

Witnessing Practice: The Treatment of Childhood Illness in Upper Guinea, Western Africa¹

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Abstract

If fieldworkers are able to witness ongoing actions of diagnosis and treatment for childhood illness, then we are able to observe practices and conditions that escape our notice. That is, were we just to rely on cognitive approaches or retrospective accounts or even rapid assessments, we would become selective about data collection despite the broad perspectives. As our analysis as well was guided by the work of Pierre Bourdieu (1977, 1990), we viewed treatment practices as the "habitus," the flow of responses to conditions that present themselves. Some of the presenting conditions were seasonal poverty, the deference to elders and their beliefs, a meddlesome patrilineage, and the inclinations to rely on labels of being constitutionally ill and to rely on ritual cures. In this paper, an examination of conditions highlights how everyday conditions need to change if treatment practices are to change.

The Aim of This Article

Our approach was not business as usual for applied anthropologists when we studied treatment of sick children in Upper Guinea, western Africa. We did follow certain customs. We sought to complete our work in a short time, eight weeks, common for applied work. Our tools of interviewing, participant observation, and tracing social networks were taken from the tool kit of anthropology (Schensul and LeCompte 1999, Bernard 2006). But the way we used these tools was different. We made it a priority to witness all that happens over the course of an illness. We sought to learn about events as they evolve, prospectively, from the beginning of an illness to its conclusion. Our team of field researchers observed sequences of activity through diagnosis, treatment, and care, that is, through all that takes place when children are sick. When we asked questions about ongoing activity, the questions were raised on the site of action, or shortly afterwards. We ask rhetorically, why not get the full story from the actors and actions that are implicated in the care of the child? We had our researchers collect data from the community, seven days a week, 24 hours a day. We will review what is entailed in witnessing treatment practices, but here we review a case study to illustrate the kind of data we had and how we collected it. We look at how this information may be useful for applied work.

We do not feel that an attempt to witness ongoing activity is necessarily the optimum strategy for all short-term applied research. But

given our experience, we strongly recommend it for understanding treatment decisions with sick children. Perhaps, close and comprehensive attention may be similarly useful in other treatment situations that call for continual attention to care giving, or when the sick person is not apt to speak on his or her own behalf, as is the case with a young child. Nevertheless, here we limit our discussion to witnessing the care of sick children, with an understanding that the approach may be useful in other treatment situations and for other research problems that will benefit from witnessing unfolding action.

Our approach was, in part, a conscious alternative to the cognitive emphasis in much of the research on treatment on illness. Usually, a cognitive approach means hearing how and what people think, and this often means being or staying remote from the action, itself, not seeing what happens. Since cognitive research presumes a close connection between behavior and how our informants describe and explain illness and treatment, it appears unnecessary to witness the unfolding activity. Furthermore, since thought is recognized as prior to action, temporally and logically, to know how people think is to know what steers them to one or another action.

There are several cognitive approaches that are part of research on treatment and illness. One is to examine rules for making treatment decisions (Garro 2004, Garro 1998, Mathews 1990, Ryan 1998, Ryan and Martinez 1996, and Young and Garro 1994). Investigators identify a

limited number of considerations such as type of illness and the gravity of the illness, as well as other issues regarding treatment such as cost and access. A decision model approach examines one treatment choice over another in light of how an individual perceives these considerations. Another quite common approach is to look at shared understandings of illness. There has been a continuing research concern with explanatory models of belief, of the unfolding of illness, and of treatment, starting with Arthur Kleinman and others (1978). Another emphasis has been to look at illness narratives and to examine how an acceptable and meaningful story comes to be fashioned and as it become an acceptable guide for future action (Kleinman, Eisenberg, and Good 1978; Mattingly 1998; Mattingly and Garro 2000; Price 1987).

A cognitive approach does yield important information about terms, beliefs and perceptions. This is helpful for developing health education and for improving patient communication. Yet, the approach is full of problems. Decision-making models may be especially helpful for understanding clear-cut acute illnesses, but not so helpful for lingering illnesses when many decisions are still to be made. A study of beliefs and narratives may be important for the design of health-education materials and assist clinicians who talk with patients, but beliefs and narratives may have little to do with what is in one's head when actions are taken (Garro 1998). Research would need to look further to know what influences a decision and what is in people's heads when they act, in short, to observe what happens.

