the large-scale imaginaries of global health.

In this chapter I engage with the “global relevance” imperative of critical medical anthropology (CMA), expanding from a more local-specific ethnography to the global discourse of global health policy and biomedical intervention. In Chapter 3, we explored the ways in a local system may also enact power relations and work to organize and structure a community. Like the HMS, biomedicine is not immune from currents of power, positioning of relations, transmission of social values, or the operation of institutions. Given this, we are now equipped to place the HMS on the plane of

biomedicine, the sort of symmetrical analysis advocated by Allan Young (Lock 2010).

This practice is important for practitioners (both healers and clinicians), policymakers, and anthropologists alike, not to mention patients and families themselves.

As Feierman and Kleinman note, the challenge facing the field of global public health is “to build strategies that make local knowledge viable and salient in settings of policy and programme development, practice, and evaluation” (Feierman, et. al. 2010: 127). Here, I challenge the notions of viability and salience themselves. Hardly stable or universally agreed upon categories, both depend on *to whom* they relate. I will probe the prevailing assumptions made in interventionist global health pursuits that seek to extricate only particularly relevant elements of local systems – such as certain remedies or influential healers – out of their nested social context. I seek to unveil how these assumptions influence not only power imbalances among medical systems, but also the practice and experience of primary medicine on the ground. I end with an account of a conference held between biomedical clinicians and house healers in Northern Togo, which makes these lived tensions visibly evident.

Global Health and Efficacy: A Discourse of Metrics

If we consider the ways in which global health, global medicine, and the arrival of biomedicine operate in communities like Kuwdé, we see that they largely miss the point of a local system such as the HMS. Local systems encounter a burden of proof: to enact and assert “work.” But quite often, as reiterated throughout prior chapters, “work” gets tightly coupled with “efficacy.” Expanding the paradigms of “efficacy” and “work” requires awareness of the politics under which these terms are constructed and spoken.

James Waldram poses the question: “precisely *who* is authorized to undertake the assessment of efficacy?” (Waldram 2000: 613) In the field of global health, “efficacy” often gets placed in the purview of metrics – a measureable way to track the relative success or failure of interventionist policies. Indeed, statistical tangibility, as Foucault notes, is one of the ways in which the population is governed; statistics provide a standard of normalization to which cases and individuals are held (Foucault 1976). But a strict reliance on metrics and a quantification of efficacy can hastily obfuscate a more holistic understanding of a system’s purpose and function. Quantifying “efficacy” via metrics not only fails to capture the intricacies of the individual case, but also adheres to a narrow conception of healed-or-not. This yields epistemological problems, but also structural and logistical issues, which themselves contribute to health disparity.

This conundrum was evident on-the-ground in Northern Togo. As I spoke with the medical assistant Basile at the *case de santé*, he told me of a Swiss NGO’s policies regarding annual provision of malaria diagnostic tests in Kuwdé and Farendé:

Every year, the *case de santé* (in Kuwdé) is supplied with a certain number of diagnostic tests for malaria. But every year, at the beginning of the malaria season, the clinic runs out of diagnostic tests. Down the mountain at the CMS (in Farendé), there are a plethora of tests, extra even, which could be used in Kuwdé. But if the CMS were found to be providing the case de santé with the tests, their supply would be discontinued, considered drug trafficking.

- Basile

This aside may at first seem irrelevant, but bears direct consequence to the discussion of efficacy at hand. First, it provides a concrete example of the central role metrics play in informing external NGO policies supplying biomedical care to the region. Indeed, as Basile indicated, the policies of the Swiss NGO run counter to the social and relational

fluidity between Farendé and Kuwdé. Instead, they adhere to the colonial division of land in Northern Togo into villages, imagined as contained and largely autonomous populations. But as remarked in Chapters 2 and 3, there exists a great fluidity between the two villages, with houses re-establishing themselves in the plains and families returning to the mountain for performance of ceremonies and funerals. As such, the grounded realities of fluid social relations challenge the presumed efficacy of quotas and distribution. They also contradict the fluidity of disease itself, which rarely discriminates between predefined village borders. Bereft of social, anthropological, and relational understanding, the work and efficacy of metrically dictated policies fall asunder.

