Medical Ethnography over Time

Penetrating "the fog of health" in a Nigerian community, 1970–2017

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Abstract: Too often, research into the health of a particular community is brief and superficial, focusing only on what is public and leaving the private health of women and children 'foggy'. By contrast, long-term anthropology can offer access to processes taking place within a local culture of illness. Here, an account of a community's experience of health over the past 50 years not only outlines the key changes as seen anthropologically but also shows how even close ethnography can initially miss important data. Furthermore, the impact of a researcher – both as a guest and as a source of interference – underlines how complex fieldwork can be in reality, especially if seen through the eyes of the researcher's hosts.

Keywords: domestic religion, Hausa, interventions, missing data, Nigeria, spirits, witches

Medical ethnography, I suggest, is more about the health of the public than about public health, but the experience of the public's health is enveloped, for Nigerian and expatriate practitioners alike, in a 'fog' which sorely limits their understanding of both patients and the actual outcomes of their health policies. Yet practitioners at all levels, I would argue, need to know what really happens on the front lines of their battle against ill health. Other scholars can scrutinise the ways of government, its policies and its health services, but the intricacies and variations in the way in which ordinary people (especially women) handle illness at home take time to record and require an intimacy that usually only an anthropologist can develop (if they will). One academic hazard, however, is that the anthropologist's original, careful analysis can go out of date – or seem to, at first sight: the health of the public can change so markedly that the value of the anthropologist's account lies primarily in its value as history, albeit history of unparalleled precision. Today, that kind of history is often otherwise at risk as modern bureaucracies keep far fewer paper records and make key decisions on the phone or by email, or simply construct policy face-to-face at meetings without minutes being taken. The impact of global health has left even fewer traces at the level I wish to examine here: changes in global health may affect Nigerian government policy, but the changes in the health of the community I am discussing are largely self-generated. It is that process of self-generated change (and its less-predictable consequences) that close, long-term ethnography alone may illuminate.

But what is also striking, in my experience, is that some key elements in people's coping with illness do not change – for example, the scarcely visible practices that women may use to prevent illness in their immediate family. These practices are more than just old 'habits' – they are integral elements in the family's own system of personal 'public health'. They do not show up in answers to questionnaires or get discussed in focus groups (too embarrassing to mention in front of others?), and they do not get mentioned in interviews (too minor so just taken for granted?),

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but they can be visible to an observant ethnographer, who can then discuss not just the practice itself but also the other contexts in which it occurs.

Here, I will outline some of the changes that I have witnessed in the deep-rural Hausa community where I lived as a (self-invited) guest for two years from 1970 to 1972. (The data in this article draws on some of my previously published research [Last 1981, 1991, 1992, 2004, 2011]). I have returned there briefly almost every year for the last 47 years (and will continue to do so if I can). In-between visits, I am told of deaths or rare epidemics (such as whooping-cough earlier this year [2018]), and can hear other news by phone and text message if there's a mobile-phone signal. But this is no substitute for simply sleeping a few nights there and being shown the physical changes to the farmsteads and their fields and hearing about people's troubles either directly or through local gossip. I admit, I am no stranger in that community, but that does not mean that I am as privileged as perhaps I imagine: simply hearing how I was seen all those years ago and all the worries I caused (many decided I was up to no good – more of this below) shows me now how much of real social importance simply passed me by. My stay had consequences in the long run – by giving out some medicine to those that came to me, and in emergencies taking women to a hospital 25 miles away, I probably brought about an acceptance of some types of treatment that lasted long after I left – and encouraged some young boys to get an education and return with a competence in community health services. I personally think that more anthropologists of whatever speciality should try and keep returning to the communities they write about, and record what has happened since they left: how interesting it might have been had, say, Edward Evans-Pritchard returned to the Zande as a familiar visitor or had Meyer Fortes stayed acquainted with his Tale hosts and chronicled in greater detail what was happening in the Tong Hills. Was Evans-Pritchard, with his interest in witchcraft, ever feared as a nasty 'witch' himself? But he never lived within a Zande compound – in those days, anthropologists camped in tents or stayed in mission stations. These anthropologists were rarely part of the communities that they were studying: did that make them seem less dangerous to ordinary people?

