# Introduction

## A Sudden Death

Every time I visit the village of Keru in southeastern Burkina Faso, I pass by Thomas's compound to say hello and hear the latest news from Thomas, Beatrice, and their seven children.[1] I first met them in 1996 when they all lived together in a compound just next to the marketplace. At that time, Thomas and Beatrice had five children, of whom Michel and Caroline were the youngest. Later, Beatrice gave birth to two more girls, Janine and Claudine. While I was doing fieldwork in November 2016, Caroline told me about her baby's sudden death. The sad story demonstrates how important, complex, and fragile social relationships and family bonds are in rural Burkina Faso, and it elucidates how present the spiritual world is in local care practices and in interpretations of tragedy.

After spending the morning at the district hospital interviewing the chief medical officer, my research assistant Landry and I drove to the village in the afternoon, hoping to arrange a couple of interviews for the following day. Landry was a young university student who grew up in a Bissa village not far from Keru and who spoke both Bissa and Mooré, the two main local languages spoken in this district. He was a very diligent fieldworker with a lot of empathy. We stopped as usual at Thomas and Beatrice's compound. Thomas was not at home, but his eldest son, Pascal, welcomed us into the inner courtyard to sit on the household's only two chairs. The chairs were placed in the middle of the courtyard under a small tree that provided a bit of shade against the strong sun. The customers of Beatrice's *cabaret* (millet beer bar), which she ran every third day year-round, found shade for themselves on a few wooden benches under a thatched shelter. The cabaret was located close to the entrance of the compound, near the fireplace where the *dolo* (home-brewed millet beer) was produced. On days when the cabaret was closed, we sometimes sat and talked there, but usually we were invited to the

inner courtyard, which provided a little more privacy, although the two areas were divided only by a low mud wall.

As customs prescribe, we were first served a calabash of fresh water. It was a busy time of the year as the last harvest was being secured. Often, people with land work collectively in the fields all day, helping each other finish the harvest. This day, many women were working in their fields together, and other women were busy in their small vegetable gardens located outside of the village, where a nearby well provided water. Many women grew tomatoes to sell on market days when buyers from Togo or the nearby provincial town passed by. After drinking a calabash of fresh water, we were, as usual, offered a calabash of *dolo*, and Caroline sat down to talk to us. It is not unusual for married daughters to occasionally stay for a few days at their paternal compound to assist with specific tasks or participate in religious or family ceremonies. However, Thomas had told me a few days earlier that Caroline had lost her small child, who died suddenly one Sunday morning. According to Thomas, the child had not been ill prior to his death, "he just died."

Caroline was a twenty-four-year-old woman who had completed six years of education at the local school. At the age of about nineteen, she married a much older man who lived in a nearby village with his elderly mother. After the marriage, Caroline moved to live with her husband and her mother-in-law, following the patrilocal traditions in Burkina Faso. She gave birth to a girl in 2012, and three years later she gave birth to her second child, a boy, delivering him alone at home with only a little help from her mother-in-law, despite living close to a rural dispensary.

While seated in the shade under the small tree, I asked Caroline if she would tell me about the tragedy. Although ten months had passed since the death of her child, I was a bit worried and uncomfortable asking her to talk about it, but to my relief she promptly agreed. I remember Caroline, or Caro[2] as she was called by her family, from her early childhood during my initial fieldwork in Keru in 1996. At that time, she was a lively, self-confident girl with lots of energy. I often saw her playing with her younger brother Michel. As she entered adolescence, she became a shy and hard-working young woman, doing farm work and assisting with Beatrice's millet beer production. During her adult years, I had not talked much with her; she always kept to herself, staying inside, I surmised, because she

had suffered a serious corneal infection and strong sunlight caused her pain. However, on this occasion, it was as if she really wanted to tell her story. I sensed a great sadness but also a kind of vacillation. It was clear that she felt locked into a situation: she could not continue living with her husband, yet moving back with her parents did not seem to be a viable solution either. She wanted me to understand her situation, and perhaps she hoped that I would be able to help her. She sat on a small stool just in front of us. To my surprise she started to disclose her story in French—I had never before heard her speak much in French. But this time, she spoke French during most of the heartbreaking interview, only switching to Mooré in the last part of the conversation. Her statements, which revealed how complex family relations can be, were very clear:

> *Helle*: Last year you gave birth at home and the baby was fine. How did your boy die?
>
> *Caro*: He just died like that. He was not ill before he died. He just died.
>
> *Helle*: He just died? He had not been ill before he died?
>
> *Caro*: No, he was not ill before he died. It was a Sunday, he died. I woke up Sunday morning and went to church with him.
>
> *Helle*: Did you go to church in this village or in the village where you live?
>
> *Caro*: Yes, at that village, at Bangri. At the prayers there, I breastfed him. He was not dead then. It was after the prayers. I placed the child on my back, and we went home. It was when coming home that I saw that the child had died. He had simply died, just like that.

According to Caro, the cause of the child's death was related to a conflict with her husband and mother-in-law, an active woman, probably in her mid-eighties, whom I had met a couple of times. Caro explained:

> *Caro*: The problem is that my husband is Muslim, and I am Christian. He has told me that if I take the child to the church, the child will die. His mother, my mother-in-law, has also forbidden me to go to church with the child, saying that in that case, he will die. My husband says that it is his child, and that the child is therefore Muslim, and that it is not my child. I have replied that it is also my child. I have said to my husband that the child belongs to both of us. The mother of my husband has talked with "things." I don't know how to explain this. My mother-in-law has

> performed some sacrifices to the ancestors in order for the child to die. She has told me that if I go to church with the child, he will die. She has sacrificed the child to the ancestors of her natal village. My mother-in-law has told me that she does not agree with me to convert the child to Christianity, as she is herself Muslim. But my mother-in-law is herself Christian, as she has done the catechist, and she is baptized. That day, both of us went to church. When my mother-in-law went [to her village] to do the sacrifice, she told me that my child would die on my back.

Caro was clearly worried about the conflict with her husband and her in-laws, and she was afraid that the mother-in-law would also bewitch her four-year-old daughter. I will unfold the story of the sudden death of Caro's son in more detail in chapter 2, as it illustrates the importance of the spiritual world in interpretations of a child's sudden death in this part of Burkina Faso and highlights that caring for a small child and caring for family relations are sometimes at odds.

## Aim of the Book

The aim of this book is to illustrate how rural citizens of Burkina Faso encounter and live with a fragile state and an elusive public health care system. At a time when medical anthropologists focus, to a large extent, on biomedicine, with clinics or hospitals serving as the main field sites (Hannig 2017; Livingston 2012; McKay 2017; Scherz 2018; Street 2014; Strong 2020; Wendland 2010), this book follows Dorothy Hodgson's recommendation to engage in research with long-marginalized rural peoples. Hodgson argues that "perspectives and experiences 'from the margins' offer key theoretical and political insights into this complicated place we call 'Africa' by challenging grand narratives of modernization, of 'Africa rising,' of supposedly 'universal' ideas of progress and justice" (Hodgson 2017: 38). The chronically precarious political and social situations of countries like Burkina Faso raise a number of questions: How do rural citizens perceive and relate to an "absent-present" state? How do they balance the insecurities and uncertainties of everyday life with the search for new opportunities to improve their lives as well as the lives of their relatives? How do rural citizens exercise hope and agency in the quest for health care? How do they relate to and imagine the state? *Fragile Futures* is based on more than twenty

years of engagement with Burkina Faso and, in particular, on my engagement with the Bancé family. Their story discloses the hardships, ambiguities, hopes, and ambitions of populations in low-income rural societies. Each of the chapters includes narratives from members of the family.

