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This Year's Theme - *Applying Anthropology: Challenging Perspectives/Creating Alternatives*

While increasingly recognized in the public sphere, the value of anthropology is also sometimes challenged in the political arena. Anthropologists have responded to this critique in different ways. Some note that the discipline enhances critical thinking skills and provides a foundation for many careers. Others note that practitioners of Anthropology can apply its lessons to better understand contemporary issues in areas such as health, heritage and the environment. For some its strength is in its ability to provide a framework for discovering social and environmental justice issues in the past and the present. Some of us see our work as a vehicle to challenge injustices and combat racism and create new alternatives for ourselves and the communities we study. Thinking about the various uses of Anthropology, this year's theme highlights the many ways we can put our discipline into action to understand, and perhaps improve, the social, political and economic intricacies of our world.

For Conference Highlights see page 8 and visit the NEAA conference website
http://www.neaa.org/conference/

In this issue...

MESSAGE FROM THE PRESIDENT

Donald Pollock
SUNY at Buffalo

For more than fifty years the NEAA has served as a regional association in which professional anthropologists, graduate students and undergraduates can meet and interact in a friendly spirit of cooperation and mutual support. My basic goal as the president of the NEAA is to make sure that we can continue to play this role, but doing so is not a simple task. A half-century of changes, in our profession, in the economy, and in technology, challenge us to think creatively about how to take the NEAA into the next 50 years, how to keep it relevant to its members and how to insure its health.

The NEAA emerged at a time when travel was more expensive and less convenient – TSA notwithstanding – and a regional organization allowed anthropologists, professionals, and students, to gather annually in conferences that were more convenient than most of our national association meetings. For students, especially, the NEAA has been an accessible forum in which they can present their work to interested peers and develop their first professional networks, without the often overwhelming experience of being lost in a crowd of several thousand professional anthropologists at national or international conferences.

The world changes, of course, and many of us now find it just as convenient to travel to national conferences as to regional meetings, and not much more expensive. The ease of travel and the expansion of communications prompt us to question the place of regional associations such as the NEAA: what role do we play in a professional world in which we can interact with colleagues internationally via email or other social media, and in which it's easier to fly from New York to San Francisco than it is to get from New York to Bangor? How does a regional organization preserve its most important functions for students and professionals in a discipline that embraces globalization? What exactly in the role of the NEAA in such a world?

I certain don't have any easy answers, but I do know that we need to think about these issues if for no other reason than the fact that membership dues everywhere are rising, and most of us have to calculate more carefully whether the benefits of membership are worth the costs. I'd like to know what NEAA members get out of membership. Are there services, functions or benefits that NEAA could offer to retain current members and attract new members? Should we be satisfied with a small but dedicated core of members? If we wish to serve a wider membership, how do we expand? Any thoughts are welcome, and I look forward to hearing from you. You can always email me at dpollock@buffalo.edu

Have a wonderful holiday season.

Asram: Knowledge, Moral Frameworks, and the Case of Newborn Illnesses in Ghana

Akua Abrah, Tufts University

This research seeks to determine the implications of translating illness as the result of biological abnormalities or as a physical manifestation of spiritual causation. I do this through an analysis of asram, both a classification and a diagnosis of potentially fatal newborn illnesses. The research was conducted in the summers of 2010 and 2011 through interviews, group discussions, and participant observation in the village of Osiem, Eastern Region of Ghana. Local community members communicated asram to me as a "non-hospital" sickness. I examine how the basis of biomedical knowledge reconstructs a person into that which is appropriate to the medical gaze by classifying illness as "naturally occurring". This knowledge is limited to those trained in the biomedical field, and subsequently reduces or excludes the participation of others on the basis of their access, or lack thereof, to this knowledge. I compare biomedical knowledge and practice with an analysis of the concepts of personhood in Akan-speaking communities of Osiem. Here, health and wellbeing are shared responsibilities among every member of society, and call for a different type of participation from the mother in response to asram than that found in biomedical practice. I posit that the biomedical and local basis of knowledge are both grounded in moral frameworks and that there is a spectrum of knowledge among community members and health practitioners in regards to how illness is understood and thus treated. This spectrum of knowledge reveals that asram can be integrated within both the local and biomedical contexts.

