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Engaging conceptions of identity in a context of medical pluralism: explaining treatment choices for everyday illness in Niger

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Abstract This article uses ethnographic research to reflect upon how the treatment of ‘everyday’ illnesses in Niger engages concepts of social identity. Inspired by Bourdieu’s concept of social distinction, as well as Appadurai’s edited volume on the ‘social lives’ of ‘things’, I present an analysis of how medications are understood by their users in terms of social and ideological meaning in one rural Hausa village. Decisions about medication choice were framed by three main themes: belonging to the ‘modern’ world, ‘traditional’ Hausa culture, and religious identity. This article does not argue that these notions of identity fully explain medication use, nor necessarily predict treatment choices. The purpose of this paper is to reflect on the dynamic meanings given to treatment decisions after they have been made, attributed to the medications themselves and negotiated through their circulation in a context where multiple medical systems are drawn from to manage illness. Producers and sellers of medication also engage these meaning-centred concepts, which have theoretical and practical interest for the social sciences and public health.

A virtual abstract for this paper can be viewed at: https://www.youtube.com/channel/UC_979cmCmR9rLrKuD7z0ycA

Keywords: social distinction, trachoma, identity, Hausa, Niger, medication

The pharmacist set the box of pills on the white tile counter that separated us. I had come into this pharmacy, located in the small town of Matameye, near the village where I was conducting fieldwork, to purchase treatment for my son’s malaria. Although malaria is a common illness in the area, I had never seen this type of medication before. I opened the small box and looked at the yellow pills and the instructional pamphlet inside. I then asked to see the familiar blister-pack of malaria pills that my friends and neighbours used to treat their children’s illness, and placed the two treatment options side-by-side.

I saw that the medications were both produced by the same pharmaceutical company and contained the same active ingredients. The pharmacist’s recommendation for my son consisted of pills hidden in a white box labelled with black lettering. The pills of the second medication were in plain sight, covered in hard plastic and divided into three columns, each representing one day of treatment. Instructions for taking these pills were in the form of illustrations. A simple line drawing showed a little boy with a pill in one hand and a glass of water in the other. Below this image, squiggly lines representing the malaria parasite were shown becoming less

and less over each column. I had seen this second type of medication for sale at the ‘tables’ that acted as informal pharmacies in my research site and also in the homes of interlocutors.

The pharmacist explained to me that the medication he recommended was the ‘premium’ version of this familiar treatment. In his opinion, both versions worked well, but the premium medication worked for ‘people like you’. He clarified that the medications ‘are the same, but this one is what all of the *nassaru* (foreigners) and other *masu kudi* (people with money) buy. That other one is for the *talakawa* (poor)’. He told me that my son, as a foreigner, needed the medication in the fancier (and more expensive) packaging. Confused and in a hurry, I bought this medication.

After returning home and treating my fevered son with the pills I had purchased, I started to question why I had not simply bought the treatment that I had seen work well for others in the village. Had I been tricked by a pharmacist wanting to increase his profits? Was there a chemical difference between the two medications that I was not aware of? Why did ‘people like us’ need a different type of treatment? Discussing these issues at the research site, my friends and neighbours agreed that because my son and I were different (foreign, ‘rich’), this ‘special’ version of the medication was more appropriate for who we were, and therefore better adapted to treat our illness episodes.

Studying how individuals attribute meaning to the substances we use to address ill-health has been a long standing research interest for the social sciences. One can take, for example, the work of Victor Turner (1967) exploring the symbols and meanings of treatments invoked by *Ndemu* herbalists. However, much of this early work was limited to studying ‘pure’ cultural practices related to healing, with narrow consideration of the complex influences and competing resources engaged in healing. The current context of globalisation brings societies throughout the world into contact with increasing amounts and types of curative substances. These complex situations where different parallel and competing treatment options are available present rich arenas for studying how concepts of meaning and identity shape the understanding of different treatments and medication decisions. The pharmacist and the friends and neighbours with whom I discussed my choice of medication for my son’s malaria all understood that the factors guiding this treatment option went beyond a simple concern for physiological efficacy. When an individual consumes a medication, this person demonstrates a conception of the ‘right’ way of managing illness, socially situated within the larger scope of how a person ‘like me’ manages life.

Scholars working in diverse geographic locations have described how perceptions about identity are used to analyse the efficacy of medication. In her research in Benin, Carine Baxerres (2010) shows that negative side effects of treatment are often perceived as caused by the medication’s lack of fit to the particular individual. Similar explanations of suitability are also found outside of West Africa. In urban Manila the concept of *hiyang* is used to evaluate a drug’s efficacy in a specific individual (Hardon 1992), and in Indonesia the term *cocock* is used to describe the compatibility between a patient and a therapy (Sciortino 1995). Respondents distinguish between medications that are suitable for themselves or their own family and not for others. ‘If the drug has no effect, then people tend to conclude that the drug is ‘not *hiyang*’ (not suitable) for the patient’ (Hardon 1992: 87). These emic notions suggest that individuals interpret the efficacy of a medication differently than biomedical professionals who prioritise a concern with the medication’s fit with a disease rather than an individual.