## Ambiguities of Care

Throughout this book, I use the term *ambiguities of care* to frame understandings of care, illness, and treatment seeking. Ambiguity refers to "the quality of being open to more than one interpretation" (Oxford English Dictionary 2008), and it is this "openness" that I find particularly interesting. Sickness itself is an ambiguous state, and one central task of caring is the management of this ambiguity (Holden and Littlewood 2015: 170). Families experience ambiguities of care when a child falls sick and decisions have to be made about how best to intervene. Each new step of the therapeutic pathway is impelled by uncertainty, but also incites hope for healing and restoration of everyday life. The decision about whom to consult in case of sickness is ambiguous. It is, I argue, not so much a choice between different epistemologies, but a pragmatic choice of time and cost and a choice about how best to confirm and nurture good relations with human as well as non-human beings. The symptomatology of a disease such as malaria is itself ambiguous, and getting a negative result from a rapid diagnostic test for malaria at the rural dispensary and then receiving a prescription for malaria medicine from the same nurse is also an ambiguous experience. As I elaborate later, this seemingly illogical praxis relates to the fact that Burkina Faso has a strong focus on the fight against malaria, and the diagnostic repertoire of the nurses at the dispensaries is limited.

Taking *ambiguities of care* as an analytical framework for exploring different forms of care relationships, I wish to illustrate, in line with China Scherz's study from Kampala (Scherz 2018), that if we want to understand the diversity of human practice and experience within the domain of health, we need a renewed focus on treatment seeking in medical anthropology that includes both vernacular healing by local experts and self-treatment at home. In this book, I argue that families, and in particular mothers of small children, spend an enormous amount of time on care work. Taking care of family mem-

bers is both about managing actual cases of sickness in the most appropriate (and economically sound) ways and about maintaining and nurturing various social relationships to humans and nonhuman beings. My core contention is that citizens of Keru actively and intelligently address the ambiguities of sickness and care and explore potentials and openings in their determination to maintain and secure a decent future for themselves and their families.

Fragility refers to being easily broken or damaged, being delicate and vulnerable. At the social level, fragility is related to other concepts such as uncertainty, insecurity, contingency, and vulnerability. While these concepts are interrelated, it might be useful to distinguish between them in order to see how they relate to and complement each other. In her epilogue to *Dealing with Uncertainty in Contemporary African Lives*, edited by Liv Haram and Bawa Yamba (Haram and Yamba 2009), Susan Reynolds Whyte defines uncertainty, insecurity, and contingency, and she briefly discusses how these concepts feed into and are often entangled with each other (Whyte 2009: 213–15). Uncertainty, she says, may be thought of as a state of mind and minding. It pertains to our situated concerns and "refers to a lack of absolute knowledge: inability to predict the outcome of events or to establish facts about phenomena and connections with assurance" (Whyte 2009: 213). Uncertainty is a way of thinking about the future, and it creates worries and fears. In Whyte's definition, insecurity denotes a social condition where there is "a lack of protection from dangers, weakness in the social arrangements that provide some kind of safety net when adversity strikes" (Whyte 2009: 214). Having little room to maneuver may generate uncertainty. Contingency is related to the two abovementioned concepts but refers more specifically to an existential situation. To be contingent "is to be dependent on, or affected by, *something else* that cannot be fully foreseen or controlled" (Whyte 2009: 214). Contingency is about the unexpected, the events that may arise suddenly and affect one's plans for the future. All three concepts relate to the present and the future: uncertainty refers to a state of mind, insecurity to a social situation, and contingency to an existential situation. However, they all take their point of departure from an existing situation entailing negative consequences for the future.

According to Whyte, dealing with uncertainty is not so much about trying to make things certain as about trying to create more

security. While insecurity and contingency are very closely related, contingency emphasizes dependency and interrelatedness. Vulnerability, which is also about dependency, is closely related to contingency but denotes a social situation. The concept of vulnerability is used by social welfare institutions and aid agencies to categorize people—such as orphans or malnourished children—with extra needs or entitlements due to their exposure to particular risks (Whyte 2009: 215). My use of *fragility* as a concept relates closely to the notion of contingency, as it also accentuates interdependence. Within the anthropology of philosophy, Paul Ricoeur relates fragility very closely to interdependency and responsibility. Ricoeur sees the human being not as an autonomous, independent individual but as an individual dependent on other people, constantly balancing definite and infinite desires while striving for the good life (Ricoeur 1986; Schaafsma 2014: 163). While Ricoeur has been an important figure within philosophy and the human sciences, there is now a growing interest in his work within the social sciences, particularly among scholars working with "narratives" and "pragmatism" (Borisenkova 2012; Schaafsma 2014; Van Nistelrooij, Schaafsma, and Tronto 2014). Ricoeur's strong focus on the fundamental importance of social relationships for the individual human being is in line with the perspective of social anthropology (Carney 2015; Kearney 1996; Ricoeur 1994). In "Fragility and Responsibility," Ricoeur elaborates on the importance (and the imperative) of "responsibility," giving the example of the birth of a child. He writes:

> Consider the birth of a child—its mere existence obliges. We are rendered responsible by the fragile. Yet, what does "rendered responsible" mean? When the fragile is not something but someone—an individual, groups, communities, even humanity—this someone appears to us, entrusted to our care, placed in our custody. Let us be careful, however. The image of custody or the burden, which one takes upon oneself, should not render us inattentive to the other component emphasized by the expression "entrusted to our care"—the fragile as "someone" who relies on us, expects our assistance and care and trusts that we shall fulfill our obligations. This bond of trust is fundamental. (Ricoeur 1996: 16)

Ricoeur's analysis of the intrinsic relations between fragility, care, and responsibility informs my work. In Keru, everyday health care activities, both preventive and therapeutic, take place in a fragile environment where each individual is, ontologically speaking, fragile.

People are connected through interdependent social relationships with other human beings as well as non-human beings, and this interdependency is expressed in the everyday, pragmatic practices of caregiving, where family members invest in the future of their children, family, kin, and community. Ricoeur's notion of fragility resonates particularly well with my ethnographic analysis because it "directs us towards the future of a being in need of help to survive and to grow" (Ricoeur and Kearney 1996: 16). Interdependency and responsibility are also about caring, understood in both a practical and an affective sense. The notion of care also has a temporal dimension: to care for someone is to engage in actions directed toward the future. Caring for a child seeks to ensure the child's growth, and caring for a sick person fosters a process of healing.

## Potentialities and Hope

In this ethnography, *ambiguity* refers to the multiple uncertainties, contingencies, and potentialities that disrupt everyday life but that also continuously provide openings and offer hope (Hage 2003; Millar 2014; Vigh 2008, 2011; Zigon 2018). Conditions of fragility and uncertainty are not only negative; they include the potential for new opportunities, the hope of a different future. The notion of hope has a number of connotations, such as desiring, wishing, wanting, waiting, and dreaming. To understand the texture of everyday life in Keru, I explore the relations between fragility, care work, and hope. As I show in the following chapters, the citizens of Keru continuously assess possibilities, seize opportunities, and take chances in their determination to negotiate and form their own futures and those of their families. Fragility, care, and hope include both social and temporal dimensions; they all "express in one way or another modes in which human beings relate to their future" (Hage 2003: 10). Societal hope, as Ghassan Hage (with inspiration from Pierre Bourdieu) defines it, is allocated through social opportunities or social routes by which individuals can define a meaningful and dignified social life: "If hope is the way we construct a meaningful future for ourselves . . . such futures are only possible within society, because society is the distributor of social opportunities for self-realization. We can call this hope societal hope" (2003: 15). The distribution of hope is, for Hage, an intrinsic quality of any soci-

ety, maintaining the possibility of upward social mobility—nursing dreams of better education, jobs, and lifestyles, even when those dreams often remain unrealized.