Our commitment to observe all that happens differs from the rapid assessments in health care (Scrimshaw and Gleason 1992, Scrimshaw and Hurtado 1987) and in other applied work.. More generally speaking, see Beebe (1995, 2001), Handwerker (2001), van Willigen and Finan (1991), and Vlasoff and Tanner (1992). Rapid assessments have a broad scope, but they, too, are dependent on cognitive approaches with their associated limitations. Moreover, much of the data collection relies on an informant's memory. Influences on treatment may be subtle or difficult to remember. Often apparently minor events and feelings are important and repeat

themselves in people's lives. This may be a clear problem with the so-called *calendar method*, recalling day-by-day events over the past two weeks (Baume 2000 Goldman et al. 1998) and with social autopsies reconstructing events leading up to death or some other calamity (Gray 1992 and Gray and Barss 1992). We often saw mothers so tired at the end of the day that they barely attend to their sick child. Being overburdened and fatigued are important and influential in the course of treatment, but these types of events are not easily recalled. Issues of mood and feeling tend not come to light in an interview. Events and actions take the front stage. Also, the presence of other people and the apparently minor roles they play in our life may also have a great impact, but these issues, too, do not necessarily come to mind in interviews. We also saw how individuals with minor roles in the child's life make seemingly casual suggestions, but their presence may be so important that they re-direct the course of the treatment plan. Frequently minor players and incidents just do not come to light in people's recollections.

Rapid assessments do have a major advantage in using many different data sources, not just memory and personal accounts. But a broad-brush approach also raises other problems. Data collection becomes selective. The researcher must decide on a range of questions to be asked. There are many diverse scenarios to be observed. The research team tries to make the best decision about the most informative time and place for data collection. Often, there is an effort to highlight the significant sphere of activity, like what goes on at a clinic. But a consequence may be a disproportionate and sometimes unwarranted emphasis on a topic that is less than important. For instance, research on the worldwide program of Integrated Management of Childhood Illnesses (see Black and Kelly 2003; Gordon, Yoder, and Camara 2005) has spent significant time in the clinic, reviewing records, observing medical supplies, training, and work routines of clinic staff. Yet we find, these factors are frequently not very important, because biomedical treatment has been taken over by the market vender of pharmaceuticals. They are the preferred provider of care. Independent vendors are more valued. They provide

familiarity with the client; they offer credit and ready access to care, day and night, every day of the week (Gordon et al. 2004, Gordon 1998).

Also, rapid assessment research, like much of qualitative research may create distortions because of the strong role of some informants, and not others. The voices of certain people, our *key informants* and confidants, play a major role in findings. This impact is especially pronounced when the research is short-term.

Finally, in rapid assessment research other distortions may come into play. Frequently, the routines of work, of collecting data take place during the workday of the field researcher, as opposed to having a fieldworker on the scene all the time co-existing in the community. Consequently, much is not noticed. We found important subjects and scenarios far off the beaten track, late at night, at odd moments, and coming from people who do not attract our attention in rapid assessments. The role they play may come to light when rapid assessment field teams tend not to be operating.

The Full Story: The Holistic Focus of Our Researchers

Our researchers heard personal accounts of what was going on as the action occurred. Most importantly, we observed the conditions in which actions take place. We followed the agenda of “practice theory” of Pierre Bourdieu (1977, 1990, Ortner 1984), which, as Ortner points out (1996: 1-20), is not really a theory at all: it is an outlook. We understand patterned behaviors as a response. Our researchers tried to witness everything - all that was happening with the child, who did what to continuing conditions and contexts, what Bourdieu would call *conjunctures*. Research focuses on the conditions to which individuals respond. Recurring or predictable responses are “the habitus” of a group. Going back to our example of the tired mother, she may fully believe in the importance of administering ritual baths for the sick children (the cognitive component), but the beliefs are not very important when the circumstances of life leave her too tired to act. She may, instead, simply decide - as mothers in this community were inclined to do - that the child is constitutionally ill, so the effort is not worth it. The

labeling procedure is the habitus. Yet under more favorable circumstances, when the mother is fresh from a night's sleep, she may aggressively seek out treatment and then another way of coping, or habitus, is evident.

Common Conditions and Variability in Practice

Our research readily disclosed the conditions or conjunctures associated with treatment practices. We had little problem studying the conditions and treatment practices in short term research. In the rainy season, childhood illness is endemic. The rates of childhood illness in Guinea are extraordinary and the child mortality rate (death of children under five) is 222 per 1000 in (*Direction National de la Statistique* 1999:23). When we studied in the rainy season, much of the illness over the year came to light during our term of study. Our focus on conditions turned up the following:

- a seasonal dimension to poverty and adversity during this rainy season. This includes increased illness, a lack of money for medications and proper nutrition, and heavy demands in agriculture work taking time from child care;
- patrilocal residence and patrilineal group membership, meaning the mother is particularly responsive to the expectations of her husband's family;
- reliance on alternative sources of treatment outside of clinic health services, these being market vendors providing “Western” pharmaceuticals as well as herbal treatment and massages provided by healers and elders who coax unhealthy spirits out of the body
- beliefs about continuing illness that may be explained by a child's sickly nature, from birth; and
- beliefs about some illnesses described as *kono* that assess the origin of illness in the bush and transferred to children via birds overhead, the scent of monkeys, and the consequence of accidentally crushing an insect.

