Behind the Dispensary’s Prosperous Façade: Imagining the State in Rural Niger

Adeline Masquelier

Pour sortir [l’état] de sa faiblesse congénitale, il ne suffit pas de prétendre le ravaler comme on le ferait pour une façade.
Etienne LeRoy, L’odyssée de l’état

Why is a building called a “national bank,” “university,” “state department,” “hospital,” or “school” when the activities which take place in it cannot be given standard meaning and realities usually covered by those words?
Filip De Boeck, Postcolonialism, Power, and Identity

For the regular visitors to the Dogondoutchi dispensary in the late 1980s whose persistent search for health was repeatedly frustrated by the inadequacy of the

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medical supplies, the empty shelves of the state-sponsored facility—a stark contrast to the usually well-stocked shelves of the local pharmacy—displayed one of the most flagrant symptoms of the decline of the Nigerien postcolony and the attendant dissolution of authority. Just as the mismanagement of food relief in famine-stricken Niger some twenty-five years ago gave rise to a host of rumors centering on President Hamani Diori’s kin and close associates—whose predatory practices earned them the title of *le clan des bouffeurs* (the clan of the gluttons)—so the resident doctor and nurses of the rural dispensary became in the late 1980s the target of disturbing rumors about the apparent mutilation of the bodies of deceased patients. While the medical personnel were later exonerated after rats were discovered near headless corpses on hospital grounds, the incident nonetheless contributed to increase people’s fear of the local facility.

“A place of death (*wurin mutuwa*), that’s what it is!” Dije, the old woman who often visited my neighbors, had once exclaimed. She was referring to the well-known fact that many of those—especially among the elderly—who were hospitalized ended up dying at the dispensary. Whether or not their deaths could have been prevented with “adequate” medical assistance is not clear. During fieldwork conducted in 1988–89, I was told on several occasions that the local doctor rarely made use of the ambulance to transport patients who were in serious condition to the better-equipped hospital of Dosso, some three hundred kilometers away. With little or no fund allocations for gas, the decision to transfer patients was only made for desperate cases. That the patients invariably died on their way to, or in, the Dosso hospital only confirmed some people’s suspicions that the dispensary was, in Dije’s words, “a place of death.” “Those who leave in the ambulance, they never come back,” my assistant Yahaya had remarked. Conversations with other residents later confirmed that indeed “the doctor always waited [to send patients away] until it was too late.” This sad reality had prompted some residents to nickname the ambulance “the hearse.”

**The Dispensary: “A Place of Death”**

Much has been said and written about the modern state’s seemingly boundless capacity to prey upon its citizens in postcolonial Africa (Bayart 1989; Mbembe 1992). Accounts from Nigeria, Sierra Leone, Tanzania, Cameroon, and elsewhere that offer culturally specific commentaries on the “politics of the belly” through

1. In his analysis of collective representations of health care in Niger, Maiga Sabbou (1974: 35) also notes the widespread perception that the departmental hospital is a place where people die.
which the state and its cronies appropriate the vitality of those subordinated to them periodically remind us of the omnivorous potentialities of the postcolony (Bastian 2000; Geschiere 1995; Masquelier 2000; Shaw 1996; Weiss 1996). Yet, while these visual and visceral displays of predation point to the specific ways in which people are consumed, depleted, or violated by a perverse—but often historically legitimized—power structure, they rarely offer concrete instantiations of what stands behind the glutinous practices and immoral politics that inscribe themselves so tangibly onto the bodies of the state's victims. Simply put, the state appears to have no palpable existence outside the discursive formations that emphasize its alleged rapacity. Even the images of perverted and predatory consumption that lend it some materiality do not disguise the increasing withdrawal of the state from public life. Despite the growing fragmentation of government, however, the state is hardly powerless, as Jean-François Bayart, Achille Mbembe, and Comi Toulabor (1992) remind us, because administrative procedures and institutional rules are “only one channel among many which the public authorities use to manage the country’s affairs” (Bayart, Ellis, and Hibou 1999: 91). The state's withdrawal has led to the rise of a multitude of parallel and independent circuits of power, alternative networks, and personal relations that “frequently offer far more effective instruments of public management” (Bayart, Ellis, and Hibou 1999: 91). It is the presence and implications of these multiple administrative fiefdoms that concern me here as I analyze the management of power, the production of contradictions, and the application of disciplinary techniques in the context of state-sponsored health care in Niger.

When the structures of its autocratic control are crumbling, when the processes of its dysfunctional economy continually blur the distinction between legal and illegal, the postcolonial state gradually becomes part of a world in which the real and the imaginary are interchangeable (see Apter 1999; De Boeck 1996; Piot 1999). Medical facilities, too, are implicated in the emergence of these regimes of pretense (Hours 1985; Hunt 1999; Scheper-Hughes 1992). In the face of such contradictory realities, people everywhere are developing strategies of exchange, solidarity, and complicity as they search for ways to overcome the fragmentation of their society. These conflations between the real and the imaginary need not be the result of dysfunction, however. As Bayart (1989) and Mbembe (1992) have demonstrated, and as the Nigerien case suggests, they can be the product of historically constituted modalities of power. The resulting political hybridity that emerges out of the apparent decay forces us to acknowledge the limitations of conventional state/society dichotomies in analyses of how ordinary people everywhere come in contact with the state and imagine it (Comaroff and
Comaroff 1999; De Boeck 1996). Akhil Gupta (1995: 377) similarly argues that we must “pay attention to the ‘multiply mediated’ contexts through which the state comes to be constructed” to grasp the workings of a translocal institution that is largely made visible in localized discursive practices.