Key Changes: 1970–2017

The single most striking change in the community where I go as a guest has been the sharp drop in child mortality. In 1970–1972, it was 50 per cent – of the 131 children whom I knew, 65 survived and 66 did not. This year (2018) only one child died, an 11-year-old girl in an accident drawing water early in the morning from the community's deep well. In 2017, another child had died, a 7-year-old, possibly of epilepsy. No babies died; year after year, I visit the private graveyard that the community maintains and my host identifies for me who is buried where – babies are buried in rows alongside the adults. With such a low mortality rate, the number of children in my hosts' farmstead has grown hugely – from 60 when I first lived there in 1970 to over 400 now: I admit that, when I visited in 2017, I was at a loss over the names and identities of all the children from the different domestic units.

Another important change, then, is that women are no longer being hugely hurt by child deaths in the way that they were 50 years ago: then, it was a regular tragedy marked by no screaming (except on one dramatic occasion) but by deep despair marked by community-wide silence and inactivity that day. Death at that time was always uneven – one wife might have eight out of her nine children alive while a co-wife (same domestic space, same water; all the children played together) might lose eight of her children. For some, the cause could well be sickle-cell anaemia, but for most the disparities in child survival amongst co-wives were simply due to Allah's will. Nonetheless, deaths might be attributed to more local sources – sorcery, witchcraft, even 'sacrifice' to the *dodo* of a man who wanted to be extra rich; these suspected sources of tragedy were always *within* the community, as in-house suspects had the easiest access. In short, not only was death, child loss, pervasive then – if not of one's own children, then of one's co-wife's or neighbour's – but so too was the scent of fear and suspicion. I think it is hard to over-estimate the wider effect of child survival today – psychologically and socially: the depths of despair, the sorrow that could be underwritten by suspicions and envy, have become dramatically reduced. But, and this is important but hard for me as a visitor to verify, there are other (new?) sources of worry and distress amongst women in the community – even perhaps a new loneliness, despite the unremitting work of raising perhaps eight children on one's own, without co-wives and their children all around you – especially now that (relatively) radical Imams from the group *Izala* insist on physical barriers being put around each family unit within the house, thus making ordinary social visiting and sharing of worries very difficult.

Child mortality is not, of course, simply about deaths – it is also about a series of illnesses, of panics and fears that the current infection may be the one that will kill the child: the search for help and the suspicions that someone close by is the possible source of harm to one's child also generate occasions for discussion and debate that may be, in their own way, therapeutic for the harassed mother. Today, that mass of sympathy and talk seems much less evident (though there is always some trouble to complain about – but to whom?).

Another huge change since 50 years ago, one that public health was indeed responsible for nationwide, is the disappearance of Guinea worm. All the local standing waters, in ponds and pits, are free of it, so that no longer is a high proportion of the household temporarily crippled with the ulcers and the slow extraction of a long worm. I knew a baby that had Guinea worm in its tongue – but that was rare (and lethal). Everyone washed after a day at work, and many used the various ponds and pits that still had water to wash themselves. The alternative was to walk, still dirty, back to the house, then draw water from the well, and finally wash: well water, if the well top was properly protected, was clean. In the two years that I was there, I never got Guinea worm, but then I was not doing the heavy physical work that required a wash. However, children were always liable to catch it, cooling themselves and swimming amongst the ducks in the huge borrow pits from which houses took their building materials. The gradual winding out of the worm from one's shin had to be done with great care, for if the worm was broken, then the site could get infected and turn into a long-term ulcer that would be hard to heal – and that would mean restricted farm work and limited mobility: a costly disability. It was not a complaint that was taken to a hospital, so its big economic (and thereby social) effects were largely overlooked.