But the recognition of commonly shared conditions does not explain individual practice.

The care of sick children is not uniformly compromised by seasonal poverty. Not all caregivers took direct orders from the patrilineage. Nor do beliefs about inherent frailty and the origin of diseases always play an important role. We were interested in why children are treated differently. We started research with the idea that the particular constellation of the agents of care – mothers, fathers, friends, cousins and so forth – may cause differences in practice. How the network of social relations is put together and functions is another condition, though it might be described as part of the micro-ecology of the child's life.

We do not necessarily think family and kin relations are always what is important to explain variability in practice. In another type of society, in one more cosmopolitan, the level of education and the type of occupation may play important roles. But here in Konindou II in Upper Guinea, there was a single ethnic and language group. Education, work, and wealth were pretty much on the same level for everybody. We found that social relations in the household, in the kin group or the living compound made for clear differences in responses to conditions and practice with regard to childhood illness.

At the start of our study, our researchers focused their attention on the micro-ecology or conditions of a child's life by collecting lists of all who would be part of the social network concerned with the child and the child's illness (see Trotter 1999). Then, over the course of research, fieldworkers examined how the social relations functioned. By the end of our research, we found four differing types of conditions of social relations affecting treatment of the child. Each type of situation had effects that strengthened or weakened the impact of general conditions such as seasonal poverty and patrilocal residence. The following were the four constellations of social relations:

- 1) children whose mothers or other caretakers who have no history in the community;
- 2) children whose parents have highly integrated systems of support both from the mothers and father's patrilineage;

- 3) children with mothers who marry into the compound and community but who have fractious relations with the in-laws and little other support; and
- 4) children with uninvolved fathers but with mothers who had developed other sources of support (Gordon, Yoder, and Camara 2004:17-35).

In this paper, we examine the case of a child in the third type of situation, which is that of a mother marrying into her husband's community and having little support and much difficulty with in-laws. Our illustration presents a day-by-day account. Then we discuss the recommendations that come from our examination of the findings. Finally we consider what ought to be done to enhance the possibilities of research that witnesses. First, though, we discuss the fieldwork.

The Fieldwork

Our research focused on the treatment of all sick children five and under. It was conducted in eight consecutive weeks spanning late June to early August. A child became the subject for research once illness was detected and research attention continued until the child was well again. Children who became ill had a mixture of maladies such as malaria, gastrointestinal infections, skin disorders, and respiratory problems. A child would often suffer several maladies in succession or concurrently.

Konindou II is a settlement of 444, which is the capital of the sub-prefecture of Konindou, itself part of the prefecture of Dabola in what is close to the geographical center of Guinea, but part of what is called Upper Guinea bordering Mali. The village was divided into geographic sectors, each named after a specific patriclan. There was the Draméla sector named after the Dramé clan, while the Camaralá sector is named after the Camara clan. Each fieldworker took up residence in a different part of the community, generally conforming to clan divisions.

Field researchers lived in the compounds 24 hours a day, seven days a week. They made observations, overheard conversations, engaged in casual conversations, and made cassette recordings of interviews. As the time of field-

work, the fieldworker blended with the time of the subjects in the study. Fieldworkers heard, and overheard, and saw much of what goes on. We had a team of five researchers each following about 31 children in the different sectors of the community of Konindou II. At the end of the field-study period, 61 of the 155 children covered were sick. Each was a separate case in our research.

The fieldworkers were Malinké women, all with at least a high school education and some who were finishing their university training in fields such as sociology, literature, or linguistics. They were curious and eager to learn about the ways of life of other Malinké who lived as many of their relatives were living or how they had lived in the parental or grandparent generations. Being Malinké, it was possible for them to enter the world of Konindou II, gain quick acceptance, and start collecting data immediately. Gaining trust in the community, though, was not necessarily smooth. There was suspicion, at first, but it quickly wore away as these women assumed their place in the compounds, sleeping close to their hosts, eating the same foods, and partaking in the small talk of everyday life.

Training Guidelines

With training and continuing supervision, we found that our fieldworkers could mostly be left to their own devices. We started out with one week of training in the field, where techniques of observing, interviewing, and taking notes for a journal were part of each day's instructional routine. Training included exposures to the field situation with submission and review of notes, observations, and tape recordings. All three co-authors conducted training. The first two co-authors, Andrew J. Gordon and P. Stanley Yoder, are both anthropologists, and the third co-author, Mamadou Camara, is a field linguist and native Guinean. Camara continued to supervise in the field from his base as a professor at the University of Conakry. Gordon also made several trips to oversee the fieldwork and follow up on data collection.