Drawing on these contributions to the study of the political imagination, this essay explores how the Nigerien state is discursively constructed and deconstructed by rural dwellers who, since the 1980s, have been experiencing its withdrawal from public welfare institutions. More specifically, I evoke the vacuum left by the Nigerien state in the wake of economic collapse and political turmoil by focusing on the ways the residents of Dogondoutchi, a Hausaphone town in southern Niger, come to think of the local dispensary as a “place of emptiness” devoid of the medicines that should ideally “fill up” the space. Despite the palpable decay, however, the dispensary effectively rules over patients through the management of inequalities and the routine imposition of discursive techniques that produce control, if not health. In an effort to describe how rural Hausa speakers deal with the increasingly abstract entity they refer to as gwamnati (government), I focus on the political imagination at work in the context of rumors and grievances that underscored the inefficiency and, at times, the coerciveness of the local dispensary, a state-run institution that, many agreed, was once accountable to them. My discussion of the dispensary highlights the circulation of images that provide compelling parallels between the facility’s empty medicine chests and the state’s virtually empty coffers for Nigeriens whose most frequent and concrete experience of the benefits they, as citizens, are entitled to receive came, until the economic decline of the mid-1980s, in the form of free health care.

Problems and Paradoxes in State-Sponsored Medicine “Why should I bother going to the dispensary, when they have no medicine for what ails me?” I often heard people protest in the largely Islamic farming community of Dogondoutchi,

2. With the collapse of the price of uranium on the world market in 1985, the prosperity that followed the terrible drought of 1968–74 ended. Major domains of civic and economic enterprise stopped functioning as tax revenues shrank to 9 percent of the gross national product. Following the slump in uranium prices, persistent drought, soil degradation, high import prices, and burdensome debts further weakened the already troubled economy. The fledgling civilian government that succeeded Colonel Seyni Kountché’s rule in 1987 inherited social crises (student discontent, restless elites) and burning fiscal problems. Further popular discontent spawned angry protests, general strikes, and a constitutional crisis that ended when Colonel Ibrahim Bare Mainassara led a military coup in January 1996. Local perceptions of the Dogondoutchi dispensary as an empty and inefficient institution must hence be read in the context of Nigeriens’ widespread discontent and distrust of state services despite the efforts of succeeding governments to escape cycles of endless deficit.
home to some 30,000 Mawri. Such complaints may not offer an accurate measure of the frustration residents experience whenever they are faced with the decision of whether or not to seek the services of the local physician. Yet, when examined together with other accounts of people's contacts with the medical facility, they are nonetheless suggestive of what the dispensary has come to signify for Nigeriens as they struggle to understand the place and role of the state in their local world. For those who have witnessed the progressive collapse of their country's economy after the mid-1980s slump in uranium prices, the shadowy structures of the state find their most visible expression in the dispensary built some sixty years ago to provide health services to the population of the entire district. The postindependence era of optimism, growth, and prosperity has given way to a period of austerity and want as major sectors of economic and civic enterprise were brought to a virtual standstill. Unable to provide basic care and devoid of medicine, the Dogondoutchi dispensary exemplifies the state of affairs described by Filip De Boeck (1996: 91) for former Zaire when concepts like “law,” “justice,” or “health care” no longer “seem to apply to the realities usually covered by those terms.”

Yet within this regime of unreality, the “hollow” building does not simply emblematize the failure of national progress and of the modernist ethos that shaped it. By condensing into monumental form the paradoxical dimensions of the state—ubiquitous, yet elusive; everywhere, yet nowhere—the dispensary provides a particular historical and social context in which to understand how some Nigeriens on the rural periphery imagine the state. By its very “absent” presence, the Nigerien state forces us to rethink the efficacy of state power in noninstitutional terms that can account for the daily contradictions generated by the system. In this essay, I argue that we must go beyond a conventional reading of the failings of state-sponsored medicine and consider the paradoxical logics of the Nigerien state. This can be done by attending to the specific ways in which fiscal crises and economic collapse have produced alternative and invisible techniques of power, production, and discipline—not to mention dysfunction and decay. The absent state, I show, is still perceived as exercising sovereign power because of the productive logics through which it is articulated locally. How such power is variously performed for the “benefit” of local patients partly explains

3. Traditionally recognizable by their facial scars, Hausa-speaking Mawri identify themselves with the Hausa, a large sedentary population of millet, bean, and groundnut farmers that constitutes about 50 percent of the total population of Niger. An estimated 95 percent of Mawris are Muslim. The rest are primarily devotees of the bori, a spirit possession religion that focuses on the management of spirit-induced afflictions and disruptions.
why some Mawri decry the dispensary as an inadequate and, to some extent, even dangerous institution, while others describe it as a functional facility.4

Such contradictory perceptions of the medical establishment must undoubtedly affect people’s choice of therapies, but I make no pronouncements here about the logic that informs such choices. The Mawri’s therapeutic strategies—particularly the way they simultaneously resist, yet embrace, biomedicine—have grown out of specific historical conditions that I cannot discuss here. I shall simply note that opinions vary as to the efficiency and technological superiority of state-sponsored medicine: some people insist on the benefits of seeking biomedical assistance while others routinely criticize the poor quality of “modern” health care, the shortage of pharmaceutical supplies, or the corruption of the medical personnel. If I highlight the voices of the faultfinders at the expense of other voices, it is partly because only those who are victimized by the system feel the need to publicize it. Those who benefit from the system generally refrain from denouncing the petty acts of corruption in which they are themselves implicated. Whether or not they are satisfied with state-sponsored health care, few individuals understand biomedicine as a stable and bounded domain that operates in isolation from other therapies. All in all, and despite the obvious degradation of local services and the alarming rumors, most Dogondoutchi residents routinely visit the dispensary. This is, in fact, one of the ways in which “the crisis” (Mbembe and Roitman 1995: 337) becomes inevitably normalized by citizens who, often despite themselves, come to internalize and reproduce its very logics, thereby potentially insuring the state’s continued presence.

Where Have All the Medicines Gone?

In July 1988, as malaria sufferers (whose numbers grew steadily with each passing day of the rainy season) loudly complained that going to see the doctor was pointless because he had no medicine to give them, the outside walls of the main dispensary building—whose blotched façade had borne long testimony to the scorching influence of the sun—were given a new coat of paint. The white walls,
whose immaculate condition was now highlighted by the freshly painted green shutters that surrounded the entrance doors, were perhaps meant to restore confidence among the disgruntled sufferers who avoided the dispensary. Besides promoting a sense of biomedical purity, the freshly painted façade also displayed what some took as a sign of newly established prosperity. For if the state had decided its medical facilities needed a new coat of paint, then surely that meant there was also money to buy and stock medicine for the sick.