The narrative at the beginning of this article presents one example of how pharmaceutical companies, their intermediaries and clients engage concepts related to the social value of

different forms of medication. The two treatment options presented in this example were both Artemether/Lumefantrine malaria medications produced by Novartis Pharmaceuticals and sold in Niger under the brand name Coartem. Although both versions of Coartem contain the same type and amount of active ingredients, they are marketed for different groups of consumers and carry meanings related to social distinction, as demonstrated by the pharmacist in the opening narrative. Along with being sold at pharmacies, the 'regular' version of the medication is also distributed by the Nigerien government's malaria programme and subsidised by international organisations such as The Global Fund in order to reach populations that have difficulty affording or accessing these types of treatments. The simplified picture-based instructions and visible pills aim in the common treatment aim to increase the acceptability of this medication for consumers with limited literacy skills and a lack of familiarity with biomedicine. The premium version of the medication is specifically marketed to individuals who desire a medication that is socially adapted and seen to be different from the common version of Coartem.

If regular Coartem is affordable and readily available in the country, then why does the 'premium' version exist and why does this more expensive version, identical except for its packaging and price, also sell? The purpose of this article is not to specifically investigate Coartem or the strategies used by pharmaceutical companies to create treatment options that are attractive for different social groups, but rather to reflect upon treatment choices and the social meanings attributed to different types of medication. How do individuals explain their treatment choices? Why are some treatments more valued than others to treat the same illness? How are notions of social identity engaged to position medication use? These questions have multiple answers; understanding them can help broaden our theoretical understanding of how medication decisions are conceptualised as well as have practical applications for public health work.

The village in Niger where fieldwork for this research took place is rich with multiple medication options for common illnesses. These include biomedical treatments such as Coartem, but also herbal and Islamic-inspired medicine. During the eleven years that I regularly worked in the research site, I witnessed diverse treatments being used from these different medical systems to treat similar illnesses. Ethnographic interviews and observations revealed that no one used one single medical system or a single medication source to treat illness. While it was very interesting to see how an individual would engage, for example, first a herbal treatment for a sore throat, then a biomedical antibiotic in combination with water from a Qu'anic verse, what was the most striking to me was how distinct concepts of identity were used to explain these choices. Individuals framed their practical and often overlapping decisions in terms of individual distinctions and values related to social group membership.

The social value of medication

Medication is a commodity that circulates and is exchanged between people: a pharmacist and his client, a doctor and her patient, between neighbours and friends. Like other commodities, the value of a medication is negotiated by the actors involved in its circulation and consumption. I find Appadurai's introduction to his edited book "The Social Life of Things" (1988) particularly useful as a framework for thinking about how social and moral values are attributed to and circulated by curative substances. Appadurai argues that the demand for a commodity acts as a way to both send and receive social messages. These messages are circulated, along with physical objects, within 'regimes of value' (Appadurai 1988: 15) created by the negotiations of social actors. My decision to first seek out treatment for my son at a formal pharmacy, rather than from one of the informal medicine sellers located in the village centre,

and the pharmacist's proposal of premium Coartem were not neutral, isolated acts. Engaging Appadurai's framework, we can observe how these acts were executed within a specific 'regime of value' requiring the construction of shared representations of malaria treatment in this particular context. The value of this medication, and of biomedicine more generally, were negotiated through and served to frame this exchange.

As a commodity that is desired and consumed within a specific social context, medication also acts to mark affiliation to particular social groups and ideologies. Premium Coartem is demanded, desired and valued *by* and *for* a certain 'type' of person. The tastes that create and are created through circulation and consumption are, as described by Bourdieu (1984: 49) 'the practical affirmation of an inevitable difference'. As individuals in Niger navigate the multiple types and sources of treatment, how is the consumption of these medications expressed in terms of social differences? The empirical data presented in this paper shows that individuals position their choices of medication as situated within not only regimes of value, but also regimes of identity.

Drawing from this Bourdieusian perspective can help reflect upon how the demand for certain medications (rather than others) is driven by social values and tastes related to identity, but does not explain how these identities are also flexible and often inconsistent. Unlike Bourdieu's work on distinction demonstrating how taste acts to mark affiliation to a certain social group in an often static way, the research presented here shows a more flexible interpretation of these distinctions. An individual may, for example, position one choice of medication as related to his social identity as educated and 'modern', and during the same interview express his preference for another medication because it highlights his affiliation with 'traditional' Nigerien society. The purpose of this article is not to oversimplify these distinctions, but rather to present how interlocutors mobilise dynamic notions of affiliation as well as cultural and religious identities to explain treatment choices.

While the symbolic meanings of medications, related to their social value and role as markers of distinction, guides how people discuss and conceive of treatment decisions, these are not the sole factors determining medication use. Studying the interpretations of identity and distinction provide a glimpse into one aspect of how medications are socially positioned and valued in this context. Medication use is also closely linked to other factors, including availability, cost, and cultural models of illness, which are not analysed here. A discussion of how these other factors are recast in terms of social identity allows for a reflection on the meanings attributed to treatment decisions in a context of medical pluralism that has theoretical implications for the social sciences. Structural factors impacting medication use, while important, are framed by imaginaries of social distinction and identity. A reflection on these meaning-centred understandings also offers a practical contribution for applied work in Niger aiming to influence the uptake of certain types medications.

Methods

This study draws on initial data and analysis from a larger work exploring the interaction of a community with the messages and materials circulated by a disease elimination initiative. Trachoma, the target of this programme, is an eye disease that presents itself as simple conjunctivitis ('pink eye'), may eventually cause blindness, and occurs frequently in individuals living in rural Niger. Although the disease has been eliminated from most 'developed' countries in the world, trachoma remains a leading cause of vision loss as well as a bothersome everyday illness for those living in rural Niger, with a particularly high prevalence in the Zinder region where this research took place (West 2004).