Our fieldworkers followed these four guidelines as instructions:

- 1) Even before the presence of illness, take a census of children who are five and under along with the network of social relations linking the child and the mother with others who may play a role in the daily life of the child.
- 2) Begin a case of study as soon as there has been recognition of signs or symptoms that suggest illness by recording the signs and symptoms that are meaningful, noting the diagnosis or diagnoses that accrue from what is recognized, and recording all the treatment and care that is provided.
- 3) Note all treatments and those who are involved in the treatments. Note assessments about treatment as well as the outcomes of treatments.
- 4) Speak with those involved in diagnosis, care, and treatment to capture just what is in their minds, and what they feel about the actions that are unfolding.

Fieldworkers were expected to note signs or symptoms that were recognized as *suggesting* illness, such as cold symptoms, fever, diarrhea, and respiratory discomfort. From this point onwards, the child was to be observed and contacted, at least once a day (though preferably more often) to know how people were responding to the child. Because work and residence are one and the same, making a household visit would entail no more than walking over to the next compound, usually about 200 feet. Frequently, news of an illness or treatment would reach the fieldworker simply by her staying put in the compound where she lived.

In accounts containing data on treatments, fieldworkers were instructed to record who gave the treatment, always getting details about who did what, and at what time. Notes and cassette recordings facilitated the task of . Fieldworkers posed questions in an open format to elicit maximum responses, to ask for illustrations of any general or summary statements, and to always ask follow-up questions so as to further probe the information offered.

A Case Study of Practice

We present a narrative of a case handled by *Maciré*, one of our fieldworkers. An eight-month-old male child, *Amara*, is suffering from a skin disorder and then from malaria. He is the only child of his mother, *Dyenabou*. Here we see commonly shared conjunctures of seasonal poverty and ambient morbidity in the rainy season. We also see the distinct conjunctures of the mother being an outsider and with fractious relations with her in-laws. Additionally, her husband is largely absent working in a town 36 kilometers (22.4 miles) away, and she has little in the way of support from others.

Day 1. On the first day in the case of Amara, Maciré learns of Dyenabou's efforts with Amara's illness. Maciré begins the case with an account of Dyenabou, whom she observes talking with her mother-in-law (Amara's father's mother). Dyenabou tells her that Amara cried all night. The mother-in-law touches Amara's head and replies that it is scabies that so disturbed the child and that the fever was due to his teething. Dyenabou remarks that Amara now only accepts the care of her grandmother.

Dyenabou brings Maciré up to date on Amara's problems. Amara had suffered this skin problem for months, visited countless healers and tried as many herbal remedies, but nothing had worked so far. All the healers offered diverse explanations for Amara's problems, one of which blamed a back sprain as the cause of fever. Dyenabou also mentioned her husband, who spends most of his time in Banko (36 kilometers or 22.4 miles away). He recently purchased tubabu basi; Dyenabou was referring to White (tubabu) medicine (basi). Dyenabou specifically cited the efforts of a well-known healer who recited verses (the maboros) and the advice of a healer who urged her to consult with Conakry-based Sousou healing women whose work with children is recognized throughout Guinea. Dyenabou had just returned from Conakry where she consulted the Sousou healing women.

Day 2. On day two, Maciré observes the ongoing action and records the conversations of others. From here onwards see stresses from her mother-in-law and others in Amara's patrilineage. Maciré records how the mother-in-law berates Dyenabou. The mother-in-law says:

It's you who doesn't want the rash of my grandson cured quickly. One who is nursing a child with scabies should turn the child over to someone else to wash it. Then the problem will quickly leave. I've always said that when you want to wash the child, let me know, but you never do it.

Then, in an off-hand comment, she mutters to herself, in a way that is audible to others:

The mother does not listen to the counsel of her mother-in-law.

The mother-in-law then takes the matter into her own hands, bathing Amara and applying methalatum Chinoise, a commercially available topical analgesic. She also applies an herbal preparation known as setulu, derived from tree sap. She summarizes the day noting how Amara's fever continues, and that he is not receiving any treatment. An eight-year-old girl, Amara's father's brother's daughter, takes watch over Amara while Dyenabou works in the fields.

Day 3. Maciré visits Amara and Maciré writes that while he is slightly better, he is still suffering. His hands are so covered with sores that he cannot even crawl. The mother-in-law crisply underscores the difficulty:

Ah, you can't even walk.

Then, directing her comments for the apparent benefit of Alpha, Amara's father's brother, she asks: "Where did this rash come from that covers Amara's body?" She comments that the problem came on bit by bit with no success in treatment concluding her remarks with, "I don't know what more to do." Then, turning to Alpha she sums up the situation:

Alpha, it's Dyenabou who makes the child worse.

Alpha acknowledges the mother's remarks then goes over to Dyenabou, hands her a tube of penicillin topical ointment, and reprimands her:

It is you who should wash Amara, who belongs to all of us. Since he is your child, take charge of his treatment yourself, for the love of God.