Other dimensions of public health have been less in evidence. The best of them, eventually, was the systematic provision of the measles vaccine. Mothers had to take their children several miles to the village where the vaccinators should be ready for them (but often failed to turn up). Initially, the cold boxes were stolen by the vaccinators and the vaccines would get warm and fail, but today the system seems to work: mothers actively want the vaccination, so the authorities have to ensure that things go right. In the past, there was much suspicion of public health campaigns, the most notorious of which was the sleeping sickness service. Everyone was gathered to be checked by the inspectors who, it turned out, were looking for affected persons to take into a camp for long-term treatment: but the only 'affected' persons taken happened to be just the most beautiful women and girls. There was nothing their menfolk could do to 'liberate' them from the men of the sleeping sickness programme. Such scepticism over the real ends of medicine applied permanently to hospitals, which under colonial days were seen as the 'power stations' generating the control that otherwise feeble whites exercised as colonial rulers. In these hospitals (enclosed as they were with high barbed wire), whites took out the parts of dead African patients and used them for their magic for exerting power. No one unless in dire desperation would dare to be admitted into the hospital: if I took someone, I would always promise to bring them, or at least their body, home (and I did). It is, I think, important in studies of public health to recognise that medicine (including such carers as those involved with the group Médecins sans Frontières) may well be being identified, by its patients and their kin, as at its root very evil – that is, as self-interested and not charitable. I like to believe that this hostility towards modern medicine has diminished – that mortuaries are now no longer seen as fridges for the body parts useful to nefarious doctors. In the 1970s, the doctors given the task of doing post-mortems had to have special protection around the clock. If a corpse was taken back home from a mortuary and the kinsmen of the dead unwisely unwrapped the body, they might well find the chest cavity stuffed with paper and various parts missing – taken for scientific testing but never returned to the original body. Occasionally, what came back was the wrong body. Is it surprising, then, that the living were scared of any kin of theirs dying while in the hospital?

Otherwise, in the community there is still little sign of basic public health initiatives having been delivered over the last 50 years: there is no pipe-borne water, no sewers, no electricity and no roads (only tracks along the traditional cattle routes [*labi*]). A primary school is now over an hour's walk away, and dispensaries or clinics are much further off. The main advance in the public's health, however, lies in the fact that transport has improved greatly: pregnant women or the seriously ill can now be taken by private motorbicycle quite rapidly along the paths, whereas before ordinary pedal bicycles could scarcely take the ill or those in difficult, obstructed labour for help. Though there was a small university-run hospital some 25 miles away, it had no ambulances available – even if a messenger was sent by bicycle to call for urgent help (appealing to the Catholic

Fathers in their mission station was the only hope villagers had, for the Fathers had a car). However, I had my old car, so I in effect acted as the locality's ambulance, being called out at all hours to remarkably inaccessible houses over – to my dismay – an increasingly wide area. The patient lying prone in the back of the car (a small, bouncy Citroen 2CV) suffered sorely from the lack of a smooth route to the main road, yet women's capacity to survive, silently, astonished the hospital doctors when we reached them: haemoglobin counts could fall as low as 2hbg (with a foetus half out) and yet the woman would recover. Stretchers were out of the question. Only the dead were carried that way, I was firmly told – so they had somehow to walk to the car. In short, items like transport need to be included within the remit of public health: clinics are essential but so are the means of reaching them, especially in an emergency. Medical anthropologists, I suggest, need to keep real-life transport systems in mind along with everything else on their lists of things to research.