The research presented here began informally when I was a Peace Corps health volunteer living in the small (approximately 100 households) village of Kawari from 1999 to 2001. At this time, the newly launched trachoma elimination programme was actively targeting the region with tetracycline ointment, medical supplies, and health education. I witnessed the new medical technologies provided by the programme quickly become part of the multiple strategies employed in order to manage and prevent eye disease in the village, and the cultural model of the biomedical disease of trachoma begin to exist as a concern for the population. I have lived and worked in the village where this research took place for several periods of different duration (ranging from three years to quick visits of one week) since 1999 and returned to conduct formal fieldwork on this topic for 12 months in 2010–2011.¹

A red eye with discharge, pain and itching is one of many ‘simple’ illnesses experienced regularly by children and adults in rural Niger. In Hausa, this condition is referred to as *ciwon ido*, literally, hurting of the eye, and this general term is used to refer to many types of ‘simple’ eye disease beside trachoma. While individuals suffering from *ciwon ido* may seek care from a specialised practitioner, like most everyday illnesses, eye problems are often treated at home with curative substances obtained in or around the village. Although this paper focuses specifically on the treatment of *ciwon ido*, analysing the themes emerging around treatment decisions for this particular condition allows for a reflection that goes beyond this specific illness.

The findings presented here come from semi-structured open-ended interviews as well as from observation. Because active trachoma occurs most often in children under nine years of age, 14 households with children fitting this profile were randomly selected for inclusion from a sampling framework developed in partnership with the traditional village leader. In addition, a purposive sampling strategy was used to identify 13 practicing medicine sellers and practitioners from several different medical systems in the village. A total of 49 interviews ranging from 30 to 70 minutes in length were recorded with 36 adult household members and 13 medical specialists. In addition, 14 continuous twelve-hour periods of observation (from 8am to 8pm) were conducted in study households, as well as during several other shorter periods in households and with specialists ranging from one to three hours. During these observation periods, many informal conversations also occurred. These observations and informal interviews were recorded as field notes every evening and saved as digital files with photographs that were taken during these periods. The study received ethical approval by the University of South Florida Institutional Review Board and all interlocutors gave verbal informed consent of their participation.² The photographs in this article were taken after an explanation that they may be used in presentations, papers, or books, and the consent of the adult or parent of the child.

Data gathered focused on how conjunctivitis is treated in order to gather information about how treatment decisions for an everyday illness are understood and explained. All interviews were conducted in Hausa and then translated to English during transcription. The 49 formal interviews were transcribed using HyperTRANSCRIBE (Researchware, Randolph, MA), and uploaded along with field notes to HyperRESEARCH qualitative data analysis software.

Data analysis began while interviews were ongoing using a grounded theory approach in order to identify categories and compare these categories with new data (Strauss and Corbin 1994). A constant comparative method and focused coding was used link data to emerging concepts and then link these concepts to other data (Bernard 2011). This paper is based on the theoretical memos developed based on the theoretical categories that emerged from these codes. I present writing from my field notes and interview quotes to contextualise and provide detail to these memos. The village’s traditional leader requested that I use the real name of the village, which I do in this paper. However, I have used pseudonyms to refer to interlocutors whose interviews are presented here in order to preserve confidentiality.

Membership into a globalised and glocalised world

Baby Hadiza plays in the sand next to where her mother is stirring a big pot resting over an open fire. One of Hadiza's eyes is very red and swollen, and her mother Amina tells me that it has been this way for five days. She thinks it's because of teething, but she is going to bring the baby in to the health centre for the nurse to have a look so that it doesn't get worse. 'That's what they say on the radio and at the hospital. If you don't get medicine from a health centre to treat what is wrong, then it can turn into something else. The problem will grow'.

Amina is one of the few women living in the village who speaks basic French and has completed one year of secondary school education. She sometimes greets the health centre nurse in French, and uses French words to describe her daughter's illness symptoms. 'I always go to the health centre first. Sometimes they have the medicine there, or sometimes they give a prescription for medicine at the pharmacy. These medicines are not the same as the ones that you can buy on the street. You know that they are originals, not fakes, not products from Nigeria, and that they work'.

While the village health centre is often closed, and frequently the sole nurse working at the centre turns away patients for unexplained reasons, the next day Amina succeeds in receiving an exam for her daughter as well as a free tube of tetracycline ointment to apply to Hadiza's eyes.

Treatment from the health centre was often described during interviews as being stronger and better than biomedical treatments available from informal pharmacies and more 'modern' than Hausa medication. These medications were seen as coming directly from Europe and representing technological innovation beyond what is available from other pharmaceutical-production areas such as Nigeria or India. Amina used her knowledge of French and level of education to access this treatment, which was difficult for others without the skills to navigate this system. Bourdieu (1984) describes the symbolic systems related to social distinction as based on binary oppositions: legitimate/illegitimate, local/foreign, traditional/modern, which depend on one another for existence. When describing experiences with biomedical medication from the health centre, individuals like Amina with advanced levels of education often situated these treatments in opposition to 'illegitimate' biomedical treatments from informal pharmacies or 'traditional' Hausa medication. By successfully accessing biomedical treatment from the health centre, Amina not only addressed her daughter's eye problem, but also demonstrated her own membership into a 'modern' and 'foreign' postcolonial social world. One patient waiting at the health centre summarised:

When the French left, we were happy . . . after independence, but they left us good things, like hospitals and their knowledge of medicine. Now the Americans bring in medicines too. And the Chinese and Indians. These medicines might not be as good as the ones that you find in Europe, but for us, we are lucky to have them. Not to be left out.