Day 4. Maciré speaks with those around

Amara and later engages the mother-in-law in a focused interview. As Dyenabou was preparing to go work in the fields, Maciré asked how Amara was doing. Dyenabou said it made her anxious not knowing what was wrong with her son, but that she was going ahead with pharmaceuticals her husband brought her. She added that the rash was drying up; mentioning that the improvements were the result of her mother-in-law's applying an herbal body wash along the reciting verses (maboros). But, Dyenabou also remarked, Amara still had a fever that morning.

Later that day, Maciré observes Amara's grandmother washing him and applying the medication from Alpha. In the evening, Maciré went to speak with Dyenabou's mother-in-law and culled her perspective on illness and the illness of Amara:

You know that the suffering here is due to our meager resources. Everyone here cultivates. The arrival of the dry season helps us to avoid suffering at other times (during the rainy season). During the dry season we have the harvest and the means to care for our children. But the dry season is now passed and leaves us now without anything and we find ourselves empty handed. If you are sick or a family member is sick in this period, you will be anxious because you go to the clinic and you don't have any money. What are you going to do? It's for that reason that we use our medicinal leaves to prepare in a boil and to wash our children... At any time a person can be sick, but in the rainy season with the humidity and cold, if there's an illness it becomes difficult and fatigues the person.... You know when the rainy season arrives there are so many difficulties, and it is a very difficult time. One day you get some rice and there's no sauce, another day you have sauce and there's no rice. Many of us are suffering.

Maciré closed the interview by asking about any governmental health care assistance and was told that yes, the government did provide assistance, but gave only medicines to prevent illness, not to cure them; she was speaking about vaccinations.

Day 5. (no entries)

Day 6. Maciré's observes Amara and is later consulted by Dyenabou who plaintively asks Maciré what to do in such a situation. After a brief discussion, Dyenabou settled on giving paracetamol (an analgesic that lowers fever) to Amara. Afterwards, Amara went to sleep. Alpha shows up to spend some time with Amara and carries him around to visit members of the family and of the compound. At day's end, Maciré found Amara still feverish

Day 7. Maciré observes that Amara is in the presence of his mother, his father, and his paternal grandmother Dyenabou's (mother-in-law) and Alpha. Dyenabou tells her mother-in-law that Amara had not slept. The mother-in-law remarked, "It's not still the rash, I hope." Dyenabou said that she didn't know anything about how such rashes were cleared up. Alpha, upon returning, shouted at his brother, Dyenabou's husband:

What are you thinking about for Amara? About this rash, they've told me that you've never done anything. He is sick again today, so what are you going to do? Are you counting on his mother? And the day she dies, what are you going to do then? You should learn what to do from now on, not for today but for the future.

At that point, Amara's father mounts his motorcycle and returns to Banko. Alpha turns to Dyenabou and asks why she had not treated Amara with the medicines he gave her. Alpha gives him a dose of this medicine, remarking that none of it has been used, and then cries out:

What more can I do? Let's quickly find a solution before there are further complications.

Day 8. Maciré observes that Dyenabou returns from a visit to her father in Konindou I, the adjacent village. Dyenabou reports that her father had plans to help with the payment for Amara's medications. Dyenabou runs into to Alpha, reports to him about visiting her father. Alpha spoke approvingly and Dyenabou said that she planned to return there the next day. That evening, Amara was feverish and Maciré

observes that Dyenabou simply went to sleep without involving herself, in any way, with Amara.

Day 9. Maciré notes that Dyenabou had not visited her father, as planned. Maciré also remarks that Amara still suffers, that he does not sleep, refuses the breast of his mother, and is not responsive to anyone. Maciré observes that Dyenabou is spent, physically exhausted, unable to keep up with her son's care. Maciré writes that she would have liked to have seen Dyenabou do more to help Amara, adding that, in going off to the fields and leaving Amara at home in the care of his 8-year-old cousin, she seems indifferent to her son's illness.

Day 10. Maciré writes that the rash clears up, but Amara comes down with what is recognized by the family as kono (malaria). Early in the day Maciré writes that the mother, despite an additional diagnosis, applies the same treatments. In Maciré's notes she record "No care for him, nothing... only the methalatum chinoise and setulu." Maciré also notes that after preparing food, Dyenabou returns to the fields. A torrential rain falls on Konindou and Maciré observes the rains worsen Amara's malaria. At 7 p.m., Dyenabou returns after working in the fields. She reports that she did not return to her father. That evening, Dyenabou washes Amara, applies setulu, heats the fire and retires. Maciré's journal discloses her negative opinion when she writes of Dyenabou's not returning to her father. She remarks, "Again it's not her problem only her cultivation interests her."

Day 11. Amara still suffers from kono (malaria); Maciré remarks that Dyenabou is not involved at this point, neither is her mother-in-law, nor Alpha, and Amara's father is always in Banko (36 kilometers away). Maciré observes that Dyenabou prepares the food, puts Amara on her back, and goes to the field, carrying Amara despite the torrential rain falling on him.