Contemporary public health in northern Nigeria to a large extent perpetuates the much earlier colonial policy of 'subsistence health' (as I call it, replicating the old notion of 'subsistence agriculture'). In subsistence health, the government lets the population get on with managing their own health and ensuring their well-being themselves with herbal medicines and healers alongside whatever modern medicines that commercial companies like John Holt might import and distribute through markets and petty traders on bicycles. Thus, analgesics like aspirin were widespread under such proprietary labels as *pengo* (= 'pain go'). The colonial government's public health policies were for long primarily designed to ensure the everyday health of colonial officers and the army and police; townspeople might have access to services, especially during the early major epidemics of Spanish flu and meningitis. Eventually, more local, rural health services were provided, often by missionary dispensaries (linked to anti-leprosy work; its main medicine, *dapsone,* was also used by women as a general pick-me-up). Healers included notably effective bone-setters and 'psychotherapists' using initiation into the spirit-possession cult as their main treatment. Childbirth, tooth-pulling, blood-letting (*amhul; kaho*) and lancing swellings (with a red-hot arrowhead) were all done at home (and often still are); male circumcisions were done by barber-surgeons who would also do whatever decorative skin markings were still wanted on boys and on girls, and he would even do the excision of both the uvula and the hypertrophied hymeneal tags in the newborn (no cliterodectomy was ever done). Today, market specialists offer a wide range of medicines (including antibiotics), bed-nets against mosquitoes are readily available, and government doctors open private hospitals of their own out of town: injections and drips can be put up by local men interested in health as a trade. There are hidden skills, alongside new versions of more traditional styles of therapy (such as those used in casting out demons), that surprise me when I come across them: people often have more than one 'profession'.

But fashions for interventions come and go. The most serious has thankfully now come to an end. It was the persistent fad for cutting the anterior wall of the vagina to relieve the 'salt' (*gishiri*) that supposedly can accumulate there and hinder delivery. The cutting, done with a razor blade, often holed the urethra, resulting in a vesico-vaginal fistula that left the young woman leaking urine all the time. The distress that this procedure caused was huge: the woman might find herself having to leave her husband's house (and her children) – the smell was so troublesome – and await a complicated surgical repair at a university hospital. The practice of *gishiri*-cutting started, I think, in a rather bizarre imitation of a hospital episiotomy, possibly in the 1950s, as a local midwife's means of preventing an obstructed or difficult labour. *Gishiri* was considered infectious; it could be 'caught' by sitting on another woman's stool or mortar (something even a man should never do). By the early 1970s, even pre-pubescent girls could 'catch' it: now the practice is very rare. Fistulae are still coming in for repair but are blamed now on too early a marriage. In the community where I was a guest, young girls were estimated as ready for marriage by their large-enough size, not by menarche; a small girl had to wait till she was broad enough at the hips.

This 'subsistence health' was built upon generations of observation and care: it worked for adults – but 'traditional medicine' cannot manage paediatrics, not even in China. It is the one area of medicine which is widely recognised as truly important, but it is therefore Allah, not the colonial whites, that ultimately brought it, as a blessing.

Missing Data

Like every anthropologist, I missed seeing, let alone noting down, a lot of what was happening that was significant to my study. By going back to my original hosts (field site is too fancy a term) almost every year

for over 45 years, I have filled in some of the gaps both in my understanding and in my observations. I will here outline only a few. Perhaps the biggest omission was my not taking seriously the role of *jinn* or spirits that are pervasive everywhere; just like ants or mosquitoes, they are ever-present, but crucially they are on the move, going with the sun from east to west each day. They pour into houses through every door and window, looking for the smells they like and the damp places that please them. They much enjoy dirt, they play in rubbish and happily play tricks on adults: their playmates are children. That sounds easy to record, but what women actually do to protect themselves and their children from potentially troublesome *jinn* is much harder to find out: people simply do not talk about it; indeed, they may be embarrassed to admit to whatever it is they do to avoid annoying *jinn*. For example, every housewife sweeps her yard daily (or more often), and as she does so her lips move: she is saying 'excuse me' (*gafara dai*) to whatever *jinn* she might be disturbing. She may sweep her hand over the cloth on her bed before she lies on it, similarly saying 'excuse me'; at other times, if she is filling a bowl with hot water, she will warn any *jinn* to move out of the way. All sorts of protective measures, scarcely visible and never talked about, are taken to keep one's domestic space safe. I missed noticing it until I later saw the same practice going on within the city of Kano. Sometimes, the presence of *jinn* can affect the price of land; some trees are dangerous to sit beneath. To its residents, the countryside's topography is more complex than geographers might realise or might map. Yet maps of spirit highways and hotspots are possible.