This superficial, but conspicuous, renovation of the building was furthered by the addition, on each side of the front entrance, of two posters proclaiming the dangers of AIDS. Written in French like the hundreds of billboards throughout the country that display slogans urging Nigeriens to be good citizens, practice birth spacing, or take pride in their nation, these two placards lent the edifice a flavor of cosmopolitanism and modernity more than they reminded mostly illiterate visitors that they were entering a medical facility. Only a restricted number of visitors could read the cautionary messages that were meant to inspire a Francophone and literate public about the virtues of safe sex—a fact that only reinforced a widely shared understanding that this façade of cleanliness and prosperity hid more than the stark nakedness of shelves that should have been filled with drugs of all sorts.

In their account of how urban dwellers come to experience, represent, and normalize “the crisis” in contemporary Cameroon, Mbembe and Janet Roitman (1995: 337) note how the present economic conjuncture becomes inscribed onto the landscape whose many abandoned and dilapidated buildings become the public concretization of the country’s decaying economy. Impressive edifices that once thrust their massive heights into the Yaoundé sky as symbols of progress and modernity are now taken over by luxurious vegetation and serve as hideouts for marginals. In the late 1980s, some of the newly emerging neighborhoods in Dogondoutchi—where most homes were made of concrete but remained unfinished—similarly displayed the signs of both prosperity and decay, but the sprawls of mud brick courtyards that lined the sandy streets of the older wards hid the continued hardship many residents faced. At a time when medical services had deteriorated as a result of the country’s virtual insolvency, the newly

5. When the posters were hung, there were no known cases of AIDS in the community and the vast majority of residents had never heard of the disease. Until the early 1990s, Niger had been relatively spared by the AIDS pandemic. With the intensification of migrancy, the country is beginning to face the ravages more commonly seen in Abidjan or Lagos (French 1996).

6. See also Beatriz Jaguaribe’s (1999) fine account of how the history of the Brazilian modernist project is inscribed in the—now dilapidated—monumental projections of Rio de Janeiro.
refurbished medical facility in Dogondoutchi stood as the icon of a state that kept on promising what it could no longer deliver.

Even as the president of the Republic, Général Ali Saibou, assured the citizens of Niger in a speech delivered on 15 April 1988 that the state had plans to pursue the creation of new medical units and the refurbishment of health care facilities throughout the country (Saibou 1988: 101, 103), there was very little that local residents could do to ward off what Mbembe and Roitman (1995: 324) have aptly referred to as the “specter of nothingness.” When in this same speech President Saibou spoke of instituting policies intended to bring the costs of medicines down and guarantee uniform access to health care regardless of the patient’s resources, the medical facility of Dogondoutchi had already become a dispensary that did not dispense anything except arbitrary rules and prescriptions for medicines that few could afford to buy. Handed to patients in the form of pink slips, these prescriptions often did little to curb the feelings of frustration the patients experienced when they found that the treatment they needed would cost them the equivalent of a goat or five day’s wages. Those who visited the dispensary complaining of a stomachache or chest pains would often be sent home with one aspirin tablet wrapped in the same pink prescription paper. During periods when supplies were especially low, patients would receive half or one-fourth of an aspirin and would be told not to come back. Despite such apparent lack of prosperity, the dispensary beds were always full. The spillover would lie on mats on the front porch or in the courtyard shaded by acacia trees. There was no kitchen available for food preparation, and patients had to rely on kin to bring them meals. On most days, a half-dozen patients could be seen boiling water for tea or performing one of the five daily prayers next to the central building while a handful of others would sit quietly, surrounded by visiting relatives.

The dispensary, everyone knew, could do very little for those who suffered from persistent pains. It lacked an X-ray machine, and patients who suspected a broken bone were faced with two choices: either undertake the four-hour drive to the Galmi dispensary run by the Sudan Interior Mission (SIM)7—one of the best-equipped medical facilities outside of Niamey, the capital—or visit a local bone setter (a much cheaper alternative, since it meant no travel costs). Whether or not they had ever set foot in the SIM facility, most Dogondoutchi residents knew

7. The SIM is a Protestant mission that built several schools and dispensaries in Niger as early as the 1920s. Because they were rarely French, SIM members taught their classes in Hausa and generated distrust on the part of the French administration. In the Maradi region, where they set up one of their first missions, they were eventually forced to close their schools, but they remained actively involved in medical and social work (see Cooper 1997).
about Galmi. A place of medical wonders because, among other things, doctors there had a machine to “see inside the body,” it was often invoked in local discussions about healing alternatives as a healthy contrast to Dogondoutchi’s own run-down institution.8

Biomedical Health Care in Niger

Unfortunately, the Dogondoutchi dispensary is not an isolated case. In the last two decades, most of the medical facilities elsewhere in the country have been equally affected by the collapse of the national economy.9 Although funds allocated by the government to the Ministry of Public Health doubled between 1980 and 1984 (thanks to revenues generated by the uranium boom), this budget increase actually translated into a steady decline in real expenditures when measured against inflation—and this decline steadily intensified even as Niger’s population grew at the rate of approximately 2 percent a year in the 1980s and 1990s (Destexhe 1987: 55). To compound the problem, personnel salaries have tended to absorb an increasing proportion of the budget for public health while the funds devoted to the purchase of drugs were diminishing (Destexhe 1987: 56). Thus while the staffing of medical facilities has perhaps improved, doctors and nurses have less and less medicine and fewer resources. The analysis of health budgets in Niger and elsewhere in Africa thus confirms what has already been reported by observers on the ground: “empty and poorly managed dispensaries and hospitals, lacking in everything, and offering meager services to people who have lost confidence and end up deserting them” (Destexhe 1987: 59). While such accounts of the failed public health planning seem to capture the disenchantment of populations victimized by the shortage of health care, closer attention to local contexts reveals how people’s discourses about state-sponsored medicine sheds light on how Nigeriens variously experience the power of the state.