Day 12. Maciré observes that Amara's condition has worsened; he vomits a great deal and cries intensely. Maciré records how Dyenabou despairs and how, in frustration, she exhorts her son to recover. We view a mother at the end of her rope, unable to cope, fatigued, overly burdened by agriculture duties, giving up at times and given to accepting her child as *sidasolo*, or

constitutionally sick. She says to him:

I don't know anything anymore. I can't do the job of weeding my peanut field if you stay sickly [*sidasolo*]. I just don't understand. Pardon me, dear "little father" (term of endearment for the child), don't tire me out like this. It's the rainy season, and I have no help. You have to have pity on me. I was left an orphan when my mother died, and only your namesake [*Dyenabou's father*] is living, and all our needs fall on him. Then little father, drop this illness. I hope you are going to understand my advice.

Day 13. Maciré had given Dyenabou money, as she did on a weekly basis. Dyenabou went to the weekly market and bought Paracetamol and Indomiel (an antibiotic), from Mamadi, the main market vender of pharmaceuticals.

Day 14. Dyenabou reports that the medications appeared to have no effect, so they are no longer being applied. Maciré notes that the malaria worsens. Amara vomits after breastfeeding and Maciré records Dyenabou saying:

Amara, you have so fatigued me in the past day. All the dry season you have not gotten sick, you choose the rainy season to get all sorts of illness, and this is the most important time for cultivation. Everyday it's another illness.

Later, Dyenabou's mother-in-law appears and says, "What now, a sprain? As soon as you lift him he cries; his father should be aware of that." Amara's father returns from Banko and asks about the problem; Dyenabou affirmed it was fever. The father replied that it was also likely to be *konodoni* (a problem linked with vomiting), and recommended a healer. Dyenabou followed her husband's recommendation and has the healer apply a *maboro* and a body wash.

Day 15. Maciré writes that Amara is still unstable. Dyenabou informs her mother-in-law that Amara had not slept the previous night. We see how the case reveals that treatment activity can shift back and forth based in beliefs about kono or spirits or belief in biomedicine. The mother-in-law says that the child has kono, adding:

I have been waiting for this because the signs indicated this was the case: he doesn't do anything but sleep, his face has changed color, his stools are black, and in the middle of sleep he jumps.

The mother-in-law advises Dyenabou against working in the fields for the day, and to stay at Amara's side and to take him to Nakura, a healer. Maciré observes Nakura performing what is planned to be a three-day treatment beginning with a massage, applying setulu and then the recitation of a maboro. Nakura indicated that if this treatment could not cure the problem, then it would be important to use another plant medication. Dyenabou observes that a maboro is more effective if used in conjunction with an herbal preparation.

Day 16. Maciré writes that Amara is still suffering from the convulsions of malarial fever (kono). Maciré writes: "The mother-in-law has discovered that the illness has not improved, but she doesn't provide any care. Since the morning, she goes to the field, leaving her grandson with his mother, alone." Nakura's treatment continues. Maciré writes, "For the moment, no member of the social network does anything." Maciré has grown accustomed to our use of the terminology "social network", so her observations show signs of social science.

Day 17. Maciré observes that the kono continues. Dyenabou hears from a neighbor that Kerfala (well known for treating kono) would be the answer to the problem. Nakura's treatment continues.

Day 18. Diaka, whom Dyenabou describes affectionately as a "sister" gets involved and urges Dyenabou to see still another healer, Naba, one of the best-known healers in Konindou II. Aiba Kalo, another well-known healer, tells Dyenabou to go into the bush, collect leaves for treatment, and prepare them in a boiling pot. In an interview with Dyenabou, Maciré asks how she was aware that the problem was kono. Dyenabou replied, precisely reciting the diagnosis of her mother-in-law, "His eyes are swollen, his stools are black." "Who advised you about this," Maciré asked. Dyenabou replied that her mother-in-law had, and that Nakura, the healer, had affirmed it. When asking Dyenabou if she was

going to take Amara to the work in the field, Dyenabou replied that she could not, because when the rains came down, it worsened Amara's condition. Maciré asked if Dyenabou had an umbrella. Dyenabou replied:

If you don't have the money, you can't buy an umbrella ... because it's the rainy season, and now it's hard on everybody.

Maciré then asked about the choice of caring for the child versus doing work in the field. Dyenabou replies that it wasn't even a question, because if you aren't involved in cultivation then things will be difficult for you. Dyenabou mentions that her husband would like to help, but that he didn't have anything. She also mentions her father, but explained that he proves to be less than helpful because of his obligation to his wives. Dyenabou adds that her mother was dead. She continued, reflecting on another theme, the problem of social support:

I don't have an older brother, nor older sister or young brothers or sisters from the same mother ... the only one who cared for me is no longer here. His child came and brought him to America. It's he who sent me money and bought me clothes. Since he left, I have no one. With his paternal grandmother, one day she is happy and comes over to play with him, and the next day she's angry or not feeling well.