Many times, I learnt important aspects of everyday life purely by chance: for example, I was in the countryside when Armstrong stepped onto the moon, so I mentioned it to my hosts: their response suddenly opened my eyes to their world – 'so what', they said to me, 'the moon's only a mile away'. Instead of my way of looking up into the unfathomable depths of the sky above (with angels, heaven and God?), for them the sky was very close, like the low ceilings of modern houses; if while walking in the dark you saw a star falling, you might sensibly fear it hitting you. The moon, being so close, affected women's periods if ever they risked sleeping outside: the moon was dangerous, as it emanated *raba* ('dew'?) that could make you ill. Instead, what was for them truly unfathomable were the depths of the earth beneath their feet, where underground rivers flowed huge distances (feeding wells, of course) and much, much else besides – snakes, the dead/ancestors, the vast roots of trees were only the knowable elements of the world below; caves (rare in Hausaland) could be risky entrances to that realm. So, if you danced, your steps were focused down towards the earth, not like a ballerina seeking to fly. And birds were of little interest, spiritually or practically (except to boys, who would roast them), though if you followed one hopping along on the ground it could lead you astray. You can never be sure that what you see is really what it is.

Hardest of all to research was – and is – how ordinary people actually understood their anatomy and physiology. Simply asking a person how their body works elicits little, or you get only what someone has heard (if they were lucky) in primary school. Yet in time, I found, simply through listening and overhearing, that Hausa 'ethno-anatomy' and 'ethno-physiology' were distinctly different from mine. It would never have occurred to me, for example, to ask whether women have 'semen' (*maniyyi*) too, but they do, and both partners need to ejaculate together to have a baby. My main point here is that some occasions are better than others for hearing such details: in my experience, the women's conversation in my car on our way to the hospital and back produced intimate information of all sorts as did nowhere else. I might get some unusual insight from someone out alone on his fields, and, as a pleasant excuse to rest, he or she would tell me things I would never hear inside the house. Similarly, this was the case with groups of children: they might compete with each other to tell me the most intriguing gossip of the day – or their personal worries. I did not do interviews or carry out focus groups: my medium was chat – all day and late into the evening. What cured me of interviewing was when I had spent three weeks interviewing every household in a Muslim village for their family's medical histories (120 in all). Being on my own, I had a record of when I had talked to whom. On analysis, the survey showed me one crucial fact – namely, that my medical 'histories' showed up less illness the closer the interview had come to lunch time. How many big sociological surveys are proof against such distortions of the data? Do they ever analyse their responses by the variable time of day during which their interviews were conducted?

My point here, nonetheless, is that no matter how serious an ethnographer one might be, no matter how long one stays, the really intimate ways of seeing and sensing – ways that may be so crucial for understanding a community's health – are chance rewards, but rewards one may still completely misinterpret. I think one can easily over-dramatise, especially to for-

eign audiences, what one thinks are subtle insights. In this regard, there is one really major dimension of my stay in my hosts' household that I missed at the time, but which I have been told more of in the years that followed. My very presence had been a matter of contention within the wider household: one half had been very unwilling to take the risk of letting me stay (for how long no one knew, nor did I), while the other half had been confident enough to take the risk of having a young white man living and sleeping within their house. Whites are known to be evil, and very powerfully, perhaps surprisingly so (what else was colonialism?): some residents of the household reckoned I was a 'witch' (*maye*), but they hoped that I was a 'good' witch who, if they took me in, might help rather than harm them. The assumption that a few of them had was that I had already consumed a thousand babies (a delicacy that witches are notorious for enjoying; hence the high infant mortality rate), and so I would not really need to eat any more: it was my relatively well-fed shape (and prosperity?) that suggested that I was a sated witch. Then, a few months later, I had rather a violent dream and tore skin off my foot on the rough mud wall of my room; I joked about it the next morning to my close neighbours – women and others (including children, my most tolerant but amused conversationalists). This wound of mine, I later learnt, was proof that I was indeed involved in a mighty mystical battle that had long been ongoing between me and another known witch in the other side of the house: at the time, I was treating him for a knee injury, but it was assumed that I was in reality trying to disable, if not kill, him. Decades later, I was told that most people in the house had thought that I would either die at the witch's hands or at least flee the house in terror: he was, after all, my senior and the stronger witch. But he was not: instead of me dying at his hands in our 'battle', it was he who finally went mad, and some 20 years later (when I visited yet again) he was being kept locked up, as he was being erratically violent to his long-suffering wife. But quite what that meant for my unspoken reputation I never knew.