The situation of NGO malaria test distribution practices raises a second crucial concern. What happens locally when diagnostic tests run out? How does the community of Kuwdé react to and compensate for this structural inadequacy, to which they have had to grow accustomed? In the conversation above, Basile proceeded to cite an increased reliance of visits to the house of Taré, a house healer who treats malaria, once diagnostic tests run out. One may interpret this practice as a “fall-back” contingency. Within the discourse of modernization and biomedicalization, time-honored local practices are often deemed efficacious only insofar as they “fill in” the absence or insufficiency of biomedicine (Langwick 2008). Or, the local remedies get posited as the more affordable or accessible option – which is indeed often the case.

But rarely, if ever, is the local system’s social efficacy and entwinement invoked. This presumption squanders several possibilities and potentials. It ignores the possibility that people – healers, biomedical practitioners, and the sick alike – actively negotiate

between systems.³⁰ It certainly precludes the possibility that local medicine could offer a *more* “efficacious” answer in certain circumstances. Most importantly, perhaps, it fails to acknowledge the possibility that inquiry into the local system may in fact *improve* the efficacy of biomedical and global health practice. A renegotiation of “work” to include social and relational positioning challenges these incomplete distillations.

As Kirmayer remarks: “evaluations of outcome are always made with reference to specific problem definitions, hierarchies of values, and contextual frames.” He claims that “differences in the calibration of health and illness” beget a void between technical definitions of efficacy and lived, embodied experience, noting that biomedicine often prioritizes the former (Kirmayer 2004: 69). The anthropologist must then probe what gets lost in translation. Such a practice should not be undertaken with the end goal of eventually ratifying or nullifying *either* the local system or the biomedical. Rather, the value lies inherent in the messy comingling.

Collaboration or Co-optation?

The overarching discourse of multinational NGOs (TCAM, WHO, USAID) and best practices in global health interventions is one of “collaboration”³¹ between traditional medicine and biomedicine. While trafficking in the language of harmonious coexistence, this perceived smoothness veils underlying fissures. As I will demonstrate, this language often operates from a biomedical paradigm: the assumption that strictly biological

³⁰ The choice between systems may not be so clearly delineated as one may think, especially in clinical settings, as Stacey Langwick demonstrates in her ethnography of a Tanzanian hospital (Langwick 2008).

³¹ The popular term “medical pluralism” can also be considered here.

forces act on physical, material bodies. What such initiatives frame as “collaboration,” I argue, more closely resembles “co-optation,” as often only the most relevant facets of traditional practice capture the interest of global health workers. The mere use of such democratic and amicable parlance in policy is insufficient when examining the lived, on-the-ground, embodied consequences.

A close reading of a UNAIDS case study of two traditional healer involvement programs, conducted in Tanzania and Uganda, reveals such discourse.³² I focus on two facets of the Tanzanian and Ugandan local medical practices emphasized and deemed most crucial by UNAIDS: traditional healers as local authorities and the physical properties of herbal remedies. I am particularly interested in the politics of these selective representations. The facets of traditional healing *not* represented in global health policy may indicate as much, if not more, than those that get enfranchised.

The title of the UNAIDS case study itself —“Ancient remedies, new diseases”— interpellates the audience within the dichotomy of “ancient” and “new” even before stepping foot into the material itself. But the positioning power of language here functions even more subtly. By attaching “ancient” to “remedies” and “new” to “diseases,” UNAIDS marks its object of focus: traditional medicine as a set of *remedies*. By doing so, as I will demonstrate, this document distills “ancient” healing practices to the material remedies themselves; relational and social workings are left wayside, un-

³² I acknowledge that these case studies confront the specific condition of AIDS, which my fieldwork with the HMS did not address. I also acknowledge West—East African regional differences. My analysis is *not* intended to discredit policies of AIDS education and prevention, but rather to examine what parts of traditional medicine get emphasized/de-emphasized in the language of global health intervention.

discussed. Hardly unintentional, such bracketing serves a purpose: to advance the goals of the global health intervention itself, subsuming only the most “effective” traditional practice (read: “remedies”), while rejecting or pushing to the margins “other” forms of work.