This sense of belonging to the world of biomedicine seemed to be a driving factor behind the use of biomedical treatments. Discussing the concept of 'modernity' with interlocutors, many people explained that for them, development and progress was related to becoming 'more like Europe or the US'. Accessing biomedical treatment coming from North America or Europe

allowed individuals to demonstrate affiliation to this 'developed' social group through the consumption of these commodities.

Over the past fifty years, mass produced biomedical-treatments have taken a prominent role in health care globally, and individuals conceptualise their engagement with these treatments in different ways. The globalised availability of biomedical treatment is relatively new, with widespread access to antibiotics only occurring after the Second World War (Whyte *et al.* 2002). In West Africa, the impact of global health projects is even more recent, but has had a dramatic impact on the availability of biomedical medication as well as the discourse related to disease treatment. Referred to by Biehl and Petryna (2013) as the 'projectified' landscape of healthcare, formal health care in Niger is supported greatly through donations of medications from pharmaceutical companies, NGOs and research projects.

Biomedical medications from these sources are often accompanied by education campaigns that encourage the use of these modern treatments, as well as promoting attendance at government health facilities. These educational campaigns are conducted in the Kawari both in Hausa and in French, and contain a strong 'foreign' element in the way that disease and its treatment are presented, for example including drawings of children from other West African countries, or using metaphors containing unfamiliar situations to educate about disease. 'It's like applying toothpaste' one health educator said about applying eye ointment to a mother who, like many others in the village, used neem branches, instead of a toothbrush and toothpaste to clean her teeth.

Parallel to this formal and foreign structure of biomedicine are informal sellers of biomedical treatment who provide many of the same treatments for sale, but present a more flexible and 'glocalised' (Robertson 2012) form of their use, based on local interpretations of disease (for example, presenting antacids as a treatment for *zahi*, a local disease with no biomedical equivalent, or stating that amoxicillin may also help with boils caused by witchcraft). While the biomedical treatments obtained from an informal pharmacy may be identical to those obtained from a government health facility or international NGO, the origin of the medications contributes greatly to the symbolic efficacy (Lévi-Strauss 1963). Baxerre and Le Hesran's (2011) research on the informal pharmaceutical market in Cotonou (Benin) demonstrates how perceptions about biomedical medications are constructed in relation to the place of manufacture, with a treatment produced in Europe being seen very differently than one produced, for example, in India or Nigeria.

For many living in Africa, the health centre is a place of fear and ridicule (Jaffré and Olivier de Sardan 2003, Jewkes *et al.* 1998). During interviews, interlocutors explained that they often had difficulty receiving the desired services from the local health centre; for example, encountering nurses who required them to wait on the benches outside the centre for hours before announcing that they cannot be received that day, or health centre staff refusing to explain medications and conditions clearly in Hausa to patients who do not speak French (in spite of the staff having sufficient knowledge of Hausa to be able to do so). Often these staff members have been sent in from other areas of the country and have limited social ties with those living in the health centre community. While care for serious illnesses often requires a passage through the trials of the government health system, common childhood illnesses like pink eye are usually treated first with treatments that are easier to access and done at home.

Treating her daughter's pink eye with biomedical medication from the hospital and not from an informal source was important to Amina. This decision illustrated her adherence to the State discourse about disease treatment that is often challenged by the practical struggles of accessing services at government health centres. It also showed her success entering into a system that pushes many others away with its use of French language to identify disease and describe the use of medication. Amina situated her choice of medication to treat her daughter's

illness as related to her identity as someone with a high education level and awareness of the larger 'foreign' world of biomedical treatment.

The sand paths of Kawari radiate outward from the village square located in front of the large compound of the village's traditional local leader. These paths lead to residential areas, while the village square is reserved for public activities and commerce. Three 'tables' are located in the square, selling identical products, everything that might be needed on a daily basis: food items, flip-flops, cigarettes and medication. The men who run these tables are from the village and know their clients well.

Underneath the wooden table covered with packages of pasta, rice, cigarettes, and magi cubes is a blue plastic basket filled with colourful boxes and transparent blister packs of medication. When I ask Hamza, the table owner, to tell me about the medications that he regularly sells, he first shows me pills that are produced in India and claim to boost sexual power. He then goes on to show me antibiotics: pills of amoxicillin or tetracycline that can be bought individually. 'It's not like the health centre here. I don't force people to buy more pills than they need. If they only need a few pills, then they just buy those. If they need more then they can come back again'.

One of the days that I am observing sales at Hamza's table, I notice that he has several tubes of tetracycline eye ointment. These seem to be the same tubes that are offered by the health centre. The same treatment that Amina was given to treat her baby's conjunctivitis. 'I am friends with someone who now works for the trachoma elimination programme'. Hamza explains, 'They were in (a nearby city) working, and he gave me a box to sell . . . I didn't pay for it, but we are friends. We both help each other when we need it'.

Biomedical treatment from these tables (see Figure 1) was more easily accessed than medication coming from the health centre and did not engage the same notions of identity, education or language. However, many of these products were the same as those available at formal pharmacies or government health facilities. The owners of these businesses adapted their products and discourse to particular client needs, encouraging agency and offering flexibility. The products sold at these pharmacies were procured through social relationships with wholesalers or health programmes, and clients at these pharmacies also relied on their social relationships with the medicine sellers to access treatment. Informal pharmacies allowed clients to access biomedical treatment on their own terms through existing relationships and were often the first source for treatment of conjunctivitis.