I think that as anthropologists we too often miss the impact that we have on our hosts, and how awful, or awe-inspiring, we may seem to some. To some, my powers were many: I had x-ray eyes and could see inside people; I could invert the uterus of a maiden/bride so she would not conceive with her new husband; and I could take away all the spirits that guarded the house and provided the house's main woman healer with her powers. Spirit possession stopped till I was back. Fortunately, I did return soon and everything went back to normal – and the bride conceived soon thereafter. I was, I thought, very circumspect in all my human relationships, though I did not really know how to behave as a proper young ba-Haushe should.

But as a would-be ethnographer, in one incident I did badly misbehave: I intervened in order to stop a possible riot and murder in the house where I was a guest. One night, in another section of the house, a roof fell in on one of the pubescent girls asleep next to her mother; the falling timber hurt her shoulder, and the next day she told her friends that she had been dreaming of a kinsman (a 'witch'?) trying to cut off her head. On hearing this, other girls and adult mothers started having similar dreams, which roused the farmstead's young men to fury. There was talk of their killing the 'witch' – still their senior and their kinsman. I panicked: I did not want to be witness to a murder and caught up in all the ensuing troubles in the community where I was a guest. So I managed to persuade a friendly hospital doctor to give me barbiturates to ensure that all the dreamers no longer dreamt. It worked, and in time the 'witch' was forced to leave the house and live with one loyal wife nearby, only to be re-admitted to his old house 17 years later (when I happened to be there).

My question here is how far should an ethnographer intervene and change significantly the milieu of his or her field site? Should I have let the violence within the household run its course and written it up later as a supposedly 'expert' eye-witness account of 'witchcraft' in action? Did I ruin my fieldwork? My university supervisor (M. G. Smith) could not guide me – he was far away – and the incident was all over before he heard about it. I personally had no doubts: I was a guest, not an intrusive ethnographer-on-the-make (as in reality I was?), but I admit that I was afraid, and I thanked the doctor for the barbiturates. I never had an assistant, or any interpreter, so I was on my own in the community: I do not think that I was ever at risk, but I was in many people's eyes clearly vulnerable (and the weaker 'witch'). I did not have (as some social anthropologists I know *did* have) a revolver or firearm of any kind: hyenas could be a worry whenever I slept out alone in the bush, and no doubt that is why some anthropologists have been armed. But it is known that at least two 'early' anthropologists used guns with effect in the field – and their victims were not wild animals. Vulnerability in my view is an asset – but what would have happened if some group of youths had taken my status as a nefarious 'witch' literally? I was so naïve, that such a possibility never occurred to me. Perhaps in that very

naivety, obvious to all (if not to passing hyenas), lies our security as ethnographers?

My puzzle therefore is two-fold: first, why did I not realise quite what mayhem my presence was generating within the house? I thought I was just being a polite but ignorant guest, smiling (as whites do, being hypocrites all) and making poor jokes – the last thing I must seem to everyone, I thought, was an arch-schemer of devilish plots, though admittedly I was a white. Second, what in fact was my impact on, say, the health of my hosts and their wider circle of kin and neighbours? Did my very presence gradually distort, or indeed invalidate, the data I was seeking? I did not 'achieve' anything (like building a dispensary) – some distinguished visitors came to see me, both Nigerian and foreign (Professor Oomen, the noted nutritionist with decades of experience in Indonesia, came and pronounced firmly that none of the children in the house were malnourished compared to Indonesian children); the occasional doctor also came out of interest, but it was too far out for casual visitors. Nothing came for my hosts from these visits: indeed if a ritual was due to be performed, they waited till everyone (but me, of course) had gone.