In this document, traditional medicine gets mentioned and represented insofar as it serves relevant value to the UNAIDS project: “involving traditional healers in increasing access to AIDS care and prevention” (King 2002: 1). UNAIDS speaks of “traditional healers” as social authorities within their communities, which is often not invalid. But this social authority serves particular value to global health projects when healers become posited as “strong communication agents.” Because of their “greater credibility than...village health workers, especially with respect to social and spiritual matters,” they are ideally positioned to spread messages of health and prevention within their communities (King 2002: 7, 31). A hypersensitivity to healers as “agents” results in a neglect of the system itself, and the healer’s position *within* that system. While, local medical systems can indicate much about a community’s social structure, hierarchy, and relationships, assuming a blanket “authority” for anyone who owns and treats with medicines could be problematic. For instance, in Kuwdé the healer does not act as a social figurehead or authority per se, but rather serves as a conduit of ancestral knowledge. Such nuance is lost in a hasty jump to the healers-as-agents paradigm.

In addition to positioning healers as disseminators of public health messages, the UNAIDS document also emphasizes the utilization of traditional medicines. Perhaps more explicitly, the document promotes a co-optation of remedies themselves in what

the Tanga AIDS Working Group (TAWG) terms “ethnobotanical research.” In the fourth condition outlining research practice, TAWG states: “we identify efficacious plant remedies already used by healers to treat targeted diseases” (King 2002: 25). We must note the agents in this statement – “we” being the institutional TAWG board – as the determiners of “efficacious.” As James Waldram notes, these remedies often fall subject to the “gold standard” of clinical trials in order to prove their efficacy (Waldram 2000: 616). In this sense, TAWG’s project and the UNAIDS document focuses on the traditional *medicines* but not the *system* and its social work. Clearly, “efficacy” is determined in a purely mechanistic way, rather than socially contextualized.

Stacey Langwick witnesses a similar scenario in her ethnography of a Tanzanian hospital:

The elaboration of traditional medicine (by the international community)...is filling out the category of knowledge and practice first evoked through colonial encounters and prohibitions...pluralism (shapes) official postcolonial efforts to delineate and modernize a field of traditional medicine. To enable medical science to assess, evaluate, and deploy them, so-called traditional treatments and practices must be conceived of *as resources for (and therefore distinct from) their biomedical counterparts*. The (in)commensurabilities evoked in this vision facilitate the *transformation of traditional medicines into pharmaceuticals* and the *reduction of healers to outreach workers* referring clients to the clinic *but not administering treatments themselves* (Adams 2002; Janes 1999).

[Langwick 2008: 428, emphasis added]

In line with the medical pluralism project of which Langwick speaks, the UNAIDS case study states as its aim to “narrow the gap between traditional and biomedical health systems in different ways” (King 2002: 8). But does such “narrowing” transiently imply a meeting in the middle, as pure “collaboration” might suggest? Or, is the narrowing process more heavily weighted toward subsuming the practices of one within

the other in favor of reaching pre-defined measures or outcomes? *Whose* pre-defined measures or outcomes? Often, such co-optation can assume eventual supplantation of the traditional by the biomedical (or co-optation of only the most useful/cost-effective remedies, as deemed so by biomedical science and its definition of biological efficacy). Extrapolating these remedies out of their structural and community context risks obfuscating much of the very work they perform –of complementarity, relationality, and hierarchy, among other social and political dimensions.