Precarious and uncertain living conditions can also be used to negotiate and explore opportunities and alternative futures. Hope is a means to imagine a future that is then projected back into the present to influence the best possible route toward that future (S. Turner 2015; Vigh 2009). Hopefulness is "a disposition to be confident in the face of the future, to be open to it and welcoming to what it will bring, even if one does not know for sure what it will bring" (Hage quoted in S. Turner 2015: 175). This complex task of balancing the present with hope for the future is a fundamental component of agency and of being en route. As Ricoeur formulates it: "I must hope in order to believe that I am able to act" (Dauenhauer 1986: xv). In the chapters that follow, I examine different modes of fragility and uncertainty with specific focus on the various practices and actions that express hope and hopefulness.

Faced with a weak and elusive health infrastructure, many citizens, both rural and urban, feel neglected by the state and mistrust of the government has been growing; yet, the state–citizen relationship is ambiguous, because "the state continues to exercise a 'crucial presence' as an 'object of desire'" (Street 2012: 16). Thus, I explore ambiguities of care in different types of relationships. I focus on the caregiver–patient relationships at the household level, where family members continually have to make decisions about how best to prevent and treat sickness. In therapeutic engagements, families choose between and consult different types of healing experts, each of whom proposes meaningful therapeutic pathways, but with no pregiven guarantee of positive outcomes. When patients and their families consult the dispensary or the district hospital, the care practices provide patients with some kind of security, but the routinization and the limited diagnostic repertoire also disclose how fragile the system is. I show how rural citizens, through their engaged and active care practices, continuously work with the ambiguities that sickness brings, and I argue that conditions of fragility and uncertainty can be productive, because they open up new opportunities. However, hope is, as Jarrett Zigon argues, not only and always about striving toward a new and better future, but it is also about the perseverance of a sane and decent life. Hope is thus also about maintaining the world

as it has been lived through, and hope is what enjoins us to 'keep going'" (Zigon 2018: 71–72). Pragmatic "trying again" and persistent tinkering are gestures of care that actively attend to openings and potentialities in the search for a sane life (Zigon 2018). Following specific cases of sickness and listening to (particularly) mothers' reflections about their therapeutic options and decisions, I trace how hopes, worries, and disappointments unfold over time.

## Structural Fragility

The term *fragility* has also been used widely within development discourse to categorize states. The characterization of Burkina Faso as a "fragile state" or, perhaps more precisely, a state with "limited statehood" (Börzel and Risse 2021) is relevant for the discussion of fragility and hope in a rural community as well as for understanding rural citizens' relations to the state.

Originally, the donor community identified a rather broad and heterogeneous group of countries as fragile. As Jörg Faust, Jörn Grävingholt, and Sebastian Ziaja (2015) explain, "fragility" summarizes various features of weak, decaying, failed, failing, or otherwise defunct states. Fragility as a concept, with roots in political theories of state formation, was taken up by policymakers when they were confronted with government failures in Haiti and Somalia. Although the original definition of a "fragile state" is not absolutely clear, there seems to be common agreement that fragile states, or states with "limited statehood," are unable to control violence, address popular demands for representation, or guarantee minimal living standards (Faust et al. 2015: 411). Burkina Faso was ranked 37 of 178 countries on the 2020 Fragility State Index and mentioned as one of the five countries whose condition had worsened the most over the previous year.[3] Yemen was first on the list, identified as the most fragile state in the world. The ranking is based on twelve vulnerability indicators grouped in four categories: cohesion, social, economic, and political. Burkina has the worst score on "security apparatus" (8.7 where 10 is the maximum), "demographic pressure" (8.6), and "public service" (8.4). The public service indicator, the one most directly relevant to providing health care, is defined in the following way:

> The Public Services Indicator refers to the presence of basic state functions that serve the people. On the one hand, this may include the provi-

> sion of essential services, such as health, education, water and sanitation, transport infrastructure, electricity and power, and internet and connectivity. On the other hand, it may include the state's ability to protect its citizens, such as from terrorism and violence, through perceived effective policing. Further, even where basic state functions and services are provided, the Indicator further considers to whom—whether the state narrowly serves the ruling elites, such as security agencies, presidential staff, the central bank, or the diplomatic service—while failing to provide comparable levels of service to the general populace—such as rural versus urban populations. The Indicator also considers the level and maintenance of general infrastructure to the extent that its absence would negatively affect the country's actual or potential development.[4]

The fact that the public service score is so high indicates that the capacity to deliver the most basic services, including health care, is very low. The Fragile States Index has issued a "warning" for Burkina Faso, just one level below the "alert" issued for the most fragile states.[5]

Burkina Faso's economy grew at an average of more than 5 percent annually between 1991 and 2016. However, the notion of "Africa rising," used to characterize the rather impressive economic growth of many African countries, does not apply to the living conditions in rural Burkina Faso. The country's economy relies heavily on agriculture—around 70 to 80 percent of the population is employed in this sector, mostly as subsistence farmers. Burkina Faso is a landlocked country with few natural resources. Cotton is the main cash crop, and gold exports play an increasingly important role in the country's economy. Unfortunately, the government has not managed to improve the living conditions of its people significantly, and many still live in absolute poverty. Burkina Faso is consistently ranked near the bottom of the UNDP Human Development Index.[6] In 2016, the country was ranked 185 of 188 countries, with 46 percent of the population below the poverty line (Zeilig 2017).[7] In 1996, when I started fieldwork in Burkina Faso, the total population was estimated at around 10.5 million; in 2020, it was estimated to be more than 19 million. Such a population increase puts a lot of pressure on land resources, the political system, and individual families.[8]

In 2014, Blaise Compaoré, who had been president since 1987, wanted to change the constitution so he could continue for yet another term as president. However, the proposed change stirred up protests and resistance against Compaoré and his brother, who also

had a prominent position in the government. A widespread *insurrection Populaire* (popular uprising) was organized by the *Balai citoyen* (broom citizen) movement led by a famous Burkinabe musician in collaboration with trade unions and other civil society organizations (Hagberg et al. 2015). Demonstrations, strikes, and other protests took place during the uprising in the major cities, but some demonstrations also took place in regional towns. Blaise Compaoré was exiled to Côte d'Ivoire, and he apparently managed to escape with cars loaded with "state money." After a short-lived military coup in September 2015, fresh elections were held in November 2015. Roch Marc Kaboré, a prominent figure in Compaoré's government until ten months prior to the elections, won the first round with more than 53 percent of the vote. Hopes were high that democracy in Burkina Faso would be revitalized and that the precarious living conditions of the majority of the population would finally be addressed.