I would like to think that my impact was rather small, despite the dramatics: I was 'managed' by my hosts, and when I eventually stopped being a full-time resident, it was my decision, not theirs. Economically, I made little difference: I paid nothing at all for my lodgings and my food, and I employed no one; but possibly local trade in snack foods increased as curious visitors came to 'greet' the red lad with the stammer (*i'ina*) in his mud room. I did try, early each morning, giving some minor treatments for cuts and fevers, and my car was, as I have said, a kind of ambulance, mainly for any four pregnant women of the house to attend the regular ante-natal clinic on Tuesdays in the hospital; and if the house's trader or his brother needed a load carried, I would fit it in somehow. But what else? I helped that trader to convert to Islam, but my contribution to this was, I am sure, minimal: eventually, many converted. They could have chosen the Christians (who offered some capital (*jali*) for trading with), but I joined with others in persuading them that in their situation Muslims in the long run offered the better 'club'. The community in consequence has grown and grown – new households build their compounds near 'ours', and change the community from being one simple, if large, 'house' to being a 'hamlet' with two mosques (including a Friday mosque for the wider area). All this success is partly due to the quality of 'our' well – it has yet to run dry even in the driest times: it now supplies the daily needs of about 2000 persons, and the numbers seem to keep growing. Water is a public good, so in a drought there is no such thing as a private well, even one inside a private house. Fortunately, conflict over 'our' well, public though it is, has not occurred, so perhaps the 'hamlet' will yet grow in time into a full-fledged village. Wells are an interesting indicator and symbol of public health practice: traditionally, human bodies, alive or murdered, are thrown into wells; suicides conventionally 'fall' into wells, and snakes sometimes drop into them. These last are left to disappear again, but humans are fished out and, if possible, revived. Otherwise, wells are not cleaned, only deepened as necessary. On them so much can depend: like grain-storing termite nests, they are links to the world below. Spirits lurk in wells too.

Conclusion

Overall, the community has done well over the last 50 years due, I would suggest, mainly to its own efforts, and not to the government's or to those of people working in public health. The marked decrease in children dying, the eradication of Guinea worm, the end of *gishiri*-cutting and the resulting fistulae have all added massively to the health of the 'public' that I came to know. And politically, the changes since 1970 have been crucial: taxation has come to an end, so too have most of the weekly extortions, with their extraction not only of money but also of young girls to 'entertain' the village head's visitors all night – both extractions were hated: my presence only slightly reduced their incidence, but oppression did not mind being on show. The downside of these changes has been, first, the move away from home of almost all the boys in search of a life in the city. Farmland does not grow in step with the population's growth, so fields are scarce and expensive, and labour demand has been reduced, if not replaced, with plough oxen (no tractors yet). Second, families no longer farm collectively in large groups (*gandu*); instead, particular tasks of tillage are contracted out field by field. Third, women no longer work for the menfolk. And fourth, migrant labour (often from as far away as the Niger Republic) is no longer needed.

These changes in the economy of the community have made it feasible for a more radical Islam to be adopted by the young (my generation are still all Su-