Dyenabou remarked that she has friends around but they follow the lead of the mother-in-law and do not treat her kindly. Maciré asked what she would do if the problem continued for another week; Dyenabou replied that she would go to the clinic and to Mamadi (the vender of pharmaceuticals), as she had been told to see him on market days because he has lots of medication. When asked who would pay, Dyenabou replied that her husband and her friend Diaka would pay.

Day 19. Maciré learns that Amara slept well, after many days without sleeping.

Day 20. Maciré observes that Amara's condition improves.

Day 21. Amara slept all day, but had cried all throughout the preceding night. Maciré writes

that the mother-in-law is seemingly unconcerned, simply telling Dyenabou to prepare food, and then going to work in the fields. Maciré observes that Dyenabou's husband, too, remains unconcerned for Amara. She adds, with some obvious displeasure, that all he does is go back and forth to Banko.

Day 22. Amara continues to sleep, but has little desire to breastfeed. At this point, Dyenabou is no longer consulting healers.

Day 23. Amara is a little better and is in his eight year old cousin's care.

Day 24. Amara appears to be recovering, having spent the night peacefully. Amara is properly nursing.

Day 25. Recovery continues; Amara is reportedly very happy and smiling. Afterwards, Amara is fully recovered.

What A Case like This Can Tell Us

This case tells us how conditions impede any effective care. Seasonal poverty and the practices of *kono* treatment block effective care. Also Dyenabou proves less than attentive to her child due to work obligations. Being so stretched in her responsibilities, she simply resigns herself to the label of *sidasolo* and thoughts that further efforts are not worth it. The answer to her problem certainly does not wholly lie in better health education or more services. The conditions of her life need to change. In Dyenabou's case, her contacts provide little buffer to adversity, and they offer insufficient support. To change practice, we need to change the arrangement of her everyday life. We recommend the following interventions to address the problems of practice we note in her story:

Practices	Recommendations
<i>The practice of local medicine.</i> The case lets us see how the authority structure based on seniority and the lack of money both enhances dependence on <i>maboros</i> and on body washes, not use of biomedicine and clinic.	An answer is to rely on the elder generation to promote biomedical alternatives. In this fashion, they may keep the authority that they have had. In fact, their authority could be strengthened, not threatened, as they become agents for biomedical practice.
<i>Fatalistic postures connected with the sidasolo diagnosis.</i> It seems a default classification of <i>sidasolo</i> , deciding that children are constitutionally ill, is another and sometimes preferred option to battling against more fatigue, despair and expenditures of personal resources.	One way of attacking the problem would be to provide linkages and support among mothers to create systems of mutual assistance so as to stave off being "burned out" by dealing with one child's illness.
<i>The practice of leaving the child in the care of other children and the practice of exposing the child to harsh conditions presented by the work situation.</i>	Instituting day care with a trained paraprofessional provider to care for sick children when mothers have to go to work.
<i>The problem of seasonal poverty.</i> This limits access to health care and causes malnutrition.	Prospective payments into a health care system and the providing of nutritional supplements.

We do not imagine that the above recommendations will be as important for those children benefiting from social networks that are broad and deep, or for those households where husbands are on the scene. But others, like Amara, will certainly benefit as with instances of grandmothers caring for grandchildren, of individuals moving into the community without any relations at all, and of husbands being out of the country.

Trusting In the Research

Our stated agenda in this article is to promote and expand research that witnesses ongoing action. Much groundwork needs to be done to enhance the reliability and trustworthiness of the approach. We recommend several procedures for (1) selecting a place to study, (2) training the staff, (3) supervising the researchers in the field, and (4) presenting the findings of the research.

Selecting a Place to Study

Researchers, especially applied researchers, need to avoid charges that the community studied, and therefore the findings, are irrelevant. Findings can be easily dismissed as being far from the norm. This situation did not necessarily happen to us, but our case did not attract the sort of attention it might have were it recognized and widely accepted that the study was representative. We should have handled our site selection differently. We should have developed consensus that the site we selected was representative and meaningful for a number of communities. With a functioning health center, as it turns out, Konindou II did closely resemble other communities in the area of Upper Guinea. It is typical insofar as its agro-pastoralist economy is populated by Malinké, who strongly adhere to the Islamic faith, and. Had we engaged others in the process of site selection and had they agreed that the findings were important for other communities, many would have been deeply invested in our findings. Nevertheless, we would likely have chosen the same community.