Global Discourse, Local Realities: On the Ground in Togo

In Kuwdé, and indeed throughout Togo, co-existence and co-habitation of local practices (such as the HMS) and “Western” biomedical practice is real, inevitable, and visceral. The biomedical healthcare providers in the *case de santé* and CMS are staffed by people who grew up in these communities, raised on and within the HMS itself. Their biomedical training has not ceased their utilization of local medicines; rather, both Basile and Odile admit to seeking treatment from house healers for both themselves and their family members in certain cases. Such a phenomenon is not confined to Northern Togo, either. In the South—even in the more developed capital of Lomé, which has several fully staffed biomedical hospitals—the use of local medicines is alive and present. This moving through and negotiating between, among, and within seemingly opposed systems could be an entire dissertation focus unto itself. For our purposes here, the key consideration is the ways global health discourse has changed and challenged the lived experience of local medicine in Northern Togo.

When asked whether the two systems can or should coexist, nearly all the house healers I spoke with resoundingly responded, “Yes, it is good, essential to collaborate.” This phrase was often followed by citation of numerous cases in which a sick person would visit the clinic for analysis and diagnosis, then seek a house remedy carrying the appropriate treatment. During one interview, the house healer Pikam retreated into his homestead to recover several remedy ingredients, and returned with an abdominal X-ray image in tow. He explained how he regularly frequented the HMS to calm his persistent and mysterious stomach pain even after visiting the biomedical clinic in Kara to get his X-rays. While neither system offered promising or ameliorating answers to his condition, he utilized both. The very fact that Pikam kept his remedies and X-ray scans alongside each other in the house evidences that many Kabre do not see the two as antithetical.

The circulation of the term “collaboration” itself—and its material demonstrations, in Pikam’s case—attests to the permeation of biomedical and global health discourse into Northern Togo. When re-appropriated from a Eurocentric discourse, the circulation of “collaborative” becomes yet another facet of what Waldram terms the “biomedicalization of traditional medicine” (Waldram, 609). Yet beyond noting the mere presence of this rhetoric of collaboration, one must also be sensitive to its relative novelty: newer than the arrival of biomedicine itself.³³ Indeed, the discourse of “collaboration” itself is a product of recent global desires and

³³ New-ness, in this sense, should not be read as a gesture to the modern/traditional dichotomy. Rather, it marks the need to situate and contextualize – within a broader acknowledgment of power flows and history.

imaginaries. I grappled with this myself: do my very research questions and interests drive and perpetuate this rhetoric, simply by marking it? Is collaboration “good” by local definition, or a placating response to Western or foreign researchers who come to Togo overwhelmingly from the biomedical paradigm?

Just as the term “collaboration” misleads in global health discourse, it also must be examined within the context of Kuwdé. While a majority of healers spoke strongly of the HMS as a viable source of medical care alongside BM in many cases, another response drew tension with the assumed amicability: the notion of the HMS as the “reflex,” as termed by Henri. This hearkens an earlier point made in the preceding section, regarding local medicine’s position as “fall back.” According to Henri, HMS treatment becomes a “reflex” or default when biomedicines are either too expensive or unavailable, and also when the presumed cause is social or spiritual. This distillation ignores how reflexivity may *affirm* the unique work offered by the HMS, especially in health cases with a perceived social root.

A Modern Traditional Medicine? (Re)articulating Local Medicine in Kuwdé

Analysis of rhetoric and discourse only goes so far, often criticized for its purely academic leanings. But in the case of medical practice in Kuwdé, the rhetoric and discourse of global health not only influence the ways in which people talk about the body, health, and collaboration. They actually affect the practice and experience of care itself – both biomedical and local. Here, we turn our attention to application and action.