Sitting with my Aunt Lucy in her kiosk by the side of Begoro Road in Osiem, Eastern Region of Ghana, she began to tell me the story of how my cousin, Kwaku, fell sick early in his infancy:

> They say it's like a cat and plantain that we've broiled. You know what I mean right? When you put the plantain in the fire, it begins to wrinkle. That's how he was. Very small, and thin. And his cry was like a cat, very weak. We thought he was going to die. Then we took him to a man in *Gydi*, who told us that it was *asram*. He picked some leaves to make medicine, and that's what we gave to him. He got much better, but when it came time for Kwaku's father to go and pay the man, he didn't. When the man saw this, he became angry and took the leaves that he used to make the medicine, and burned them in the fire. The sickness came back again! It wasn't until Paapa and your uncle went to *Gydi* to pay the man did Kwaku get better. It's a terrible illness!

Many of my informants translated *asram* as a "non-hospital" illness affecting newborn infants and caused by bad people, *nipa bonifoɔ,* out of spite and greed. In this paper I examine concepts, practices, and moral frameworks relating to *asram* in the context of both biomedical and local understandings of illness. I argue that the ways in which people talk about illness create social boundaries and hierarchies that shape the mother's role as a participant in knowledge. I show that although biomedical and local understanding may in some contexts be incommensurable, in other contexts the knowledge of health practitioners and that of local mothers concerning *asram* form two ends of a spectrum of knowledge from both the local people and the health practitioners as it pertains to *asram*.

Fieldwork

I conducted this research predominately in the village of Osiem, located in the Fanteakwa District of the Eastern Region of Ghana. This small, rural town serves as the national headquarters of the Saviour Church of Ghana, or *Gydi* in the vernacular tongue spoken by the predominate ethnic group in the village, the Akans. The Saviour Church built the Hawa Memorial Saviour Hospital, hereafter referred to as Hawa, a relatively new health center that facilitated the preliminary part of my research in Summer 2010. Stationed in the Maternity Ward as in intern, I was able to conduct unofficial observations of practitioner-patient relationships. I also interviewed the five nurses, three midwives, and one doctor in charge of the Maternity Ward, as well as the local Chief of Osiem, and the Osiem Assemblyman, whose role was to voice the people's concerns in the community.

Osiem is my mother's hometown, so many of my informants were my very own extended family members. I stayed with my mother's youngest sister, Auntie Ma, who owned a small kiosk across from the Seventh-Day Adventist (SDA) Junior Secondary School. Both this kinship relationship and my ancestral heritage in the community served as a means of integrating me in Osiem, beyond the medical community of the hospital. At the same time, the difficulties of being both a member of the community through kinship and a researcher who had just come from abroad informed how I collected and interpreted my material..

My 2010 fieldwork revealed the existence of a discourse about "ignorance" when the health practitioners talked both to and about women from Osiem who came for natal care. I found that when I spoke with the health practitioners, many would point to the mother's "ignorance" as one of the underlying factors contributing to maternal and infant health problems. According to them, mothers would rather listen to the influences of others at home whose suggestions were sometimes against what the health practitioners had prescribed. After former President John Kufour declared Ghana's maternal mortality rate a national state of emergency in 2008, the National Health Insurance Scheme, or the NHIS, offered free antenatal, delivery, and postnatal care for all pregnant women across the country. In Osiem, there was a general assumption among some health professionals and community leaders that with the increased access established by the NHIS, women would be more likely to use hospital resources. When women did not come for ante-natal care, hospital births, and post-natal care, they were deemed "ignorant".