fis), with the result that the wives of 'radical' men are now greatly restricted: they cannot even go out and gather the grass to feed their sheep and goats. Without such livestock, wives have no 'bank': the work and foodstuffs that went into raising fat sheep, goats and chickens were women's way of saving. Cash, if you had any, was always being 'borrowed', coin by coin; you cannot, however, 'borrow' a leg of a live sheep or a few ribs of a goat. Such livestock might be turned into cash only for contributions to marriages and for new clothes for children at one of the Muslim festivals. Take away a wife's ability to contribute to others, and you make her financially wholly dependent on her husband – and therein can lie trouble? So, wives today have new distresses – first, their children may survive only to disappear to the city, giving them sorrows of a new kind of child loss, and second, the economic and social restrictions now imposed on their daily lives make for a much lonelier life, almost a diminution of their independent sense of social self-worth. Divorces by women may have declined because the future for a divorcee is bleaker than ever. *Shari'a* law, new to this area since ca. 2000, has seen many a refuge (*gidan mata,* run by a madam) for women between marriages either closed down or else taken over by male Christian entrepreneurs who also sell alcohol. And with labour less in demand (and the household full of live children), who needs now to marry a (costly) divorcée? Do they too now have to immigrate to a big city and leave their kinsfolk behind? I have not the complete statistics, but the numbers of women in the house that I lived in is I think now lower than the 40 I knew in 1970, many of whom were divorcées drawn from a wide area and so possessed of an equally wide range of earlier experience. With their songs and chatter, they could be the joy of the household, telling stories to children and joking; they were the ones playing musical instruments. All that has now gone. The community, in 50 years, is now 'modern'; my generation has passed away.

I have also tried here to draw attention to aspects of ethnographic fieldwork that may have passed ordinary readers by. The original aim of my study was to understand Hausa peasant modes of thought and action in relation to health. Initially, I wanted to make a dictionary of Hausa medicine for the students and doctors of the new medical school that had just been started in Zaria so that they, almost all non-Hausa, might better understand their local patients. (In practice, patients use a special 'hospital Hausa' that they think doctors and nurses will understand – but there are often misunderstandings.) And of course, I wanted to understand what therapies were being used domestically. My idea here was that what women actually do within their own rooms and yards has rarely been recorded. There is, I suggest, a 'domestic religion' quite separate from the public religions of Islam and Christianity, which are amply recorded by local and visiting scholars.

But in this article, I also offer readers some of the messiness of field study – its impact on one's informants, one's own ineptitude at seeing or recording everything, one's sheer luck in being told some items of importance. I emphasised my vulnerability, both in my hosts' eyes but also in my own, but it reminded me (as a historian of the Sokoto Caliphate) how extraordinarily vulnerable the old colonial officers were. Very few whites in northern Nigeria were ever murdered – a few were, for example, when on railway construction – even when they were clearly racist and decidedly unpleasant humans. Whites were more mocked than attacked (for example, in spoof spirit-possession performances, where the white 'doctor' was always shown with the most beautiful girl beside him while he used his stethoscope to suck her blood; I was 'performed' complete with stammer and endless questions). In short, having been for seven years a student of elite scholarly Hausa culture, I was now seeking to know what Hausa life was 'really' like at the bottom end of northern Nigerian society; and at that bottom end I sought to focus specifically on women and children (who statistically experience most illness). Hausa medicine was (and still is) a fascinating route into an otherwise private, if 'foggy' world of patients; it was a route of service to the medical school perhaps, but an eye-opener for me. The 'fog' is thinner.

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References

Last, M. (1981), 'The Importance of Knowing about Not Knowing', *Social Science and Medicine Part B: Medical Anthropology* 15, no. 3: 387–392. doi:10.1016/0160-7987(81)90064-8.

Last, M. (1991), 'Spirit Possession as Therapy: Bori among Non-Muslims in Nigeria', in I. M. Lewis, A. al-Safi and S. Hurreiz (eds.), *Women's Medicine: The Zar-Bori Cult in Africa and Beyond* (Edinburgh: Edinburgh University Press), 49–63.

Last, M. (1992), 'The Importance of Extremes: The Social Implications of Intra-Household Variation in Child Mortality', *Social Science and Medicine* 35, no. 6: 799–810. doi:10.1016/0277-9536(92)90080-A.

Last, M. (2004), 'Hausa', in C. Ember and M. Ember (eds.), *Encyclopedia of Medical Anthropology: Health and Illness in the World's Cultures,* vol. 2 (New York: Kluwer Academic), 718–729.

Last, M. (2011), 'Another Geography: Risks to Health as Perceived in a Deep-Rural Environment in Hausaland', *Anthropology & Medicine* 18, no. 2: 217–229. doi:10.1080/13648470.2011.591198.