Although many citizens, including many in Keru, expressed their disappointment with Roch Kaboré's government, he was reelected in November 2020. However, his time as president was short. In January 2022, Colonel Paul-Henri Damiba staged a military coup and installed himself as the leader of an interim government. He accused the sitting government of not being able to provide security in the country. Only eight months later, another coup d'état took place and


**Figure 0.1.** Polling Station in a rural area, Burkina Faso (© Helle Samuelsen 2023)

Damiba was removed. This time, Captain Ibrahim Traoré, who originally supported Damiba's coup, took power. He accused Damiba of being more concerned with politics than with fighting the jihadists in order to restore peace in the country.

Instability and insecurity characterize several countries in West Africa. Political conflicts in Côte d'Ivoire, particularly during the period from 2012 to 2014 and during more recent presidential elections, have brought to the surface fundamental ethnic and regional tensions. The borders to Burkina Faso were temporarily closed during a political crisis in 2014, the economy of Côte d'Ivoire slowed down, and many Burkinabe migrants returned home during the crisis with little chance of finding a job at home. The security situation in the Central Sahel, including Mali, Burkina Faso, and Niger, has been particularly tense since 2014. The political conflict in Mali, where jihadists have controlled the northern part of the country for several years, revealed the weakness in the country's democratic government, and the military coup in 2020 exposed the volatility of the current situation. In Burkina Faso, terrorist attacks, mainly by AQIM (Al Qaeda in Magreb), Ansaroul Islam, and the Islamic State of the Greater Sahara (ISGS), have become more frequent. The jihadist groups no longer restrict their activities to the border areas in the northern part of the Sahel, where the security situation has long been delicate, as had been their strategy for years (Hagberg et al. 2019). In January 2016, bomb blasts took place at a hotel and a café in Burkina Faso's capital, Ouagadougou. Both places were known as hubs for Western tourists and aid workers. Serious attacks on military barracks, public schools, health facilities, and civilians have increased since 2016. Kidnappings of national citizens and foreigners have occurred in Mali and Burkina Faso in recent years. The Ebola epidemic in Guinea, Sierra Leone, and Liberia shattered the countries' economies and revealed how weak and vulnerable their health care systems were. All three are among the poorest countries in the world. West Africa, in other words, is politically tense and economically fragile, and understanding this is important for my analysis of everyday life and health care in rural Burkina Faso.

The combination of a rapidly growing population and the majority of the population surviving on subsistence agriculture places rural families in Burkina Faso under pressure. With few natural resources, political unrest in the region, high unemployment rates

in urban areas, and a weak government barely able to deliver even the most basic services, most people are left to fend for themselves. Many families depend on remittances from their relatives among the nearly 1.6 million migrant workers who move to other countries in the region or abroad to work in the agricultural or service sectors. The most important destinations are Côte d'Ivoire, Ghana, Mali, Niger, Italy, Benin, France, Nigeria, Gabon, and Germany.[9] In Keru, most families include one or more migrant workers, and many women and children depend on the often unstable remittances they send home. However, far from all migrants experience success. During my visit to the village in 2014, in the midst of conversations about the proposed changes to the constitution, the Bancé family was discussing whether to send Michel, at the time nineteen years old, abroad, as local options for finding work or making a living in subsistence agriculture were very limited.

This book, *Fragile Futures*, is about both fragile relationships and fragile institutions. It is about the fragility of lives in rural Burkina Faso, where people depend on and are responsible to each other, care for each other, and worry about their own futures as well as the futures of their children. It is also about people's experience of hope as they look for opportunities, seize possibilities, and anticipate that the state will take up the responsibility of providing basic services, including improved health care, to all Burkinabes. *Fragile Futures* is about the ambiguities of sickness, care, and seeking treatment in rural Burkina Faso. It is about the everyday life and about the ordinary and relentless care required to keep children healthy. It is about mothers' paths in and out of biomedical state institutions and their use of local, informal health care providers.

## The Absent-Present State

Looking at the Burkina state over recent decades, we see at least three paradoxes. First, Blaise Compaoré's presidency, which lasted twenty-seven years, was both weak and strong. Second, the government, at both the local and national levels, is stable and fragile at the same time. Third, the state is simultaneously absent from and present in people's lives (Law 2002; Masquelier 2001; Street 2012).

The first paradox relates to the fact that Compaoré's presidency had been quite strong until 2014. He was elected and reelected sev-

eral times, and, during his rule, he managed to steer clear of a number of conflicts between ethnic groups inside the country, balancing the power of the government with that of the traditional chiefs. Furthermore, he succeeded in negotiating "peace deals" with jihadist groups in the north and west by offering them certain privileges. In addition, the economy grew, but that growth did not benefit the rural poor, who were largely ignored by the government.

The country's health policy, which, since the signing of the Alma-Ata Declaration in 1978, has been characterized by a long-standing focus on district-based primary health care, highlights a second paradox, this one about the stability and fragility of governance. Despite a number of successes, such as high vaccination rates, a reduction in the average distance to public health facilities, and the introduction of the rapid diagnostic test for malaria, the health care system continues to face huge challenges in delivering basic services and quality care (Melberg et al. 2016). The third paradox—that the state is both absent and present—is conspicuous in the rural parts of the country. The notion of the absent-present state is central to my analysis of health care practices and the use of the public health facilities in rural Burkina Faso. I draw here on John Law's definition of the "absent-present." In his analysis of aircraft stories, he describes heterogeneity: "How it is that whatever is not there is also there. How that which is there is also not there. Both/and rather than either/or. Or both/and either/or and both/and. Heterogeneity, then, is about the differences that reside in connection and disconnection. Or, more precisely, it is about the ambivalent distributions entailed in dis/connection" (Law 2002: 96). As in the case of the aircraft brochures Law analyzed, where the technical descriptions of the aircraft included both an absence and a presence of "the real world," of "what actually happens" (Law 2002: 95–99), so too do state-governed rural health facilities include both absences and presences. Government buildings, such as schools, dispensaries, and prefectures, dot the landscape with their distinctive architecture, but they are remarkably empty of both people and equipment. The physical facility is there, but it is at the same time characterized by material absence, as in the case of health facilities, basic diagnostic equipment is usually unavailable or broken, and basic elements of infrastructure, such as running water, stable electricity, and toilet facilities, are absent.

As I show in my analysis of the medical field and the services provided by the local dispensary (chapter 6), another type of absence-presence also emerges in the health care system. While the health care policy of Burkina Faso clearly states that rural dispensaries serve as the first point of contact with the government health care system, patients are often uncertain about how much to pay for the services, whether health workers will listen and understand, and whether the diagnoses and therapies provided will secure recovery from illness (thus proving that the visit was "worth the money"). Patients bring these unspoken questions with them, but they do not fit into the algebra of health policy.[10]

In this book, I look at the presence—and absence—of "the state" in everyday life, focusing particularly on how the rural citizens of Keru and neighboring villages managed their lives in the context of an "absent-present" state. Within the social sciences scholars have produced a substantial literature (and corresponding debate) on the definition of the state and the role of the state in the context of a globalized world (Adebanwi 2022; Blom Hansen and Stepputat 2001; Bouchard 2011; Das and Poole 2004; Engberg-Pedersen, Andersen, and Stepputat 2008; Ferguson 2006; Inda and Rosaldo 2002; OECD 2010; Sharma and Gupta 2006; Street 2012). I primarily subscribe to an analysis of the state as a cultural constitution—that is, as Aradhana Sharma and Akhil Gupta (2006: 11) formulate it: "how people perceive the state, how their understandings are shaped by their particular locations and intimate and embodied encounters with state process and officials and how the state manifests itself in their lives." This approach implies an investigation of everyday practices during which citizens encounter representatives of the state, whether they are standing in line for vaccinations at the health center, participating in a public meeting at the local school, or filing a complaint about a neighbor at the office of the *préfet*. The state is substantiated through these banal bureaucratic practices, usually located in a set of institutions (Sharma and Gupta 2006).