While the assignment of particular remedies to certain homesteads in Kuwdé is steeped in history, the injection of GH and BM challenges the temporality of the

“traditional.” This is most visibly evidenced by a move towards “professionalizing” the traditional practice in Northern Togo. Spearheaded by the Chef du Village of Farendé³⁴, a powerful political figure and healer himself, the *Association de Guérisseurs*³⁵ has emerged in recent years as an entity apart from the HMS. When I asked the Chef du Village whether there existed an exam or assessment to qualify one as a guérisseur, he responded, “No, it is entirely reputation-based.” One could speculate, perhaps not inaccurately, that the Chef could selectively hand pick those whom he wanted to join his association; often these selections carry strategic political undertones.

I attended an Association meeting on July 9, 2011 in Farendé. At this meeting, the dialogue overwhelmingly centered upon cross-referrals between healers and the clinic. In fact, one healer referenced a law requiring guérisseurs to send patients to the clinic for analysis, in every case. I was struck by how these discussions of establishing a normalized practice, adhering to laws, etc., starkly contrasted my discussions with HMS house healers, who often chose to focus on the remedies and social qualities of disease. I could not help but note the echo of colonial discourse – regulations and standards. At the same time, these Association healers still invoked many of the same treatments and ancestral payments characteristic of the HMS, interwoven into this parallel conversation. I noticed later the heading of a print-out the Chef du Village had handed me listing the names of Association healer-members: *“Ministère de la Santé – Département Médecine Traditionnelle – Association des Herboristes Guérisseurs Albarka de la Binah (AHGAB).”* A reference to the Togolese Department of Health, the prior

³⁴ Village chief

³⁵ Healer’s association

discussion on laws and regulations suddenly crystallized. I began to see the conversation as nested not only within local politics, but also within a larger set of national and infrastructural power dynamics. Most notably, the gestures towards legalization, systemization, and regulation conjures up notions reminiscent of the colonial era. This movement toward professionalization or systematization is just one of the myriad ways that the traditional or local practice is being re-appropriated into larger state projects, echoing the “collaborative” rhetoric of global health.

A New Stage for Power: The “Collaborative” Conference of August 2011

If the Chef’s Association illustrates how new dimensions of politics and power come to inhabit and meld local medical practice, the “Collaborative” Conference of August 2011 further exemplifies this tension. At the end of my first fieldwork visit to Togo in the summer of 2011, we³⁶ hosted a conference between several HMS healers and the three biomedical figures in the region: François, Odile, and Basile. Jespér mediated, posing questions and facilitating discussion while also serving as scribe, recording with chalk on the Farendé schoolhouse blackboard. The conference fixated on several key illnesses commonly invoked in *both* the local and biomedical paradigms: *paludisme* (fever, or malaria), *kotong susoko*, and *tension* (hypertension). While house healers largely focused on the spiritual causes and relational aspects of medicine, the BM figures were intensely concerned with displaying the physical symptomology,

³⁶ “We” includes myself, fellow undergraduate fieldworkers Stephanie Rotolo and Kathleen Ridgeway, and our mentor, Dr. Piot.

translating the local notions of illness into biomedical terms, and displaying curative effects of biomedicine.

Kotong susoko yielded perhaps the most contested ground. François took the stage, chalk in hand, and began to diagram the liver and heart, explaining the physiological mechanisms that may account for the swelling of limbs. Those from the local paradigm silently and attentively engaged. François impelled his audience to consider the biological gravity of *kotong susoko*:

Often, swelling can indicate a heart problem, kidney or liver malfunction. It could mean hepatitis B, or liver cancer. It can be fatal. Yes, it's important to address what people believe to be the spiritual and social causes of the illness. But it's a real issue, because people actually die if you only treat the social or spiritual. You lose valuable time when you try to discern the social underpinnings, even though they may be there.

- François

An undeniable appeal to the gravity of the situation, François' proclamation positioned Kabre deference to social causation as a risk that could result in fatality. Not one of the house healers vocally objected, as François proceeded with his diagrams. I myself struggled with reconciling these two positions. What does it mean that we treat the two as separate, contrapuntal? What are the consequences of looking at it in that way? Does sociality wind up being romanticized? Leaving people without access to medicines that are helpful and can save lives? Western biomedicine is incomplete without local understanding, but what about the reverse? These difficult questions Kabre increasingly must navigate.