Medication available at these tables was subject to ambivalent discourse: it was seen as being of lower quality than from the government health centres or pharmacies ('the pharmacy has medicine from France, at the tables their medicine can be expired or fake' one client expresses) but was also admired for its social value, adherence to village social links and respect for the autonomy of its consumers. Personal relationships with the owners of these informal pharmacies, as well as flexibility in medication prescription (for example, offering one or two pills rather than a full treatment course) encouraged the use of these sources for the treatment of everyday illnesses. One client explained to me:

Hamza is the son of my cousin, I have known him since he was a little boy. He asks about the medication that I want, but also explains to me what works best. He says that I can buy a little to try and see if it is the right medicine for me.



Figure 1 *Medications for sale at a village table*

When an individual bought medicine from a village table, he engaged with a participative system that encourages active negotiation about the type and quantity of medication to be purchased. This ‘easy entry’ into the margins of biomedical treatment did not require the same notions of identity as obtaining medication from the health centre, and drew upon social relationships in the village. The client’s agency in making decisions about medication was not encouraged at the health centre that often handed patients written prescriptions with no discussion or explanation. Concerns about medication quality were mitigated by the autonomy and social relationships offered by informal pharmacies. The symbolic efficacy of these treatments was viewed by clients as contained not only within the medications themselves, but also in how they were delivered.

Embracing cultural heritage

Many individuals used both biomedical treatments and ‘traditional’ Hausa treatments for the treatment of conjunctivitis. In his research on medical pluralism in Hausa-Africa, Murry Last (1981) argues that users of these multiple systems put aside ideas related to the *meaning* of medication in terms of practical reasoning. He uses the analogy of travel to illustrate this argument: the Hausa villager who may switch his mode of transportation from truck, to walking, to donkey, according to Last, is not concerned with the symbolic value of these transportation choices, but simply arriving at his destination. While ethnographic observation showed choices to often be opportunistic: what is available and affordable, when asked to reflect upon their treatment choices, interlocutors situated these choices within frameworks of identity. These frameworks were often multi-faceted and flexible and engaged to explain the use of different medical systems during a single conversation.

For the purpose of this article, I broadly define Hausa medicine as anything referred to as *maganin hausawa* during interviews: dried herbal powders, amulets, and prayer ink consumed in water. These were produced and sold by individuals within the village, or by travelling salespeople who came in from nearby areas. While many individuals used both biomedical

and Hausa medicines, different concepts of identity were engaged to explain the meaning of these choices. 'Hausa medicine is ours. Even at the hospital they can sometimes say 'we don't have medicine for your illness', then they tell you to try your own medicine. Not the *nassaru* (foreign) kind', one man told me. Interviews revealed that consuming Hausa medicine was seen to confirm a cultural identity different from, and sometimes in opposition with, the globalised culture of biomedicine. Similar to Marc Nichter's (1980) research in India showing the perceived importance of *abhiyasa* (habitude) in determining a medication's efficacy, interlocutors often described being used to (*saba*) or not used to (*ban saba ba*) certain types of treatment when reflecting on medication use.

Although Hausa medicine was omnipresent during interviews and observations in all households, some individuals were reluctant to speak about using these systems of treatment. This reluctance was especially present in individuals working in government jobs (teachers, nurses) and others who had attended secondary school or spoke French. For these individuals, Hausa medicine was something to be consumed in private, while the use of biomedicine was an important sign of their identity belonging to the postcolonial Francophone context. However, usually towards the end of interviews or during informal conversations, interlocutors often explained their use of Hausa medication in terms of a traditional and African identity, often situated in a reflection about a 'true' identity unmarred by the French colonial period.

When I ask Ali, a school teacher, about his household's use of Hausa medicine, he explains that he has seen this medicine work, even for very severe illness, and that it is an important part of his African identity. 'You may not believe it if you have never seen it, but I know it is powerful. Even more powerful than what you can buy in a pharmacy. Africans have innovation. Sometimes we forget this. Hausa people were powerful once, and a lot of this medicine comes from this time'.

Ali has four wives, which also means that kids seem to be everywhere in the compound. Babies crawling on the sand, two different groups of teenagers sitting around small piles of red hot charcoal waiting for their tea to boil, and a group of little girls cutting out small pieces of fabric to serve as clothes for very worn-out Barbie dolls. Ali is a teacher at a nearby secondary school. He is one of the few individuals living in the village that has a latrine, and also owns a Chinese motorcycle that he uses to travel to and from work each day.

During repeated visits to Ali's home, I saw that many of his children wore Hausa amulets used to prevent illness, including pink eye perceived to be caused by teething. I also saw that Ali himself regularly consumed a traditional Hausa medication, a brown coloured powder that he poured into the *hura* (millet porridge mixed with sour milk) that he ate after lunch each day.

Many of the treatments that were classified by respondents as being traditional Hausa medicine used Islamic prayers and verses from the Qur'an. I asked Ali whether these treatments are really Hausa or if they were brought in with Islam from the North. His response was similar to what others in the village had told me:

You can't separate what is Islamic from what is Hausa. Before, there were animists here, but now we are all Muslims. What is Hausa is Islamic, we were both of these things before the French came, and we are still both of these things now.