In one sense, this is a book about people living at the margins of the state—or rather about how marginal the state seems to be to many rural citizens. It is a state that, on the one hand, sees its role as creating order and, in a Foucauldian sense, works hard to control the population (Foucault 2007, 2012; Scott 1998). On the other hand, it is a state that has neither the means nor the will to secure a "bare"

**Figure 0.2.** Municipal office in a rural area, Burkina Faso (© Helle Samuelsen 2023)

life for its citizens (Agamben 1998). The "absent-present" state is marginal to the everyday life of those in rural villages. The citizens of Keru experience the representatives of the state as strangers. This becomes particularly clear when they enter the dispensary or hospital. Here they are almost silent, speaking only when addressed directly, and their approach to the public health staff is usually very humble.

In a simple spatial sense, the villages are geographically marginal, located far from the capital, where the main government and business centers are located. The network of roads, electrical service, public water supplies, and other infrastructure becomes thinner and thinner the greater the distance from the capital of Ouagadougou; often the quality of those services becomes poorer and poorer as well. Alice Street's description of "weak" or "absent-present" states in her work on Madang Hospital in Papua New Guinea resonates very well with the situation in Burkina Faso. In Papua New Guinea, Street notes, "the state exists primarily as an absence. The state is not imagined as an abstract entity but as an urban elite of politicians and administrators who have little interest in bringing governance, and associated 'development,' to the nation's rural inhabitants" (Street 2012: 16).

In Keru, state institutions related to education, health care, and local government are visible, but few services are available. Mothers with small children queue up early in the morning on vaccination days at the dispensary in Tenga, which serves about twelve villages, but nurses confirmed that few patients turn up for other consultations. Not only was the dispensary almost empty of people, it was also empty of instruments and essential utilities such as running water and latrines. The classrooms at the local school provide wooden benches for the pupils and a table for the teacher, as well as a large blackboard. However, there are no books or other supplies; the children have to bring their own notebooks and "Bics" (pens). The lack of services has continued from my first trip to Keru in 1996 until the present, despite the village's growth.

State institutions, even those located in the village, feel distant from the experience of everyday people. Staff are frequently absent from their posts. Often, the prefect and mayor attend meetings in the district headquarters, and many of the government staff drive to the nearest town in the afternoon, where their families and friends may live, as few of them are locals themselves. The architecture of the government buildings clearly signifies that they represent the state. The square buildings with cement floors and tin roofs, built with proper bricks, stand out from the village's round mud-brick houses with thatched roofs, though local architecture increasingly resembles that of the government buildings. At the school, most of the teaching is conducted in French, the official language of Burkina Faso, although most children speak Mooré or Bissa at home. In the last chapter, I shift focus from rural Burkina Faso to an analysis of urban responses to the COVID-19 pandemic in Burkina Faso with a particular focus on how the state–citizen relationship was temporarily affected by the lockdown and the understandings of COVID-19 as an exceptional disease.

## Biopower

In Keru, most people believed that the recent economic progress of the country had benefited only the urban elites. Both men and women in the village explained how difficult it was to make enough income from subsistence farming or small-scale trading to sustain and care for their families. Hage explains the role of nation-states:

"Nation-states are supposed to be capable of providing a nurturing and caring environment," and if citizens are "cared for," citizens "care back" through their active and affective participation in the nation (Hage 2003: 29–30). That was not happening in Keru. Understanding the fragility of Burkina Faso's government—partly due to a weak economy and an unstable government and partly due to massive security threats from jihadist groups operating in Central Sahel—is important for getting a sense of how citizens in Keru as well as in a city like Bobo-Dioulasso imagine and relate to the state and its services.

In addition to their experience of economic marginality, many people in Keru were disappointed in politicians. They expressed concern about the dominance of the Mossi people in government and other powerful positions. The village (and other parts of the Boulgou province) is primarily inhabited by Bissa, and the tense relationship between the Bissa and the Mossi, the major ethnic group in the country, has a long history. The Bissa claim that they were the first to settle in this area, later providing some land to the Mossi. However, the Mossi have always been politically strong with powerful kingdoms throughout Burkina Faso. A Mossi king continues to rule through the traditional chieftain system in Tenkodogo, and he is supported by both Mossi and Bissa people of the region through various gifts in return for different forms of protection. However, in recent years, the tensions between the groups have escalated, particularly concerning land and water use (Cissao 2019; Korbeogo 2013), and some villages now have both a Bissa and a Mossi chief.

Inspired by Veena Das and her colleagues (Das and Poole 2004), I explore the relationship between the margin, in this case the experience of everyday life in Keru, and the representations of the state.[11] I am particularly interested in how "technologies of power" are practiced and perceived within the domain of health service provision. This is not a simple relationship since many of the conventional technologies of power do not work well in Burkina Faso. The state attempts to "manage" the rural population in various ways, while at the same time failing or neglecting to provide the most basic public goods. In the chapter on COVID-19, I examine the ambiguous local responses to the many restrictions introduced by the government and show how the imposition of the lockdown as a technology of power was praised by some urban residents—at least temporarily.

Veena Das and Deborah Poole discuss marginality and relations to the state noting, that "the state is continually both experienced and undone through the *illegibility* of its own practices" (Das and Poole 2004: 10) when the state resorts to illegible acts, such as corruption or falsification of documents. Although the health sector in Burkina Faso is characterized by extensive corruption, or irregular administration (REN-LAC 2018), I will not here focus directly on how the state and its representatives establish laws and engage in illegible practices. However, the underlying discussion of authority is relevant for this book. Max Weber describes three basic types of authority: legal, traditional, and charismatic (Weber 1978: 215). Bureaucratic organizations, such as public health facilities, are ideally built on legal authority. They are rational, set up to perform specific tasks. Weber explains how offices, statuses, and roles within a bureaucracy are clearly defined and hierarchically organized with specific and precise rules and regulations guiding the work of bureaucrats. As a result of the rules governing practice, bureaucrats are expected to be impersonal in their work, treating others fairly and objectively in all situations (Weber 1978). Bureaucratic organizations are thus contrasted with systems based on traditional or charismatic authority. When focusing on the margins, the notion of authority becomes central. How do members of the "local bureaucracy" perform their authority? How do the rural citizens relate to this type of authority—and to other forms of authority, such as the traditional authority enacted by the local chiefdoms (Pare Toe and Samuelsen 2020)?

Das and Poole also study the margin as the space between bodies, law, and discipline in which biopower is produced (Das and Poole 2004: 9–10). *Biopower* and *biopolitics* have become key terms in contemporary theorizing about the interface between biomedicine, the biological body, and politics. This discussion takes its point of departure in Michel Foucault's work on the role of statistics, population counts, and other regulations in the modern state, where the emphasis has shifted from the sovereignty of the state over territories to the state's management of human life (Das and Poole 2004; Foucault 2012; Samuelsen and Steffen 2004). As I discuss in chapter 6, metrics, based on standard reporting formats, play an important role in the government's health care policy and its continuous focus on the fight against malaria.