Only now in retrospect do I recognize the significance of this conversation, and the conference itself, as complicit in a larger trend. The very fact that the conversation

was being *had* could be read as a colonizing moment. An encounter between Tswana rainmakers and European evangelists, observed by anthropologists Jean and John Comaroff, offers striking parallels regarding the colonizing nature of such conversations.

Consider the Comaroff's account:

Increasingly...the argument over such issues as rainmaking became a confrontation between two cultures, two social orders, in which each had a palpable impact upon the other...they joined the conversation that was so profoundly to alter their sense of themselves and their world. ... In being drawn into that conversation, the...Tswana had no alternative but to be inducted, unwittingly, and often unwillingly, into the *forms* of European discourse. To argue over who was the legitimate rainmaker or where the water came from, for instance, was to be seduced into the modes of rational debate, positivist knowledge, and empirical reason at the core of bourgeois culture [Comaroff and Comaroff 1991: 213].

The interactions witnessed between healers and biomedical clinicians, posited as a clash of cultures, interpellates local practice into Euro-American (biomedical) discourse. The appeals to rationality are not unlike our larger discussion of medical efficacy at large. The discursive practice of François' diagramming, of speaking within biomedical terms and slotting in "social cause" as an umbrella category, epitomizes the same sort of colonizing "reason" observed by the Comaroffs. As we saw in the preceding section, questions of legitimacy infiltrate the local; which healers *qualified* to partake in the Chef's Association? The Kabre experience this induction, whether "unwittingly...and unwillingly" *or*, in the case of François, actively partaking in its creation. What results is a sort of asymmetrical collaboration, a reflexive tendency to position the local as "other." Here, we lose sight not only of the potential efficacy of a local medical system, but also a larger and more holistic conception of health.

The point here is not to simply argue that, once extracted from its social embeddedness, local medical practice loses much of its self and significance. I neither intend to lecture on the social consequences of this loss. This line of argumentation has been extended and reiterated by theorists for decades and is increasingly self-evident. Regardless of whether we deem the interaction of biomedicine and local medicine as beneficial, detrimental, or perhaps somewhere in between, the fact remains that these interactions will continue and grow. The critical issue at hand remains cultivating awareness of how definitions of efficacy may frame experience and practice of medicine in Northern Togo, and in turn, of health.

Why does this matter? As Lévi-Strauss once stated, “physical integrity cannot withstand the dissolution of the social personality” (Levi-Strauss 1963: 130). The HMS is more than just a collection of herbal remedies passed down for generations, more than a romanticized testament to Kabre resourcefulness using the land to treat bodies in one of the most disease-rife (and biomedically underserved) regions of the world. Healers are more than mere community authorities conveniently positioned to distribute public health messages; they are neighbors and ancestral arbiters. The HMS is more than a cultural artifact to be preserved in the name of nostalgia, traditionalism, or antiquity. It represents not only a set of physical practices carried out by predetermined actors, but also a way of arranging and relating individuals to each other in a locally-defined context of community. The integrity of that local definition becomes arguably as central to health in Kuwdé as the treatment of illnesses themselves.

CONCLUSION

Spoken and Unspoken: A Return to “Work”

Often, anthropology and theory fall subject to the very same skepticism that traditional medicine encounters: “what *work* do they do?” What is the value of immaterial critique? What does it solve? Anthropologists, and the discipline itself, must grapple with this self-consciousness and self-awareness. I, too, grappled with it, as a student of anthropology and throughout the course of this research. One question posed throughout this project haunted me for months: “so *what?*” This question was only an emblem of more questions and doubts that circulated through the fieldwork and writing process. What were the larger implications of my work to the grounded realities and complexities of health, tradition, and modernity in modern Togo?