I returned to Ghana in 2011 with the intent of understanding natal care from the perspectives of community members—especially mothers—in Osiem. It was through daily interactions in this community that I became aware of the local knowledge of *asram.* My 2011 conversations about *asram* were mostly with women. They were more knowledgeable on the matter because they had the greatest responsibility of taking care of the newborn, beyond the financial support provided by the father. As a "non-hospital" illness, the method of treatment that many of my informants prescribed was herbal medicine, *abibidro*. Some strongly asserted that even though the doctors thought that they knew how to treat *asram*, in actuality they really couldn't. To some women, health practitioners were "ignorant" about *asram.* The problem, they said, was that doctors would call it something else, like malnutrition, inferring that health practitioners medicalized *asram* and would thus treat it accordingly. This method, they would say, didn't work. The ineffectiveness of biomedical knowledge, to them, was based on its inability to cure the illness. But the biomedical framework also reduced local moral and social meanings of *asram*.

Biomedical Approaches to Illness

The biomedical approach to knowledge is grounded on principles of the natural sciences through which it has claimed legitimacy (Low 1988:417). It is therefore no surprise that illness in the biomedical model is assumed to be a "natural object": disease (Low 1988:419). According to Arthur Kleinman, this assumption creates the tendency for those within this system to "narrow the assessment of healing to biological and psychological change, and to play down the significance of social and cultural change" (Kleinman 1977:13). Disease as naturally occurring reconstructs a person into that which is appropriate to the medical gaze (Good 1994:73). Although the reconstruction of the person allows the practitioner to work within the capacity provided by the biomedical system, this reduction of illness threatens to transform clinical practice into what Arthur Kleinman calls a "veterinary endeavor" (Kleinman 1977:12).

In the health system, "professionalization", as Steven Feierman argues, has placed the physician in a position such that he is the most authorized to determine a procedure or the course of a treatment (Feierman 1985:114). Medical training, as described by Hahn and Kleinman, is "'paternalistic', in which a logical necessity of medical disturbance is regarded as far more significant than the subjective judgment of the patient" (Hahn and Kleinman 1983:316).

Local Understandings of Illness

For community members in Osiem, however, illness was located within a broader moral framework. After telling me about the various ways that *asram* could manifest itself in the newborn, Auntie Lucy exclaimed that "Some people are very wicked!" By this statement, she connects the illness with the types of people believed to cause it. Although locals didn't know exactly how "wicked people" caused *asram*, many of them mentioned that it was done through some extra-human power. It is *honhom*, they would say, a spirit that gives them this ability. My father, who was a psychiatric nurse in Ghana, and who at a young age assisted his father, an herbalist, in treating cases of *asram*, mentioned that there were people who had *suman boni*, small gods who were very mischievous. These small gods used *sukusare*, powerful dark magic, to bring *asram* upon the newborn. Many of my informants were devout Christians and framed the illness within the context of Christianity, calling it a *bonsam yareɛ*, a "devilish illness". "A true Christian can never do this," they would say. Although *asram* is considered a "wicked", "devilish", and "terrible" illness, there was no such thing as a "good" illness. There were, however, illnesses that the community members did regard as naturally occurring due to their commonality. For example, malaria. The label of *asram* as a "wicked" illness was based on its association with the person thought to cause it. A "good" person, who has compassion for humanity, could never wish to bring illness upon another member of society. Contrary to the biomedical model in which the body is taken out of its social context, and the disease treated on an individual basis, local understandings of illness is social and necessarily moral. This has various implications for how the illness is treated.

The Medical Practitioner's Concept of *Asram*

I remember a conversation that I witnessed during my 2011 fieldwork in the hospital between a doctor and a mother who had brought in her sick two-year old. I wasn't working on this particular day, but decided to go the hospital to speak with Dr. Asiedu, a pediatrician. In his office sat two fourth-year medical students who were interning at Hawa that summer. While thinking about the information that I had gathered thus far from mothers in the community about *asram,* I decided to ask Dr. Asiedu whether he knew of the illness. The following is the conversation that ensued.

Doctor: Of course I do. (He pauses) It is tetanus.
Medical Student A: No, they have another name for that: *asensen.*

(The doctor and the two medical students go back and forth for about a minute deliberating what asram could be, while the mother sits patiently across from them)

Doctor: It is malnutrition.
Medical Student B: No, they call that something else (although he didn't mention what that something else could be)

(The doctor then asks the mother)

Doctor: Mame, do you know what is called *asram?*
Mother: Yes. It is an illness that grips the child, and he becomes very wrinkled. He'll keep losing weight…
Doctor: But that is malnutrition…

Mother: No, that is different. You have to get medicine for this and the child will keep having bowel movements before he is healed of the sickness.