The capacity to perform medical sovereignty on biological bodies is limited. Government health care professionals have neither the skills nor the technologies to accommodate the biomedical and bureaucratic agenda of government institutions. The institutions are the loci for biopower, but they are relatively weak. The relationship between the state and the margin moves in two directions. The health staff (or other government employees), who have the authority to be in command and manage the medical treatment of patients, depend not only on having the relevant technologies to execute their power but also on being recognized and visible to patients as professional experts with decisive capacities for action. In turn, patients struggle to make their bodies seen by the health care professionals. This interdependent relationship of "rights and duties" is analyzed by Adriana Petryna in her study of life after Chernobyl, where people affected by the catastrophe accept their duties as citizens but also claim their rights as biological citizens and seek disability entitlements (Petryna 2013a). In chapter 7, I return to the discussion of biopower and the rights and duties of the state to take care of its citizens.

The question of "rights and duties" is also taken up by Vinh-Kim Nguyen in his discussion of therapeutic citizenship in relation to the AIDS epidemic in West Africa, where it became important to recruit HIV-positive patients for various treatment trials. Being part of a treatment trial implies certain rights, such as the right to medicine and the right to food aid (Nguyen 2010; Samuelsen 2016). Likewise, Susan Reynolds Whyte, Michael Whyte, Lotte Meinert, and Jennipher Twebaze explore therapeutic clientship in the relationship between clients and an AIDS care program in Uganda, where the participants, by joining the program, gained access to new benefits and opportunities (Whyte et al. 2013). Nguyen's and Whyte's research does not directly examine the relationship between citizens and the state; rather, they consider the relationships between citizens and nongovernmental organizations, because such groups often fill the gap left by states unable or unwilling to act.

In *Fragile Futures*, I unfold the complex relationships between health authorities and citizens in Keru with a specific focus on how rural citizens manage illness and treatment under circumstances where little professional biomedical health care is available. In the last chapter, I examine the exception: how the government man-

aged to deploy biopower during the COVID-19 pandemic—and how urban citizens responded to these powerful interventions. *Fragile Futures* is in conversation with anthropological literature on global health, where "local" ethnographic studies are combined with critical questions about the role of security, politics, and power (Adams 2016; Adebanwi 2022; Biehl and Petryna 2013; Bierschenk and de Sardan 2014; Das and Han 2015; de Sardan 2008, 2015; Farmer 1999, 2006; Holmes 2013; Manderson, Smith-Morris et al. 2010; Nguyen 2010; Team and Manderson 2020; Van der Geest and Whyte 1988; Wilkinson and Kleinman 2016). I explore how "ordinary" care practices in rural Burkina Faso are shaped by household, community, and national politics within the political and economic framework of an unstable state. With the notion of the "absent-present state" (Law 2002; Street 2012, 2014). I show that the state is indeed present in people's perceptions despite its elusiveness or absence in their everyday life.

## Anthropological Engagement

*Fragile Futures* builds on more than twenty years of engagement with Burkina Faso and particularly on fieldwork in three villages in a southeastern province. Throughout my work in Burkina, I have remained in contact with the Bancé family in the village of Keru. This close contact has allowed me to follow the ups and downs of this family and the village where they live. During fieldwork periods, I have followed the everyday life in the village; at other times, I have been absent for long periods and even more eager to catch up at the next visit. In other words, I do not claim to have in-depth knowledge about village life during the whole period, but returning to the village again and again has given me a sense of continuity.

This book is a response to the call for "slow research" by Vincanne Adams, Nancy J Burke, and Ian Whitmarsh (2014). The slow research movement argues for a change of research perspectives, particularly in relation to global health, that pays increased attention to local specificities: "Slow research takes the local as a starting point. It calls attention to and focuses on the importance of particularity and specificity" (Adams, Burke, and Whitmarsh 2014: 182). It recognizes that all knowledge is produced in context and that this context is usually local; it opposes the tendency to push differences

in beliefs, practices, and context to the background (Adams, Burke, and Whitmarsh 2014: 181). A strengthened focus on the local does not imply that we analyze specific phenomena in isolation; rather, the local is always connected to a larger context. Taking local realities "on the ground" (Biehl 2007: 107) as a point of departure is important for making "evidence"-based anthropological contributions to the conversation about what works and what needs to change within global health.

This book is based on four related research projects carried out in the same villages. The first project, carried out in 1996 and 1997, focused on health-seeking practices, explanations of illness, and how theories of illness transmission related to spatial practices. During that period, I spent a lot of time in the field getting to know Thomas and his family, who have been among my most important interlocutors. I conducted many interviews with mothers on sickness and childcare, as well as with traditional healers and local experts, many of whom specialized in treating specific symptoms and offered their healthcare services on a part-time basis, spending most of the time tending their fields like any other villager. The second project, carried out in 2001, explored the medical field in more detail, with a specific focus on the use and nonuse of government health facilities. In 2010 and 2011, I revisited Keru, investigating changes within the social and "medical" worlds of the villagers. The third project, which took place from 2012 to 2017,[12] involved a larger research group that examined the relationship between rural citizens and the state. Here, our main purpose was to analyze how rural citizens use government facilities (especially public health care facilities), what rural citizens expect from the state, and how they imagine the state. The project was inspired by the Arab Spring and the unstable political situation in the whole region, where many people forcefully expressed their disappointments with the state. The fourth project, which took place from 2018 to 2023 focused more specifically on state citizen relationship during epidemics with a specific focus on the COVID-19 pandemic. Between these four project periods, I visited the village of Keru on several other occasions as well.

Over the course of two decades, I have conducted hundreds of interviews with villagers in Keru and two neighboring villages, spoken with health care specialists of all kinds, carried out small surveys on treatment-seeking practices, engaged in document research, an-

alyzed health systems reports, and spent hundreds of days observing, conversing, and walking in and between the three villages. The Bancé family has been my anchor throughout my research engagements in Burkina Faso. Each day of fieldwork began by passing by Thomas and Beatrice's compound and saying hello. *Fragile Futures* draws on data from all four projects—and the lives of Thomas, his wife Beatrice, and their seven children play a prominent role in the story. Both Thomas and Beatrice, and Jean, a relative of Thomas I introduce in chapter 1, facilitated my first contacts to many of my interlocutors, and over the years we developed a kind of friendship.[13] They served as gatekeepers (Atkinson 2007) to numerous therapeutic specialists offering their services in the communities. The huge inequalities between the Global North and the Global South become very visible and material during fieldwork like mine, and my long-term engagement with one particular location and with one particular family has generated a number of ethical dilemmas. I have, as many other scholars from the Global North, done my best to be sensitive and to address various ethical challenges.[14] Providing transport to people from the village who needed to go to town and supporting the family and other community members in various ways is of course one way of recognizing otherwise unmet needs. But I am also aware that these small gestures in no way compensate for the obvious and profound inequalities between my life in Denmark and the everyday life of rural citizens in Keru. In addition, I am aware that my presence and my close bonds with the Bancé family most likely also presented them with a range of ethical dilemmas.