This vein of questioning exposes a parallel and concomitant project of this thesis: understanding, affirming, and re-charting the role of anthropology in global health and the “work” *it* can perform. A nuanced examination of discourse offers one of anthropology’s most resonating contributions to applied contexts and policymaking. While often criticized as esoteric or obtuse, the language and words we speak reveal (and create) our world and our space. Just as the politics of translation complicate the interpretation of Kabre into French, and French into English, the translation between medical epistemologies traffic in power and politics. The rhetoric of medical pluralism, often lauded and praised, serves an important arena to probe and push. Much of the current literature asserting the role of anthropology in global health practices still perpetuates this notion of co-optation, more heavily weighted towards forwarding

health policy goals. While these concrete goals (ie. reducing maternal mortality rates, improving public hygiene, increasing access to biomedicine) are noble in their own right, they often obfuscate local experiences, offering only a partial, Westernized “health.”

As such, a central role of anthropology surfaces: awareness of what gets spoken *and* gets unspoken. People in Kuwdé live their medical system, each and every day. There is a lot that we live that we may never articulate; such does not mean it does not exist.³⁷ The role of anthropology is then to acknowledge that which silently and invisibly moves. This acknowledgement can, in turn, expand notions of work and efficacy to encapsulate a broader conception of health and body. Doing so, I argue, enables a more complete healing – in its multiple dimensions.

(Un)justifications

On my last night in Togo in December 2012, I sat down to dinner with Charlie, Anne, and Dr. Patassi at a restaurant in the capital city of Lomé. Dr. Patassi is one of the leading infectious disease physicians in the country. He is also Kabre, from the North. He lived in the villages until the age of 20; he grew up on the very HMS medicines I had observed and documented. Yet he left the villages to pursue higher biomedical training outside Togo, eventually settling in Lomé to practice. We had met with Dr. Patassi that

³⁷ This assertion is not meant to patronize, or to imply that Kabre are inarticulate in describing their medical beliefs and practices. Much to the contrary; when prodded they put these beliefs and practices into words. But rather, they don’t have a need to articulate them in their lived everyday context. As someone situated on the outside sees these discourses about the local

night primarily to discuss Elli's condition.³⁸ Inevitably, though, I found myself explaining my presence in Togo to Dr. Patassi. I told him about my research, my interests in local Kabre healing practice, and the challenges facing true "collaboration" between biomedical clinics and the HMS. His response, though I had grown to anticipate it, still jolted me. "Why study it? Why are you interested?"

I was jolted not by his words per se, but by a very familiar internal pang. It was the same pang I felt justifying to some of my own pre-medical peers back at Duke my interest in *non*-biomedical forms of healing. In the two years since I chose *not* to pursue a career as a physician and instead to explore the anthropology of medical belief and practice, I have come to question the idea of justification itself. I have grown to notice it, rather than accept it without resistance or inquiry. My research on the HMS – and the discourse of medical anthropology I tapped into – allowed me to see it as epistemic, larger than myself, nested in histories and power plays. In fact, my own "justifications" were not unlike strictly conceived notions of "efficacy" themselves. Part of my own development – as a thinker, anthropologist, and person – required moving *past* justification, past stark either/or ultimatums.

Studying (or practicing) local medicine does not disavow biomedicine: far from it. Enlarging the definitions of healing and efficacy to include the social, relational, and spiritual does not require a denial of science. Only through living among the Kabre did these statements become visceral and real. In this sense, my thesis evolved with me.

³⁸ To rule out the possibility of neurological problems, we had brought Elli down from Kuwdé to seek diagnostic testing and neural imaging unavailable in the clinics of the North.

One comment in particular from Dr. Patassi resonated strongly, lingering long after I departed Togo. “The two (biomedicine and the HMS) ignore the best in each other.” By envisioning the HMS as not only a medical system, but also a social system, health and the body become situated with neighbors, villages, histories, and futures. My hope is that this work may elucidate how these theoretical inquiries into traditional systems are important, relevant, essential, and irreplaceable – to health and to *alafia*.

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