Older individuals or those holding titles in the system of traditional leadership often spoke of the superiority of Hausa medicine over biomedicine. These individuals drew from the imaginary of a true Hausa identity that is being threatened by the government and NGOs working against it. For many of those interviewed, the use of Hausa medicine was essential to their membership within a society that had increasingly grown weaker with the growing presence of foreign influence. Bourdieu's (1984) concept of social distinction may be engaged here to frame how the consumption of these medications by a social elite different from the group emerging from the postcolonial system (government and NGO workers, etc.) was engaged to highlight this membership.

Howa, an older Fulani woman who made and sold Hausa treatments in the village explained that many young people only tried these medications after biomedical treatment had failed. For Howa, some diseases specifically affected Hausa people and required treatment with Hausa medicine; failing to do raised questions about perceptions of identity. To return back to the example presented at the beginning of this paper, my son's case of malaria was biologically the same as experienced by other children his age, yet his treatment was different. The pharmacist recommended a medication that not only addressed his physiological need, but one that was also seen to fit with his social identity. Interviews showed that diseases, as well as medication, were sometimes seen to have a social identity. Howa explained that young people in the village often tried many different types of treatment before realising that they needed a treatment that corresponded with their own identity as well as the identity of their illness:

They go to the hospital, or they buy pills from the tables, and they are still sick. Maybe they are even sicker. And then they come to me, and they say, mama, the hospital medicine is not working. When they take the medicine that I give them, they recover right away. I say to them, it is good to go to the hospital, but when you have a traditional disease, you need traditional medicine. You need the medicine that belongs to us.

For Howa, the new generations of the village were denying their true identity and pretending to be someone who they were not. In her view, this denial led to additional health problems that could only be addressed through acknowledging true cultural identity and engaging corresponding treatments.

[The new generations] want to leave Niger. They don't want to be Nigerien. They see that we have many problems here, but I know that these problems were not here before. There was not so much sickness before. We used to only use Hausa treatments. There was no hospital, and people were healthier.

In the Nigerien environment of precarious health, Hausa medicine, like the plant-based treatment in Figure 2, signalled a 'true' Hausa identity, and a world where problems could be addressed with local means without relying on exterior, foreign assistance. The act of consuming Hausa medicine distinguished individuals from the passive role assigned by the biomedical system in Niger. An individual who treated illness with Hausa medicine saw himself as demonstrating his membership within a society where the imagined 'traditional' reigns superior and social power lies within a perceived local, 'natural' state of being.



Figure 2 *Pounded dried plants used to treat eye infection*

Construction of religious identity through Hausa treatment

I watch Nana applying kohl to her eyes, and then her eyebrows, staring seriously into the small mirror that she holds in her left hand. She finishes up by adding a single dot on her forehead and looks at me with the sparking eyes and slight smile of a little girl who can already feel her future as a woman.

While nine-year-old Nana used the kohl to increase her beauty and highlight her newly forming adolescent identity, the same container of kohl was used in different ways by other members of the household (see Figure 3). Her mother Hassia explained to me:

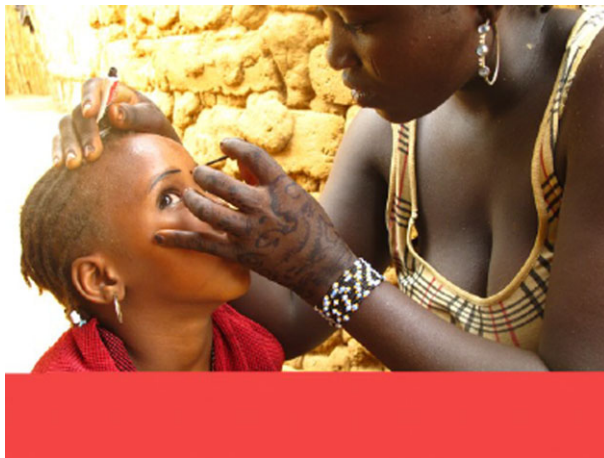


Figure 3 *A mother applies kohl to her daughter to increase beauty and prevent illness*

It is for beauty, but also for medicine. For women, once we get used to wearing it, if we go out in the morning and we don't have kohl on our eyes, then we can have problems . . . our eyes hurt, and the sun can cause us to have eye diseases. The kohl makes us look beautiful, but also to feel healthy.

Hassia went on to tell me that, when a woman wears kohl, people were able to tell that she took care of herself and was being 'true' to her religion. She explained that these efforts to be beautiful and clean had direct health outcomes.

When I asked if the men in the household also used kohl, Hassia stated that men use kohl 'only if their eyes have problems. The men here would not use kohl every day, but if their eyes hurt, then kohl can stop the burning and the redness'. Hassia described how kohl was regularly applied to the eyes of infants, both male and female, to prevent eye problems, especially the 'white lice' that were seen to cause problems in the eyelashes of young children. She equated applying kohl with praying; 'It is something you must remember to do. It's important to focus on your intention regularly, just like when you pray'. Hassia explained that kohl also acts as a marker to show that efforts to promote health have been made. 'When you see a baby with kohl, you know that the mother is taking care. That the mother wants her baby to be healthy'.

Kohl was seen by those interviewed as an aesthetic tool, a medication, and a symbol of religious identity. Because no mention of medical practice is made in the Qur'an, practitioners of Islamic medicine, historical and contemporary, have turned to the texts of the hadith in an effort to understand health and healing on divine terms (Pormann *et al.* 2007). References to kohl are found in these texts, but were not directly cited by those interviewed, who instead explained that their knowledge of kohl came from family members or religious leaders in the village, especially those who had travelled to Mecca. Islamic-inspired medication has historical significance in the area, where it had been promoted since at least the 18th century as a part of Islamic political and social movements such as the Sokoto Caliphate, one of the largest empires in Africa in the 19th century before being defeated by colonial forces (Al-Jauziyah 1993, Boyd and Mack 1997). The promotion of religious affiliation through treatment choices still seemed salient during fieldwork for this project.