But let me return for a moment to my discussion of decaying medical facil-

8. The Catholic mission established in Dogondoutchi in the 1940s originally had its own dispensary where residents could receive free medical care.
9. In 1986, Niger had 2 national hospitals, 11 district hospitals, 39 medical centers, 239 rural dispensaries, and 6 mobile units (République du Niger 1988). Other health facilities included 31 pediatric units where infants and toddlers are given checkups and vaccinated, and 72 maternity centers. In 1979, there were also 3 antituberculosis centers (République du Niger 1980). With dwindling funds to maintain them, services have deteriorated. In 2000, many of these facilities were run-down and could not accommodate the needs of the steadily expanding population. In Niamey’s main hospital, for instance, some patients were never able to secure a bed inside the facility. Even if they paid a nurse to “reserve” a bed for them, they had no guarantee that they would receive treatment.
ties. In Gechema, 90 kilometers south of Dogondoutchi, people complained so loudly about the deficiencies of local health services that the dilapidated dispensary was eventually the object of an article in one of Niger’s quarterly magazines (Kotoudi 1988). Up until 1976, SIM missionaries, who provided health care and medical supplies to the entire region, had run the Gechema dispensary. Built in 1952 by missionaries whose major aims were to evangelize and heal the population of this large village, the original facilities had been progressively expanded to include fifteen hospitalization rooms and a maternity section. Staffed by personnel from the SIM, the medical center had seen its reputation spread so far that dozens of patients arrived each day from as far away as Nigeria (Kotoudi 1988).

After some disagreement surfaced concerning the potential role state personnel would play in the facility, the missionaries departed abruptly in 1976, leaving the dispensary in the hands of the state even as they continued to provide subsidies. In 1982, the SIM stopped financing the medical center altogether. With no funds, no medicines, and no doctors, the state-run facility at the time of journalist Idimama Kotoudi’s exposé was only a pale shadow of its former self (Kotoudi 1988). Where there used to be a unit that provided nutritional information as well as eggs, milk, and fruit, in 1988 medical resources were hardly adequate enough to perform urine analyses. When the facility was run by the SIM, a local student recalled, “Everything was free, and I remember, we were expecting surgeons, dentists, ophthalmologists, etc. Today, we only get prescriptions” (Kotoudi 1988).

Like the people of Dogondoutchi, the inhabitants of Gechema were frustrated by the state’s apparent inability to provide for its ailing citizens even as its leaders regularly promised to improve Niger’s health services. Villagers were complaining, Kotoudi noted, as much about what ails the local dispensary as about their own afflictions. At a time when 68 percent of Niger’s population had no reasonable physical access to Western health services (Bossyns 1997), even minimal funding, it seems, would go a long way toward fighting some of the serious diseases commonly afflicting rural as well as urban Nigeriens. Biomedical health care in Gechema and elsewhere often amounts to little more than dilapidated buildings, empty shells whose palpable hollowness only serves to confirm what many already suspect: namely, that just as barely competent medical personnel are limited to handing out pink slips to those who patiently wait for their turn, so the state can deliver promises only in the form of presidential speeches to the

10. These numbers are contradicted by the information provided by the Ministry of Health for 1987 (République du Niger 1988). It was then estimated by the Ministry of Health that at least 60 percent of Nigerien villages had at least one health-oriented worker and that the health system infrastructure reached 47 percent of the population.
nation—the content of which are duly published as a series of official booklets. In postcolonial Niger, the elusive state affirms its presence not through territorial logics but through empty, yet productive, discursive techniques that effectively extend its public power amid the ruins of a bygone prosperity.

Niamey’s main hospital has not been spared by the country’s spiraling descent into bankruptcy. In September 1997, it appealed to international donors for supplies to help treat young malaria sufferers who were dying at the rate of one or two a day for lack of drugs. Out of forty children admitted every day during the month of September, twenty to thirty had malaria; but low supplies forced the hospital to restrict the daily allocation of quinine to five vials, enough for only five patients. To make matters worse, the number of malaria cases, which always increases during the rainy season, grew more rapidly in 1999 because sanitary services in Niamey lacked the funds to spray for mosquitoes. If quinine is in limited supply, other medical resources appear at times to be totally nonexistent. In 1996, the government admitted to some CARE officials that they had run out of chemicals to test for AIDS (French 1996). While local pharmacies often carry a relatively varied assortment of the most commonly needed drugs, the latter are often imported from France, a factor that contributes to their high cost. Hence, when three-year-old Tahirou was diagnosed with scurvy, the nurse who had examined the little boy’s bleeding gums handed Mamou, his mother, a prescription for vitamin C. Since I had accompanied Tahirou and his mother to the dispensary, I also went with them to the local pharmacy. The container of ten orange-flavored vitamin C pills Tahirou’s mother was given by the pharmacist had been manufactured in France and cost the equivalent of a day’s wages. Knowing well it would take more than ten pills to cure the boy’s problem, I nonetheless offered to pay for the prescription, to the relief of Mamou who was not prepared to pay such an extravagant sum for medicine.

When the CFA franc was devalued by half in 1994, the price of imported drugs doubled, and some patients have since been unable to afford even basic treatments. In the wake of a currency devaluation that has had disastrous consequences for the local economy, the government has tried since 1997 to privatize

11. It may be the case that Western medicines are often unaffordable for Nigerien patients not simply because of their limited income. Studies have demonstrated that in Mali and Burkina Faso, the price of French brands in private pharmacies was 150 to 200 percent higher than the price paid by customers in France (Foster 1991; see also Klimek and Peters 1995). Poverty, then, is not the only factor that must be considered in assessing the affordability of drugs for African patients. Pharmaceutical companies also unfairly penalize the poor by inflating the costs of medicines in African markets.

12. The monetary unit in Niger is the CFA (Communauté Financière Africaine, African Financial Community) franc.
the Office National des Produits Pharmaceutiques et Chimiques. It remains to be seen how such reforms will affect consumers already hard hit by the rising costs of imports—especially in the rural areas where pharmaceuticals can end up costing more than in Niamey, which prompts patients to buy their medicines in the capital whenever they can (Gado and Guitart 1996: 182).