Although the symptoms described by the mother in this case seemed to correlate with what the doctor knew to be malnutrition, the mother, in asserting that it was not, placed *asram* in a context that required treatment beyond that of biomedicine.

In another instance, while speaking with a senior midwife, she explained to me that the indigenous belief concerning *asram* was inaccurate, saying that it could actually be neonatal jaundice that if not treated properly could kill the child. By proper treatment she meant that mothers should bring their sick children to the hospital.

Social Boundaries

In local models of *asram* in Osiem, the mother and her kin play a large role in diagnosing the newborn's illness and finding the treatment. Diagnosing the illness is a shared responsibility, and because *asram* can be any newborn illness, the moral framework created in the local model puts a greater demand on the mother to find a cure. Although in Akan understandings of this illness a "wicked person" may have caused it, the mother is expected to find and administer the proper treatment rather than to seek revenge. "You pray," many women told me. By going to the healer the mother takes charge of her maternal duty in addressing the physical ailment of her newborn. In prayer she addresses the spiritual causation by leaving vengeance to God. In the biomedical model, practitioners expect mothers to bring their sick infants to the hospital, where doctors had the authority to both diagnose and treat the illness. In this context, the mother has limited participation in knowledge and her responsibility is to adhere to the physician's regimen. Biomedicine therefore creates a moral framework constructed around the mother's response to the physician's regimen, which could label her as either a good mother or a bad one.

A Spectrum of Knowledge

These two models of illness are incommensurable in that they cannot be reduced to a common set of rules that "tell us how rational agreements should be reached" (Lambek 1993:396). This does not mean, however, that they cannot be used in treating the same baby. I found that there was a spectrum of knowledge among both the community members and the health practitioners, revealing that *asram* and biomedicine could be integrated within the different contexts

Some people believed that *asram* was caused only through spiritual agency and should be treated using only herbal medicine (*abibidro*). On the other hand, others said that it was strictly biomedical in both cause and cure. Others again had opinions that placed them between these two extremes. Auntie Ma once mentioned that it was OK for a mother to take the sick infant to the hospital because sometimes the child will have headaches, and the hospital had medicine to treat that. The mother should, however, also use the herbal medicine, *abibidro,* because it worked. Several others acknowledged the success that they had with hospital medicine, but still stressed the importance of using *abibidro* simultaneously. Biomedicine's success in addressing their health issues made them more accepting of the hospital's treatment methods. Even if *asram* had spiritual causation, it manifests itself physically. Therefore, it wasn't that the *abibidro* couldn't address the infant's headaches, because it was also meant to treat the physical symptoms of *asram.* Rather, mothers accepted that biomedicine could treat an aspect of *asram*, just not the whole illness. This could only happen if local treatment methods were used. Thus, of the two methods, the *abibidro* was a greater determinant of recovery than biomedicine.

John, one of the medical students who had been in Dr. Asiedu's office in the dialogue I quoted earlier, was a member of the Saviour Church of Ghana, *Gydi,* which built the hospital. He told me that even in *Gydi* people believed in *asram*. John mentioned one of the Out-Patient Department nurses who bathed with certain herbs while she was pregnant as a preventative measure against her newborn getting *asram*, and continued to bathe her child with these herbs after he was born. As a medical student, John has never personally encountered a case of *asram.* Yet, he participated in ideas about the negative spiritual agency of people who cause it, saying "It is not just an ordinary person who does this. They need a power". When speaking about *asram*, he never made an "us" vs. "them" distinction by reducing *asram* to tetanus or malnutrition like other practitioners had.

Other practitioners mentioned that the hospital itself was not entirely free of spiritual influences. As one Maternity Ward nurse said, "Some nurses have bad spirits, and they can give it to the child that they deliver. So you need prayers." This spectrum of knowledge is a continuum of beliefs, a gradient along which people can fall at different points. This continuum of beliefs allows flexibility in rational but also creates social boundaries and hierarchies that determine the role of the mother as a participant in knowledge.