Gano holds up a black bottle of eye drops labelled in yellow with Arabic lettering (Figure 4). He is one of the oldest men living in the village, although he claims to not know his exact age. He bought this medication from a nearby weekly market and has been using it to treat an infection in his eye that causes blurred vision and itching.

He says that he thinks the medicine originally comes from Saudi Arabia. 'It must be from Mecca. It is very strong. Stronger than what is from the Europeans'. Gano says that the older he gets the more religious he becomes. 'When I was younger, I often missed prayers, now I rarely miss them. I pray five times a day, even when I am sick or when it is hot'. I examine the bottle, and it seems to be similar to biomedical eye drops sold by the informal or formal sources of biomedical treatment, but labelled in French or English.

I ask if the writing on the package is the only difference, and Gano looks at me like I don't understand anything at all. 'These are made for Muslims. By Muslims for Muslims, and they are stronger than anything that you can buy made by Atheists. Maybe for Christians, you have your own medicine, but for Muslims, this is what we have that is ours. It comes from the same place that our religion comes from . . . It comes from the direction we face when we pray'.



Figure 4 *Eye drops bought from a nearby market for treating conjunctivitis*

While kohl is historically tied to Islam, other eye medications used in the village seemed to be more loosely connected, many, like these eye drops, appearing to be reinterpretations of biomedical treatments positioned within religious frameworks during their circulation. Medications labelled in Arabic connected their Nigerien consumers with a broader imaginary of the Muslim world and the birthplace of the religion. Interlocutors explained that the value of these medications came not only through their physiological properties, but also through the larger healing power represented by Islam. Unlike other medications, these treatments were grouped together with other religious objects when sold in the market and by local vendors.

These hybrid Islamic medications produced physiological effects, but were also seen to contain power from their origins and packaging. Aziz told me, 'I feel comfortable with this medicine. I know it is not made by someone just wanting to make money . . . It is strong, and is made for people who believe'. One way that Aziz has constructed his visible religious affiliation as a 'believer' is by purchasing an eye ointment labelled with Arabic writing from a travelling salesman who came to Kawari to sell copies of the Qur'an and prayer beads. Although kohl had a much broader function than eye drops or ointment because of its capacity to enhance attractiveness as well as address and prevent eye problems, it served in a similar way to confirm membership into a world of identity that positioned healing technologies within a context of religious identity.

Conclusion and discussion

The paper presents the theoretical categories and emic meanings used to explain treatment decisions for common eye infections after they have been made. These findings show that individuals framed decisions about medication choice in terms of three main themes: (i) belonging to the 'modern' world; (ii) 'traditional' Hausa culture; and (iii) religious identity. Identifying and describing these categories allows for a greater understanding of the appeal of

different types of medication and how consumption influences (and possibly is influenced by) conceptions of identity. I do not argue that these notions of identity fully explain medication use, nor that they may be used to predict treatment choices.

Medical dialogue can serve as an important social idiom, especially in a post-colonial, 'developing country', context. Medication in Niger, like in many other sub-Saharan African countries, is characterised by both what scholars have referred to as 'rarity and abundance' (Desclaux and Egrot 2015). In Kawari, a rural village that receives much of its medical care in the form of unsolicited governmental and non-governmental interventions, and where access to certain medications may be very limited, micro-level conceptions hold great importance in how treatment choices are explained. Like the tastes of the working class as theorised by Bourdieu (1984), these 'virtue of necessity' conceptions act to justify and explain treatment choices that are heavily influenced by availability and access.

The theoretical categories described in this paper show how individuals conceptualise medication use within one particular environment and social context. Although the context and categories are very different, Libbet Crandon-Malamud's (1991: xi) work in Bolivia shows similar findings. She writes that treatment choices in this developing country facilitate 'the permeability of ethnic and religious boundaries as well as movement across class lines because, as people talk about medicine, they are also negotiating a redefinition of their own identities'. The categories presented here show that the definition of identity was often elaborated through the interlocutor's conceptions of his or her distinction from others or by membership to a particular social group.

Simon J. William (1995: 599) uses Bourdieu's social distinction to theorise health related behaviours and describe 'the way in which health and lifestyles are caught up in struggles for social recognition'. However, Bourdieu's theory of distinction cannot fully explain the multiple and dynamic identities expressed by interlocutors engaged in the parallel use of medications from different systems. Unlike in France, where Bourdieu's sociological work took place, socioeconomic distinctions in rural Niger are themselves more fluid. Although social elites such as school teachers or traditional leaders may have access to greater social and economic capital, many of the everyday challenges experienced by these individuals, as well as the resources available to negotiate ill health, are shared by others living in the village. While Bourdieu's theory may not adequately explain all of the factors at work in this precise context, it is useful to highlight how distinction and identity may frame the consumption of different types of commodities. Last's (1981) argument that the treatment of illness in Hausa society is oriented toward practical rather than meaning-based considerations leads to the question of how these conceptions of identity influence treatment decisions before and while they are made; a possible topic of future research that is not explored here.

I began this article with a vignette describing my experience treating my son's malaria. I would like to end with a passage from my field notes about an experience treating my own conjunctivitis.