In the absence of an officially regulated pharmaceutical market, illegally produced drugs are increasingly available from itinerant pill sellers. Often displayed in full sun and amid a varied assortment of other small items, these medicines are sold freely and with no explanatory leaflet to people who already know what they need (Gado and Guitart 1996). To satisfy the growing demand, imitation drugs with fake Made in Nigeria labels are flooding local markets (Klimek and Peters 1995). If we add obsolete products and medicines sold beyond their expiration dates, the traffic of these illegally manufactured drugs accounts for 70 percent of the market in Nigeria and neighboring countries (Klimek and Peters 1995). In France, an investigation was recently launched to probe into the distribution of false vaccines during a meningitis epidemic in Niger in 1995. Not surprisingly, the inquiry uncovered the Nigerian government’s role in distributing pirated products in the guise of aid (Bayart, Ellis, and Hibou 1999: 107). Citing the overcrowding of outpatient clinics; the nonavailability of drugs; and preferential treatment based on wealth, ethnicity or “who-you-know,” patients sometimes avoid hospitals altogether and instead seek diagnoses from retail pharmacists and drug sellers whose services they describe as fast, convenient, and efficient (Igun 1987).

Whether or not Dogondoutchi residents routinely seek the services of the biomedical doctor or shun the dispensary altogether, the point is that their critical assessment of the postcolony has often centered on the growing shortage of medicines and the state’s inability to provide for its citizens. Although, during my 1988–89 fieldwork, some complained of the rising cost of pharmaceutical products, the issue was usually not—at least, not entirely—a matter of whether or not one could afford Western medicines. Rather, the problem hinged on the fact that the state could not provide these medicines to a needy public because there simply was not enough to go around. Generally speaking, Nigeriens expect state institutions to be accountable to them, but experience has also taught them that

13. For a description of the role that parallel markets play in the pharmaceutical scene in Senegal, see Fassin 1988.
14. Several European multinationals are flooding the African market with nonessential and unreliable pharmaceutical products. Evidence suggests that half or more of these export medicines are without effect, obsolete, or elude low therapeutic action (Klimek and Peters 1995).
expectations are rarely satisfied by outcomes. Moreover, not everyone agrees as to what each citizen is entitled to: while some people I knew openly distrusted the public school system—in their view it corrupted young minds and bred immorality—and had opted instead for Qur’anic education for their children, they nonetheless felt entitled to free health care. Paradoxically, my neighbor, a staunch Muslim and virulent critic of state-supplied medicine, had sent all of his children to public school—perhaps in an effort to ensure their acquisition of the cultural capital required to use the very system he complained about.

These various claims about entitlement are grounded in an expectation of free medical care inherited from the colonial period. When they nostalgically evoked the “good times” of late colonialism, people in Dogondoutchi often would mention the free services provided by a resourceful and responsible administration willing to cater to local people’s needs. Until the 1980s, patients could also seek free health care—and sometimes food—at the Catholic mission where a nun dispensed medical advice and treatment on a daily basis. Now, those who stop by the mission in the hope of receiving free vitamins or powdered milk are kindly told they must purchase these items at the pharmacy. The days when the local missionary nurse drove to neighboring villages, medicine chest in tow, may be long gone, but many still remember with delight the free vitamin-packed cookie they received daily from the Canadian nuns who participated in local relief efforts during the famines of the 1970s and 1980s. It is against such idealized representations of the health services offered by mission and state hospitals that the complex economy of pink prescription slips, fake drugs, empty medicine chests, and—as we shall see below—hospital “incarcerations” must be assessed if we are to understand the nature of people’s disenchantment with state-sponsored health care. In 1974, Niger had 4 beds for every 10,000 inhabitants and 1 physician for every 68,000 inhabitants. While the number of beds and physicians has since expanded, many Nigeriens feel that the quality of health care has declined. In retrospect, it is easy to think that people’s widespread mixture of ambivalence and cynicism toward modern medicine is justified, despite official claims that “the arrondissement of Dogondoutchi is self-sufficient in the treatment of common diseases” (Ousseini 1990: 11). Despite having doubled, thanks largely to the short-lived prosperity generated by uranium revenues, in 1988 the government of Niger’s operating budget for the Ministry of Public Health was a paltry $20.9

15. “The medicine chest,” Jean and John Comaroff (1997: 337) note, “with its glass-stoppered bottles and its drawers below for pestle and mortar and small boxes” was a regular item of evangelical equipment in many parts of Africa.
million for a population then estimated at around 7 million—that is, about three dollars per person.

**Prisoners of the Clinic: Health, Reproduction, and Medical Authority**

All form, no substance, the dispensary whose glossy surface never completely managed to hide its internal emptiness was both repelling and alluring. While the refurbished façade overtly denied the inevitable decay of the state—and of the building that concretized its presence—as we shall see, this fraudulent prosperity only further highlighted the absence of medicine and the degradation of health services. In its whiteness, the repainted building offered a striking contrast to the mud-colored walls of other state institutions that, like the medical facility, occupied one of the hills overlooking Dogondoutchi. The white paint was meant to impress and attract crowds of anxious customers with its appearance of cleanliness, order, and authority, yet it also seemed designed to keep people out—there was, after all, nothing inviting about the sterile, white façade for people accustomed to the warm earthen tones of mud brick homes. The paradox of a place that simultaneously drew people in and excluded them was further compounded by the hospital practice of keeping some customers against their will. Parturients who delivered their babies while en route to the dispensary or who came to the dispensary because of complications during or after a home birth were forced to stay as in-patients a few extra days. This widely unpopular practice was intended to prevent the risks to women and their babies that could result from complications arising in home births—if there were problems, women would seek help at the dispensary after it was too late. The only way that hospital personnel could effectively prevent women from delivering on their own had been to threaten them with incarceration for a week.

Women rarely stayed more than two days at the dispensary if their newborns were healthy, and they all looked forward to the naming ceremony that would take place seven days after the birth. The parturients who were forced to stay longer thus missed the naming ceremony that gave a child its social identity. I never actually met a woman who had undergone such confinement, despite claims by women who insisted that they knew someone to whom this had happened. Nor did I ever find out if other health care facilities threatened mothers-to-be with similar treatments to discourage home births.16 In 1988, my friend Rakiya deliv-

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16. In the Belgian Congo, people were fined for giving birth outside of the dispensary, a practice that similarly illustrates the coercive workings of state power (Hunt 1999).
ered a healthy baby girl in the privacy of her room before I drove her to the dispensary on a cold November night. When the midwife on duty interviewed her as she held her baby in one arm and the placenta wrapped in a plastic bag in the other, no one hinted that the new mother would be kept away from her home as punishment for what the nurse termed her “reckless” behavior. I never found out whether or not Rakiya’s seven previous and unproblematic deliveries had weighed in the midwife’s decision not to “discipline” the parturient. My friend was nonetheless duly admonished not to wait until the baby was born to seek a ride to the dispensary “next time.”