In Osiem, individuals, both health practitioners and local community members, are aware of local understandings of *asram* and apply it in their own ways to address newborn illnesses. Different knowledge bases require different types of participations that are deemed acceptable. This influences how the mother can go about treating her newborn's illness, but as I have mentioned, there is a spectrum of knowledge. Mothers who use both methods are able to cross certain social boundaries where they use the physician's prescribed method of treatment while still maintaining a level of control in treating their newborn's illness.

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Some 2013 Conference Highlights

- **Modest Registration fees, discounted for students** (includes Conference Fee and NEAA membership dues; Presenters must register in advance and be NEAA members)

- **Book exhibit room**

- **Preconference Tour, Thursday, February 28, 2013, 2:00-4:00 PM Smithsonian Museum Support Center Tour**
- Pre-conference behind-the-scenes tour of the facilities at the Smithsonian Museum Support Center in Suitland. The tour will be limited to the first *20 people* to reserve a place. Contact Mike Roller to register before February 10. (mroller@umd.edu)

- **Conference location provides convenient access to historical sites in Prince Georges County, Maryland and Washington, DC.** See the following sites for great ideas of places to visit: http://www.anacostiatrails.org/, http://www.nps.gov/anac/index.htm and http://washington.org/.

Friday, March 1 - Saturday, March 2: Papers, Symposia and Poster Sessions

- **March 1, 2013, 4:00 Cash bar and reception**

- **March 1, 2013, 5:00 First Keynote address from Dorothy Lippert**

Dr. Dorothy Lippert is currently a Case Officer in the Repatriation Office of the National Museum of Natural History at the Smithsonian Institution. In her current position, she responds to repatriation requests from Indian tribes for human remains and sacred material. She is Choctaw, currently serves on the Executive of the World Archaeological Congress and is a past member of the Board of Directors for the Society for American Archaeology. She was recently appointed to the Advisory Council on Historic Preservation.

- **March 2, 2013, 5:00 Banquet at Busboys and Poets.**

- **Keynote address from Erve Chambers, "If It Isn't Real Can It Still Be The Past?"**

Erve recently took his family on a five month road trip around the USA, visiting as many tourism towns and tourist traps as they could fit in. His object was to have fun and experience some of the ways in which ideas of heritage and the past have come to shape contemporary tourism initiatives.

Dr. Erve Chambers is a Professor of the Anthropology Department at the University of Maryland, College Park, where he has taught since 1981. He has conducted field research in Thailand, Mexico, and in several parts of the Unites States. Over the years, Erve's research has evolved from a general interest in regional and urban development to more specific work in tourism and environmental and heritage resource management. He currently has a strong interest in community-based tourism initiatives and in the public delineation, appropriation, and use of heritage resources. Dr. Chambers' current research and theoretical activities focus on issues related to sustainable tourism development.

Session and Paper Abstracts:

Session, paper, and poster abstracts will be accepted via this website through February 1, 2013. Papers should be 20 min long (max). College Park will provide Windows laptops and digital projectors for all sessions. Please make sure your presentation is Windows and Microsoft Powerpoint compatible.

If you wish to submit a paper or poster abstract, please login (or create a new user account) and submit your abstract here.

If you have organized a session, please login (or create a new user account), submit your session abstract here first, and then submit all related papers and discussants here. *Note, if you are invited to be part of an organized session, your session organizer is responsible for submitting your abstract.*

When you are logged in, you can view your submissions by clicking on the "My Submissions" link in the red menu on the left.

Conference Registration

Online conference registration is now open and accepting online payments. If you wish to pay by check or pay at the door, you may still register online and select "pay later." All presenters are required to register in advance (by the Feb. 1 abstract deadline) to secure their position in the program. Other attendees may register at the door. Register now by clicking here.

NEAA conference website http://www.neaa.org/conference/

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YOUR INVITATION TO JOIN THE NEAA!!

TO JOIN THE **NEAA**, visit http://www.neaa.org and click on "membership" or you can SEND this form and your membership dues to:

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