It's ironic that I am conducting interviews about eye problems with my left eye red and swollen . . . I bought eye drops made in India from Daouda's table which seem to be working so far. There was a lot of interest when I bought these eye drops. Several people nearby came over to watch me make my purchase. Daouda seemed hesitant to sell them to me, and said that they worked well for people living in the village, but he didn't know if they would work for me too. I applied the eye drops after lunch today, sitting on the blue mat where I had eaten lunch with two of my favourite women from the village. The younger of these women, Zanaib, laughed about me 'becoming African' when she recognized that the eye

drops came from the table. She said that they would work on me because I'd been spending so much time in the village and was therefore 'used to life here'.

As shown in this passage, my own choice of treatment was not spared from analysis by emic conceptual categories of identity by those around me. If the eye drops that I bought to treat my eye infection had not proven to be medical efficacious (which they did), then the findings of this research suggest that this failure may have been explained by a lack of fit between the medication and my social identity, rather than the quality of the treatment or its appropriateness for the type of infection. There is therefore an important space for social scientists and other interested parties to explore how treatment failures are understood as well as how conceptions of identity may predict treatment decisions and influence engagement with health services within the specific rural Hausa social context.

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References

- Al-Jauziyah, I. (1993) *Natural Healing with the Medicine of the Prophet*, trans. M. Al-Akili. Philadelphia: Pearl.
- Appadurai, A. (Ed.) (1988) *The Social Life of Things: Commodities in Cultural Perspective*. Cambridge: Cambridge University Press.
- Baxerres, C. and Le Hesran, J.Y. (2011) Where do pharmaceuticals on the market originate? An analysis of the informal drug supply in Cotonou, Benin, *Social Science & Medicine*, 73, 8, 1249–56.
- Baxerres, C. (2010) Du médicament informel au médicament libéralisé: les offres et les usages du médicament pharmaceutique industriel à Cotonou (Bénin) (doctoral thesis) Ecole des hautes études en sciences sociales, Paris.
- Bernard, H.R. (2011) *Research methods in anthropology: Qualitative and quantitative approaches*. Fifth Edition. UK: Altamira press.
- Biehl, J. and Petryna, A. (eds) (2013) *When People Come First: Critical Studies in Global Health*. Princeton: Princeton University Press.
- Bourdieu, P. (1984) *Distinction: A Social Critique of the Judgement of Taste*. Cambridge: Harvard University Press.

- Boyd, J., Mack, B. and Mack, B.B. (1997) *Collected Works of Nana Asma'u*. East Lansing: Michigan State University Press.
- Crandon-Malamud, L. (1991) *From the Fat of our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia (Vol. 26)*. Oakland: University of California Press.
- Desclaux, A. and Egrot, M. (2015) *Anthropologie du médicament au Sud: la pharmaceuticalisation à ses marges*. Paris: IRD/L'Harmattan.
- Hardon, A.P. (1992) That drug is hiyang for me: lay perceptions of the efficacy of drugs in Manila, *Philippines, Central Issues in Anthropology*, 10, 1, 86–93.
- Jaffré, Y. and Olivier de Sardan, J.P. (2003) *Une Médecine Inhospitière: Les Difficiles Relations entre Soignants et Soignés dans Cinq Capitales d'Afrique de l'Ouest*. Paris: Karthala Editions.
- Jewkes, R., Abrahams, N. and Mvo, Z. (1998) Why do nurses abuse patients? Reflections from South African obstetric services, *Social Science & Medicine*, 47, 11, 1781–95.
- Last, M. (1981) The importance of knowing about not knowing, *Social Science & Medicine, Part B: Medical Anthropology*, 15, 3, 387–92.
- Lévi-Strauss, C. (1963) The sorcerer and his magic, In *Structural Anthropology*, pp. 167–85. New York: Basic Books.
- Pormann, P.E., Savage-Smith, E. and Heilmeyer, I. (2007) *Medieval Islamic Medicine*. Edinburgh: Edinburgh University Press.
- Nichter, M. (1980) The layperson's perception of medicine as perspective into the utilization of multiple therapy systems in the Indian context, *Social Science & Medicine, Part B: Medical Anthropology*, 14, 4, 225–33.
- Robertson, R. (2012) Globalisation or glocalisation? *Journal of International Communication*, 18, 2, 191–208.
- Sciortino, R. (1995) *Care-takers of cure: an anthropological study of health centre nurses in rural Central Java*, 2nd edn. Yogyakarta: Gadjah Mada University Press.
- Strauss, A. and Corbin, J. (1994) Grounded theory methodology. In Denzin, N.K. and Lincoln, W.S. (eds) *Handbook of Qualitative Research*. Thousand Oaks: Sage.
- Turner, V.W. (1967) *The Forest of Symbols: Aspects of Ndembu Ritual (Vol. 101)*. Ithaca: Cornell University Press.
- Van der Geest, S. and Whyte, S.R. (eds) (1991) *The Context of Medicines in Developing Countries: Studies in Pharmaceutical Anthropology*. Amsterdam: Het Spinhuis.
- West, S.K. (2004) Trachoma: new assault on an ancient disease, *Progress in Retinal and Eye Research*, 23, 4, 381–401.
- Whyte, S.R., Van der Geest, S. and Hardon, A. (2002) *Social Lives of Medicines*. Cambridge: Cambridge University Press.
- Williams, S.J. (1995) Theorising class, health and lifestyles: can Bourdieu help us? *Sociology of Health & Illness*, 17, 5, 577–604.