Women’s general dissatisfaction with maternal health services appears to be widespread. In Niamey, where maternal mortality remains elevated despite a high concentration of health services and health personnel, women often complained of the aggressiveness of midwives and of their lack of respect for the parturient’s cultural practices (Jaffre and Prual 1994: 1070–72). Because the midwives’ technical skills were often at odds with the parturients’ modus operandi, health care providers were sometimes forced to violate social rules, thereby occasionally entering into conflicts with patients. Meanwhile, workshops and training programs aimed at improving maternal and infant mortality and morbidity rates in Niger failed to produce results (Jaffre and Prual 1994: 1069).17 Lacking the training that would allow them to conciliate productively medical care constraints and cultural habitus, midwives would accuse patients of being stupid or refusing to comply (Jaffre and Prual 1994: 1071). For parturients forced to deliver on a table or compelled to clean the floor after delivery if they insisted on squatting, the maternity ward did not so much provide services as it produced control—in the form of belligerent birth practitioners who would not hesitate to hurl insults at their patients.18

Returning to the rumors of punishment,19 what matters is that for many mothers the Dogondoutchi dispensary has become the equivalent of a prison. While keeping newborns and their mothers several extra days is justified as a routine

17. In 1987, infantile mortality in Niger was estimated at around 158 per 1,000 (Raynaut 1987: 44). Yannick Jaffre and Alain Prual (1994) argue that the infant mortality rate is much higher in Niger than in southern Africa or North America, and, without providing specific numbers, they infer that it has not decreased.

18. See Paul Brodwin (1996) for a similar situation in Haiti.

19. I use the term **rumors** here because as the stories women told about other women’s experiences in the dispensary spread and circulated, their contents seemed to shift and their origins could not be ascertained. I am less concerned with the veracity or origin of these stories than I am with their capacity to articulate Mawri concerns about state institutions. Like the stories that centered on the mutilation of corpses at the dispensary, these rumors are revealing of local anxieties and local experiences.
preventive measure, the widespread perception is that local midwives are acting unfairly and burdening kin who have to bring hot, nutritious food and firewood to heat the parturients’ bath water. Instead of providing medicine to those who line up patiently to receive treatment, the dispensary incarcерates those who try to avoid it altogether. To add insult to injury, in 1994 there emerged yet another category of rumors: about male nurses who were rumored to have replaced the female attendants who traditionally assisted women during delivery. “If there are men, that’s it, I am not going there,” my pregnant neighbor had snapped upon hearing from a friend of the alleged gender substitution at the maternity ward.20 For women who typically shied away from any kind of physical scrutiny during medical examinations and for whom healing often did not require any touching on the part of the practitioner, the idea of exposing themselves to a male gaze during delivery was particularly horrifying. Aside from the fact that many of them still shunned the delivery table and instead gave birth by squatting, for my neighbor and a number of other women who had heard of the rumored change in personnel, the dispensary was no longer a safe place to deliver. Subversive, yet contained, these women’s attitudes toward the medical establishment illuminate a dimension of the general distrust and resentment many Mawri have felt toward the state and state institutions during the postcolonial period of economic collapse.

Taken altogether, these rumors that center on the transformation of the once hospitable and resourceful dispensary into a male-run, state-sponsored reformatory provide a good example of the costs of modernity for rural Mawri who traditionally associated “progress” with free access to the wonders of modern medical science. Powerless at many levels because it often fails to dispense what patients need, the dispensary paradoxically enforces its own regulations concerning the coming and going of patients. It may thus send away those who are too sick to be helped—I was once admonished by the resident doctor not to bring him any more dying infants on whom he had no medicine to waste—while conversely choosing to sequester parturients who fail to follow the rules.

From an economic perspective, these transformations in the quality of public service are only one of the inevitable consequences of the policy of structural adjustment Niger has been implementing since the early 1990s to renew the critically needed support of international donors. Forced to reduce public expendi-

20. Older women told me how uncomfortable they were in the presence of midwives and assistants who were young enough to be their daughters. Jaffre and Prual (1994: 1071) similarly report the discomfort experienced by midwives who, when assisting the delivery of pregnant women older than they, felt as if they were “delivering their mother.”
tures to a minimum since the end of the uranium boom despite the continued growth of the country’s population, the state also faces a shrinking power base. A general lack of productivity on the part of most civil servants and the rising degradation of what is left of public service have further accentuated the dramatic absence of the state (Grégoire and Olivier de Sardan 1996). For those who experience intimately the workings of the state through the assistance provided by a core of health practitioners who forbid, enforce, and coerce, the dispensary becomes essentially defined as a controlling mechanism. In an era characterized by the very inefficiency of state institutions and the absence of material infrastructure, what the local dispensary dispenses best and most efficiently is not medicine but discipline.

A Hall of Mirrors: Medicine, Power, and Fraud

Repelling yet alluring, empty of medicine but also replete with the possibilities of what could or might go on behind the deceptive façade—the dispensary has become, like the state it metonymically stands for, a negative space whose presence is often more palpably experienced through the ways it deprives, forbids, and denies than through what it dispenses or produces. As the following story illustrates, however, the absence of drugs on the shelves is deceitful, a situation that further discredits the illusion that the state has a material, embodied existence. Rabi, a widow who sold fried bean flour cakes for a living, had once gone to the dispensary for some medicine. The doctor was not in, so she had seen one of the nurses. Upon hearing her request, the nurse promptly told Rabi that she had no medicine to give her. While she lingered a bit before making her way home, Rabi casually mentioned that her son was a doctor in Niamey. “Why didn’t you say so!” the nurse exclaimed as she whisked Rabi away from inquisitive stares. “I will give you medicine.” While Rabi stood waiting, the nurse promptly went into the back room. She returned minutes later with the medicine the old widow had been asking for. “This goes to show you how dishonest they are. Nowadays, you can’t tell who people are by looking at their faces,” Rabi had concluded after recounting the incident to a group of women among whom I was sitting.