One of the goals of this book is to illustrate the continuity and change in Keru and the surrounding villages over two decades. As a result, I am particularly attentive to the temporal context of the specific events or cases I describe. The last chapter of the book is based on data from a new project, Emerging Epidemics: Improving Preparedness in Burkina Faso (2018–2023). The idea for this project arose out of the West African experiences with the Ebola epidemic in 2014 to 2016, long before the COVID-19 outbreak in Wuhan. Due to the worsened security situation, it had become impossible for me to conduct fieldwork in Keru, and due to the COVID-19 outbreak and lockdown, it was not possible to travel to Burkina Faso for a long period. Thus, in this project, I partly relied on remote fieldwork with colleagues living in Bobo-Dioulasso, who managed to conduct

interviews on site. Data from this most recent project allows me to examine the state–citizen relationship during a very exceptional period, where the state suddenly emerged as an agent that seemed to care for the people.

## The Structure of the Book

The book is organized in three parts dealing with people's active engagement with ambiguities of sickness and care in different types of social relationships: Part I: "Family, Care, and Everyday Life" (chapters 1, 2, and 3); Part II: "Technologies of Care" (chapters 4 and 5); and Part III: "Care of the Public" (chapter 6 and 7).

The first chapter, "A Family Narrative," takes its point of departure from the narrative of the Bancé family. As their experiences demonstrate, village life in Burkina Faso is vibrant, but also tough. It is a life at the margin: contacts with state representatives are rare, and much work is invested in caring for and creating opportunities for the next generation. In this chapter, I introduce the reader to Thomas and Beatrice and their seven children. Thomas, the head of the household, has always been dedicated to being a good citizen: taking responsibility in the village, casting his vote at elections, and encouraging his children to continue schooling and further education. He is a religiously devoted man with high moral standards, but ambiguities concerning how best to care for the family and the future of each of his children are challenging. Following Thomas and Beatrice over more than two decades, I show how they continuously consider options and opportunities in cases of child sickness and reflect carefully about how best to support schooling and job opportunities for each of their seven children, hoping that they will all fare well and be able to support their own families as well as their parents, when Thomas and Beatrice become too old to farm the land.

Chapter 2, "Ambiguities of Child Care," follows up on the story of the sudden death of Caro's small baby. Caro and her in-laws accused each other of causing the death of the child. In this chapter, I show that small children are seen as particularly precarious subjects. During this liminal phase, before another sibling is born, they are both particularly vulnerable and powerful. They are vulnerable in the sense that they can easily die if not properly cared for. They are powerful in the sense that they have a particular relationship with

the spiritual world until another sibling is born. This special position is reflected in the ways children are cared for, both when healthy and in times of illness. During early childhood, sickness is part of everyday life (and death): children fall sick, get better, then soon relapse. Child sickness is in this sense endemic rather than episodic. In this chapter, I pay particular attention to the often implicit, unarticulated, and silent care ethics of mothers as the main caregivers (Barnes 2012; Fink 2007; Mol 2008; Van Nistelrooij et al. 2014). The "doing of care" includes hard labor (Arendt 2013; Wilkinson and Kleinman 2016), and seeking treatment is seldom linear. Although consultations at the public health facilities have increased over the years, caregivers continue to juggle between home treatment, consultations with local healing specialists, and visits to the dispensary. By following cases of sickness and listening to mothers' reflections, I demonstrate how families, and mothers in particular, "keep going" in very pragmatic ways, addressing the ambiguities of sickness and care in continuous engagement with uncertainty and hope.

In chapter 3, I focus on labor migration as a form of care work. In the village of Keru most families depend on long-distance social relations, as many young men migrate to other countries to look for work. Many hopes and dreams are invested in the *aventure*,[15] both for those leaving the community and for those staying behind. Labor migration is not only about striving for material gains beyond subsistence agriculture; it is also about care labor, to use Hannah Arendt's distinction between work and labor, and it is about exploring potentialities and taking risks. Michel, the youngest son of Thomas and Beatrice, left for Libya in 2014 to seek work. The story of Michel's *aventure* illustrates the extremely high stakes for the migrants themselves, but also for their families at home. In the second part of this chapter, I focus on the wives whose husbands were away on *aventure*. Among those who "stayed behind," some became even more immobilized, as they were left with all the everyday responsibilities at home. Others managed to find new pathways to generate their own incomes. While many couples had little contact during the often-yearlong migration periods, the husbands remained important "absent-present" figures within the households. Increasing use of mobile phones enabled most wives staying behind to keep contact, at least sporadically, with their absent husbands. However, in their everyday life, these women were engaging with multiple uncertain-

ties, including very concrete uncertainties about how to manage the next meal and the next case of illness, as well as relational uncertainties about their ambiguous position in the household of the absent husband's family. This chapter highlights how labor migration, embarking on *aventure*, presents both the migrant and his or her family staying behind with numerous uncertainties, but also with new opportunities to care for their relatives and to nurse hopes for a good, and perhaps better, future.

In chapter 4, "Technologies and Cosmologies," I focus on care practices in a broader context where various preventive and therapeutic technologies are used to nurse relationships between the individual and society. I argue that certain technologies involve tending relations with the state in order to secure access to public health services while other technologies help cultivate relations with non-human agents in order to confirm connections to the spiritual world. The chapter takes a closer look at the various techniques and technologies used for protection and strengthening of the body. For example, there are similarities between a local incision technique practiced by a local *vaccinatrice* and the biomedical vaccination service provided by the rural health center. While the general utilization of the government health services is relatively low, there is an active demand for vaccinations among rural citizens. Mothers are particular about attending immunization days in order to get their children vaccinated. The chapter also explores the relationship between the popular practice of using amulets to prevent and treat various illnesses and the relatively new practice of using rapid diagnostic tests for malaria at health care facilities. Here the ambiguity of care is not so much about choosing between different preventive or therapeutic logics, but about being open and taking advantage of the available options. By doing so, patients and families of small children confirm both their biosocial citizenship, which authenticates their relationship to the state through signatures of belonging like prescriptions, finger pricks, and vaccination cards, as well as their "spatial citizenship," which reinforces their relationships to the local spiritual world through signatures of belonging such as bodily scars and amulets. Again, tending to relationships both to other people and to non-human agents is important to keep children alive and healthy.

In chapter 5, I describe the therapeutic pathways with a specific focus on how mothers and families navigated between different

types of healers and health care institutions. A number of treatment options were available in and around Keru. In addition to the public services, numerous part-time healers and herbal specialists provided services for specific symptoms and diseases. Many ailments were treated at home with herbs collected in the surrounding bush or medicines bought at the local market. I analyze the health care system as a medical field where the different healers and health care institutions position themselves and are positioned through people's therapeutic pathways. The absent-present nature of the public health services places them as just one option among many. For many years, Dr. Sorgho, a relative of Beatrice, was a key figure in the local medical field. As a pensioned government-trained nurse, he had set up a private clinic within his compound where he offered diagnostic and therapeutic services using a biomedical approach. He was extremely popular, and his services competed with the governmental dispensaries in the area. The chapter shows how mothers of sick children seized opportunities for treatment based on their reading of the symptoms, and on their individual constraints and possibilities for maneuvering within the medical field. The high social capital of Dr. Sorgho and many local healing experts also played an important role in local decision-making about whom to consult in case of sickness. The flexible routes between vernacular healing specialists and the public health facilities were saturated with uncertainties and hope, revealing a tension between hoping for something, that is, hoping that each consultation or treatment would result in recovery, and living in hope, that is, reconciling themselves to an everyday life subject to recurrent episodes of sickness (Ricoeur in Huskey 2009). Mothers' therapeutic pathways are undertaken in what Whyte call a *subjunctive mood*, a doubting, hoping, provisional, cautious, and testing disposition to action (Whyte 2005: 250–51).