Training the Staff

The training of the staff, similarly, needs to be a standardized. Teaching about making observations, keeping field notes, interviewing,

and developing a case study was a process that we knew how to do because we had done it before, many times, either in the classroom or in the course of training collaborators in field study. However, a method needs to stand independently of its practitioners. It will be necessary to write it all down for protocols to be clearly spelled out. The process along with its goals of training will need to be codified. That will help maintain quality control and reduce uneasiness about the techniques that may seem to outsiders as highly idiosyncratic, and perhaps perceived as variable as the personalities of the fieldworkers.

Supervising the Researchers in the Field

Defined guidelines about the breadth and data of collection will enhance fieldwork and increase the trust of the readership. Our researchers were well prepared and well trained for the experience of fieldwork, but there was considerable variation in the extensiveness of field notes. Over our time in the field, we realized the need for standards. They should have been more fully developed before fieldwork began. Then the fieldworkers would have had a guide for what constitutes a well-developed case study. They would know how a case might fall short, either in quality and quantity.

Also, we found that standards of excellence, or even of sufficiency, cannot be readily conveyed. Just turning over instructions, however much they are detailed, will not ensure adherence to standards. Continuing dialogue and interaction among fieldworkers, and with the supervisor, will go a long way to sustain norms about what persons and what actions should be observed and in how much depth, basically, to know when there is enough material.

Motivating community cooperation is another important area in need of clear procedures. For Konindou II residents, there was not a lot of interest in participating in interviews, especially when our informants found work in the fields or found their household chores to be far more compelling. Often, they would consider relaxation after a day's work to be far more desirable than hunkering down with a fieldworker. We needed to motivate informants. Several weeks after research began, we responded to the problem by providing each fieldworker a small

sum of money that they would give to informants with whom they would want to talk and interview. We discussed dangers of making an interview a quid pro quo for a gift, as community members might fashion reports just to get paid. Our fieldworkers were instructed to give gifts casually, at a time and place apart from the interview itself.

Our paying for information, however indirect, may not sit well in all societies, but here, in Konindou II, we were comfortable that we were acting in a fashion consistent with local norms since gift giving is an essential part of life in the community. Not to give a gift after someone had generously given time and information would, in fact, be contrary to custom. In other fieldwork ventures, the supervisor of the field workers would need to arrive at the best decision.

Finally, we found motivating our fieldworkers to be similarly important. Among the five, there was not the same appetite for running after information and tracking down interviewees. This situation presented a considerable challenge for the supervisor who could not simply rely on the eagerness of fieldworkers to go after that next interview. Like all of us, at certain periods of the day, such as late at night, early in the morning, or perhaps on a particularly hot afternoon, the inclination is to relax. Also, there was no way for a supervisor to know if someone should be interviewed or if there was no need for a specific research task. Midway through research, we decided to change the reward structure. While there are many problems connected with payment according to the production of evidence, it did, in this case, work for us. For follow-up interviews, we gave an extra supplement for each interview completed.

Presenting the Findings of the Research

As a basic expectation, a report that witnesses treatment of ill children should reflect the range of alternative practices. One way to proceed is to present in-depth case studies of different types of practices and conditions. The report should describe variability within each type of practice as in the work of Mathew Miles and Michael Huberman (1994), develops a number of tabular formats to show subtypes and subtle

differences from case to case. Combining extensive case study and tabular distillations of textual data will both provide an intimate knowledge of the local situation as well as give the reader confidence that variability has not been ignored and that the full story has been told.

A Final Thought

Those planning this sort of research should be alert to the way that official bodies sometimes resist efforts like ours. Data collection is a little like trawling the ocean floor since one is not at all sure what will turn up. This is not to say that organizations that oversee and fund research necessarily fear the unexpected, though that may well be the case in certain circumstances. Yet people and organizations do, though, want to work within a zone of comfort. The preference is to turn up problems for which there are recognized remedies.

Another point of resistance is uneasiness with fieldworkers having so much latitude to organize their time and efforts. Such freedom of action is rare, and it is usually given to those at the upper echelons of professional practice. Those above in the organizational hierarchy fear that those lower down will shirk responsibility and not be up to the task. Furthermore, they fear that unplanned interaction with community members will lead to breaches of etiquette, threatening official relations.

The development of guidelines and procedures is likely to lessen some concerns. But for remaining uncertainties, aside from encouraging experience with the research process, there is little we can do to quell many anxieties. Only going through the research process will make the benefits apparent and make the liabilities seem not nearly so great. Those responsible for health-care programs are rarely exposed to cases like the one of Amara. These individuals are usually tethered to offices in capital cities, far from community life. They do not commonly have the close exposures with people in communities like Konindou II, nor are reports like ours common fare. Reports that witness day-to-day activity do provide considerable possibilities for empathy and understanding. The insights to be culled may lead to interventions and innovation far more bold than those that are commonly

inspired by statistical reports that usually conclude with the need for more training, more education, or improved clinical protocols. Research that closely witnesses what is happening is likely to lead to trenchant and lasting changes. ○

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