The corruption of health workers and other civil servants was hardly a state secret. In the late 1980s, many in Dogondoutchi knew that the medicine sent by the state to fill the dispensary shelves ended up on the black market. Moreover, the supplies of powdered milk, oil, American sorghum, and blankets that nurses were instructed to distribute to pregnant women and impoverished families at the local pre- and postnatal care center rarely reached their intended recipients.
because, as a friend explained, the personnel “would sell everything even though it said ‘Not for Sale.’” It is precisely because most pharmaceutical drugs had become the object of a lucrative business for civil servants eager to supplement their income that, since the 1980s, some charitable international organizations have stopped sending gifts of medicine to the people of Niger. Whether they secretly purchased the drugs from health workers or discreetly received free samples upon their visit to the dispensary, the lucky recipients were all part of an invisible, but privileged, coterie to which only wealthy traders and biomedical personnel and their families could claim access.

The fraudulent practices that Rabi had inadvertently stumbled upon provide yet another context in which to appreciate how agents of the state operate behind the chimera of solidity and stability in the vacuum created by the lost illusions and broken dreams of a short-lived postindependence prosperity. Belied by the apparent prosperous façade, the palpable emptiness of the dispensary itself hides what lies behind it—stocks of medicines waiting for clients with connections. Like a hall of mirrors that simultaneously reproduce and conceal multiple reflections, the dispensary creates layers of illusions that dispel each other so that it becomes difficult to know whether reality hides behind a mask or is the mask itself. Nonetheless, Rabi’s story suggests that the “real” powers are invisible, hidden behind deceptive fronts and accessible only to those with secret knowledge or powerful friends. At another level, Rabi’s revelations illustrate once more the fragmented nature of the state that, by its very erosion, promotes the development of parallel spheres of power through which state authority is managed and redirected. With the declining standard of living, the inevitable delays in the payment of salaries, and the climate of uncertainty that pervades the bureaucracy, state employees in hospitals and elsewhere feel compelled to build their own spheres of power and sources of wealth through the creation and management of social networks that defy the conventional state-society dichotomy.

I came to appreciate the ways in which power operated in the dispensary when, three months into my 1988–89 fieldwork, upon feeling weak and nauseated, I consulted the local doctor. When I arrived at the dispensary, it was only eight in the morning. Yet, the line of patients waiting to be examined already stretched from the physician’s office all the way to the entrance of the medical compound. I was standing at the back of the queue, wondering if I would even get my turn before the doctor’s lunch break, when the door of the office opened to let out a patient. Upon seeing me at the end of the line, the doctor motioned for me to come closer. I worked my way to the front porch where he was standing. “Come in!” he said peremptorily. I was whisked into his office before I had a
chance to even protest, and, after briefly introducing myself, I told him the reason for my visit. He wrote a prescription on a pink slip and promptly dismissed me. As I left the dispensary, a glimpse at the long line of sickly individuals brought back the embarrassment I had felt minutes before when thirty pairs of eyes had watched me pass everybody in the queue. While pondering the implications of what had happened (in light of the fact that white people are routinely assumed to be wealthy and therefore powerful), I also wondered just how many people, and specifically who, received preferential access to the medical resources I had just had the privilege of sampling without much wait. The medical facility, it dawned on me, dispensed in priority to the rich or the powerful, or to those with connections to the rich or powerful. Those who could boast connections or display wealth were not made to wait for their turn in the hot sun. And for these people, disillusioned customers had informed me, medicine was available even after the regular folks had been informed that supplies had run out.

The management of such inequalities is, as I have already noted, authorized by the state’s increasing fragmentation. Partly because government no longer functions in a “normal” way, nurses, doctors, and clerks feel both threatened by the absence of clear rules and free to invent their own rules about, for instance, who gets preferential treatment and who does not. Instead of following directives that emanate from a centralized locus of power, civil servants operate within alternative networks and apply locally constituted rules. As a result, confusion, contradiction, and corruption prevail. That these structural inequalities and oppositions remain fluid rather than fit the conventional distinctions between public and private explains why the doctor chose to spare me the long wait in the sun even though I was not a member of the local elite. While everyone is probably sincerely in favor of stamping out corruption, ironically, the struggle for survival forces many to participate routinely in the reproduction of the system they denounce. In this sense, “corruption is someone else” (Olivier de Sardan 1999: 34).

In Dogondoutchi, discrimination was certainly anchored as a customary practice in popular perceptions of the medical facility. Some residents thus believed that bringing in a baby severely dehydrated with diarrhea would not increase the child’s odds of surviving because the supply of glucose was so low that nurses were usually instructed not to rehydrate a baby intravenously. In special instances, however, certain babies were given preferential treatment on doctor’s orders. When his distraught mother brought him in for severe dehydration, two-year-old Harouna was administered fluids intravenously for three days. His mother, Bibata, was the best friend of Zeinabou, a young woman who was sleeping with the resident doctor. Upon witnessing her friend’s despair, Zeinabou had pressured
her lover into using his precious resources to save Harouna's life. Day after day, she had steadfastly convinced him to continue the treatment—despite his own perception that the little boy was beyond help. To the doctor's averted eye, the stress caused by prolonged dehydration had obviously been too severe. Despite Zeinabou's efforts to save him by ensuring that he would receive privileged care, the baby died on the third night.

Harouna's death was immediately blamed on his stepfather who was, as everyone knew, very angry at Bibata for being a promiscuous and insubordinate wife. After all, people were muttering, hadn't little Harouna always been a healthy child prior to this dreadful illness? Bibata knew better than listen to such unfounded accusations of sorcery. Harouna's death, Zeinabou kept telling her, had been God's will. At another level, and besides leveling inequalities between those for whom the shelves are empty and those for whom the shelves are full, Harouna's death ultimately demonstrates the powerlessness of modern medical institutions that, despite clever attempts to hide a crumbling infrastructure behind a glossy façade, can no longer pretend that they dispense anything but prescriptions.