Chapter 6, "The Availability Logic," explores the services provided at the village dispensary in more detail. In reality, the dispensary was only able to manage a very limited repertoire of diagnoses, so the villagers mainly consulted the dispensary when their sickness corresponded to the diseases the dispensary was able to address. The pattern of diagnosis is a materialization of what I call "the availability logic." A malaria diagnosis was applied in more than half of new clinic visits, and there was a remarkable absence of other presumably frequent diseases. The absence of diagnostic capacity can

be seen as a "technology of invisibility" (Biehl 2005), where only a few diseases are named, categorized, and reported. In line with discussions of the importance of statistics (Adams 2016; Wendland 2016), I raise questions about the consequences of having a routinized—and almost ritualized—consultation practice, where many ailments remain invisible and unreported, either because they are never brought to the dispensary or because the diagnostic capacity at the facility is limited. The social contract between the government's health care services and rural citizens remained weak throughout my study of health-seeking processes in Keru. Despite a number of improvements over the years, including the use of rapid diagnostic tests, the duties of the modern state to care for the health of its citizens, as embedded in the term "public health" (Prince and Marsland 2014), were never really followed through.

In chapter 7, "Moments of State Presence," the focus of attention shifts from the routines of the dispensary in Keru to state–citizen dynamics during the COVID-19 pandemic in 2020 and 2021. Based on public announcements, readings of plans and policies, and a series of conversations with urban citizens in Bobo-Dioulasso, the second largest city in Burkina Faso, I discuss how local responses to the epidemic and the precautionary measures introduced by the government temporarily affected and changed relationships between citizens and the state. Despite the relatively mild course of the epidemic in the country in terms of registered cases and COVID-related deaths, COVID-19 was talked about as an exceptional disease, as an epidemic like no previous epidemics. I argue here that the exceptionality of COVID-19 compared to previous epidemics was not so much related to its specific risks or symptoms, but rather to the fact that people had never before experienced a government that introduced such severe general restrictions in order to safeguard the health of the population. The otherwise "absent" or distant government had suddenly stepped in and deployed its sovereign authority and biopower to "discipline the population" in order to preempt an uncertain future of COVID-19 in Burkina Faso. In this specific situation, the state responded to the wish that it care for its citizens, although some critique remained.

In the conclusion, I briefly summarize my main arguments with an emphasis on rural citizens' openness to different interpretations and their continuous work with potentialities and hope in a social,

political, and economic context shaped by global inequalities and specific regional and national insecurities. Over time, improvements in public health care services have materialized: a new dispensary was built in Keru (now equipped with electricity), the rapid diagnostic test for malaria became a routine, and after 2016, free health care for children under five was introduced. The number of consultations at public biomedical health facilities has increased over the years, yet rural citizens continue to explore and juggle between different treatment options, including self-treatment at home and consultations with vernacular healing experts. This is not only due to a lack of diagnostic technologies and qualified staff at the public health facilities; citizens are actors with pragmatic and open minds trying to alleviate suffering and manage the ambiguities of sickness through engaged social encounters with different types of experts. The relationship between citizens and the state remains in many ways weak; still, the state is present in people's perceptions, engagements, and hopes for a better future as observed during the COVID-19 pandemic, where many people praised (at least temporarily) the government for deploying statecraft and willingness to care for ordinary people. Lastly, I discuss future perspectives for health care in Burkina Faso and reflect on how this ethnography of the social imaginaries of health care and health care institutions may contribute to a more general discussion of health care systems in the Global South.

## Notes

1. Village names and the names of my interlocutors are all pseudonyms.
2. I call her Caro from this point.
3. The Fragile States Index (formerly known as the Failed States Index), developed by the US think tank Fund for Peace together with the magazine *Foreign Policy*, is published annually. All sovereign states that are members of the United Nations are assessed in terms of their vulnerability to conflict or collapse. Fragile States Index, "Country Dashboard." Retrieved 10 October 2020 from https://fragilestatesindex.org/country-data/.
4. Fragile States Index, "P2: Public Services." Retrieved 13 May 2021 from https://fragilestatesindex.org/indicators/p2/.
5. Recently, the use of *fragile state* as a specific term has been critiqued for simplifying complex situations and underpinning the notion that international interventions are necessary to mitigate the risks they pose. Danish Institute

for International Studies, "Fragile States" policy brief, 9 March 2022. Retrieved 13 July 2023 from https://www.diis.dk/en/research/fragile-states.

6. UNDP, "Burkina Faso," Human Development Report 2020. Retrieved 17 August 2023 from https://hdr.undp.org/data-center/specific-country-data#/countries/BFA
7. In 2019, Burkina Faso ranked 182 out of 189 countries. UNDP, *Human Development Reports*. Retrieved 17 August from https://hdr.undp.org/content/human-development-report-2019
8. Macrotrends. Retrieved 02 October, 2023 from https://www.macrotrends.net/countries/BFA/burkina-faso/population-growth-rate.
9. United Nations, *A Survey on Migration Policies in West Africa*, ch. on Burkina Faso. Retrieved 13 July 2023 from https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/unpd_ws_201509_burkinafaso_migration_fact_sheet.pdf
10. Just as the pilots' vomit, sweat, and fear do not fit into the aircraft brochures (Law 2002: 98).
11. The traditional chieftain system is not part of the official state apparatus, but the chiefs are recognized by the government and play important roles in conflict management at the village level (Cissao 2020).
12. The 1996–1997 project was generously funded by the Danish Bilharziasis Laboratory and was undertaken as part of my PhD in Anthropology at the University of Copenhagen, Denmark. The 2001 study was funded by the Council for Development Research under Danida (RUF journal no. 91092). The 2010 study was funded by the Carlsberg Foundation and included two terms as by-fellow at Churchill College, University of Cambridge, UK (project no. 2009_01_063). The 2012–2017 study was funded by the Ministry of Foreign Affairs of Denmark (Danida project no. 11–014-KU). Chapter 7 is mainly based on a collaborative project entitled Emerging Epidemics: Improving Preparedness in Burkina Faso, funded by the Ministry of Foreign Affairs (Danida project no 17–06-KU). My field trips to Burkina Faso after 2018 were financed by this project. Research permission has been granted by CNRST (Centre National de Recherche Scientifique et Technologique) in Burkina Faso.
13. I agree with Michael Jackson that "there is often a world of difference between these bonds of kinship and friendship in the field, and nominally identical bonds back home. The intimate and incorporative bonds of fictive kinships and friendships that belong to the fieldwork situation are frequently opportunistic and transitory, what they often connote is a deep sense of gratitude that the ethnographer feels toward his host community for having saved his or her sense of dignity in a culturally disorientating and debilitating environment" (1998: 104). While my relationships with Thomas, Beatrice, Jean, and others may have included opportunistic elements, they have not been transitory. Even though traveling to Burkina Faso has been restricted over the last couple of years due to the COVID-19 pandemic and the tense security situation in the country, I continue to stay in contact with family members via WhatsApp.

14. All the research projects involving fieldwork have received the necessary research permissions and ethical clearance.
15. As Jesper Bjarnesen highlights (2013: 24), labor migration represents an important sociocultural process in the lives of the migrants and their families in Burkina Faso: "The move away from home is often inscribed into local cosmologies as a move towards maturity and independence." The word *aventure* (adventure) alludes to the double perspective of a journey full of uncertainties but also with openings and potentials.