**Conclusion: Filling Out the Void**

With its AIDS posters that reminded illiterate visitors that the content of their seemingly democratic message was nonetheless privileged information, the Dogondoutchi dispensary exemplified the kind of clinic Michel Foucault had in mind when he wrote of nineteenth-century French medical facilities as institutions of power and control whose disciplinary tactics construct patients as objects of knowledge. In the French clinic described by Foucault as well as the one in Dogondoutchi, power was imposed not through direct domination but through normalizing strategies—such as having patients line up for hours in the sun-drenched courtyard—that permeated the life of individuals in a capillary manner (Foucault 1975). An impersonal and often inhospitable place whose personnel, not being from Dogondoutchi, operated in a fairly businesslike manner toward

21. Sorcery (*maita*) accusations are common in Mawri communities, especially in cases where the alleged victim is young and was relatively healthy up until death. Traditionally understood in terms of desire (sorcerers being, by definition, jealous and greedy persons), sorcery has become a popular currency of discourse for addressing the contradictions of an increasingly monetized economy. From this perspective, the loss of traditional moral standards in a rapidly changing and chaotic world leads people to kill kin or neighbors (by offering them to a bloodthirsty spirit) in order to reap financial rewards.
the sick, the dispensary was even perceived by some as a penal institution, which, like the mental hospitals described by Foucault, imposed prisonlike conditions on some of its female patients—when it did not altogether prey on the tangible remains of the deceased.

Mired in contradictions reflective of those of the larger society, the dispensary remained, even in its failure to dispense, a microcosm of the state whose authority, influence, and stature it should have ideally reflected for local residents. Powerful only through its ability to deny resources to the needy, confine patients against their will, or keep them out altogether, the dispensary did not simply epitomize the deficiencies of a democratic society that should have ideally dispensed free medicine to all. It was also a productive site of deceit, pretense, and paradox. Even when the medicine shelves were glaringly empty, the beds kept filling up, some occupied by allegedly healthy individuals who needed punishment, not care. Despite widespread discontent with unsatisfactory and often blatantly discriminatory practices, everyone lined up to visit the doctor. To briefly ponder on these paradoxes, I return to the image of the deceptive façade and of the supposed hollowness it simultaneously hides and highlights. People’s attraction to the hospital should be understood in terms of the relation between the spectacle of emptiness that poor residents are forced to contemplate and the visions of abundance associated with the rumored practices of local elites seemingly hollowing out the dispensary bit by bit. Many Dogondoutchi residents had at one point or another experienced the penury of medical supplies, but they were also intensely aware that, for a minority of privileged others, the shelves remained well stocked. They stood for hours waiting to see the doctor at the dispensary, but they also knew that some never waited for their turn. It is the simultaneous absence and presence of prosperity and privilege that creates a space of desire filled with the collective fantasies of ordinary citizens who struggle to make sense of the paradox of a state that exists largely by virtue of its unreality. In this space, people can both decry scarcity and indulge in the pretense that the dispensary is full. Not unlike the situation described by Mbembe (1992: 25) in which ordinary people throughout the African continent “guide, deceive, and actually toy with power instead of confronting it directly,” Dogondoutchi residents participate in myriad ways in the reproduction of the coercive, discriminatory, and deceptive practices they are routinely denouncing because only by doing so can they reaffirm their own rights even as they hope to modify them. Malaria patients die after being injected with fake vaccines, ambulances play the role of hearses, and prescriptions are handed to those who can’t afford the cost of pharmaceuticals, but the sick keep flocking to the dispensary. For they share with those who
preside over their afflictions a whole economy of signs, images, and practices that has come to define the dispensary in all its real and fictive dimensions.

Even as the hollowed-out dispensary epitomizes the absent state in a country where corrupt health workers steal public resources while sick patients are turned away for lack of medicine, it is paradoxically a productive space of fantasy—where reality and fantasy coexist to the extent that it is impossible to tell which is which. When the reported absence of medicine is experienced as a deceptive front that covers up the actual presence of supplies, the medical facility becomes part of a hyperreal space in which “things no longer exist without their parallel” (Mbembe and Roitman 1995: 340). In their attempts to understand the logic guiding a world that seemed to have lost much of its taken-for-grantedness, some residents actively cultivated the illusion of an empty-yet-full hospital through the circulation of rumors that belied the failure of public health planning. Perhaps it was only through the circulation of such rumors that the dispensary’s façade of progress and plenty allowed them to entertain dreams of fulfillment. Such a meaning-making process seems to make sense, given that they needed to “continue to live in a world that seem[ed] to be falling apart before their very eyes” (De Boeck 1998: 25).

It is from this space of contradictions where truth and pretense become indistinguishable that we must understand the state’s effort to create a hygienic facility that offers, from the outside at least, the illusion of progress, prosperity, and cleanliness. Within the specific logics of postcolonial health care that encompassed both doctors and patients, the rulers and the ruled, the haves and the have-nots, a simple coat of paint on the walls of the medical facility revived the fantasy and turned the dispensary into a positive spectacle. Perhaps the illusion of care was better than no care at all for those for whom prosperity and development are always out of reach. Even if the sturdy façade only managed imperfectly to hide the internal hollowness and decrepitude, the medical facility—like the state whose ghostly presence it extended in the lives of some Nigerien subjects—survived thanks to the face-lifts it received. When rats feasted on the bodies of deceased patients, when evacuation to another hospital amounted to a death sentence, and when tired patients were handed illegible pink paper slips in place of medicine, a few gallons of paint appeared to be the only affordable remedy against further disenchantment and disaffection. Sadly, while rebuilding popular confidence in the benefits of public health care—and by extension, in the state’s own health—by resorting to these cosmetic changes may be strategies of questionable efficacy, to those for whom the predictions of the World Health Organization’s Global Strategy for Health for All by the Year 2000 (1981) still remain a
distant dream, such embellishments have become one of the ways in which to create the “real” world in postcolonial Niger.

**Adeline Masquelier** is an associate professor of anthropology at Tulane University. She is the author of *Prayer Has Spoiled Everything: Possession, Power, and Identity in an Islamic Town of Niger* (2001).

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