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Narrative Practices in Malagasy Healing

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Abstract

Building on a period of research in central highlands and eastern Madagascar between June and early July 2014, in which interviews were conducted with traditional and allopathic medical practitioners as well as ordinary Malagasy, this paper primarily seeks to rectify gaps in contemporary Western research on narrative medicine. It investigates narrative practices in traditional Malagasy healing, as well as the ways in which narrative is deployed in formal and informal preventative health efforts. In doing so, it seeks to suggest expansions of what constitutes "narrative health." It also problematizes the Western narrative health movement's emphasis on literary theory and analysis, arguing that ethnographic research on traditional medicinal practices may provide valuable yet under recognized insight into the various uses of narrative in maintaining well-being.

Introduction

There are many who believe the U.S. healthcare system is broken. Criticisms are wide-ranging: both practitioners and patients frequently lament doctors' impersonality, hospitals' overpressured case-loads, and treatments' increasing, often technological, complexity (Charon 2004: 826, Parsons & Hooker 2010). However, there are some who seek to ameliorate these deficits by linking medical education and practice with the humanities, particularly literary theory and analysis, philosophy, and ethics. Termed "narrative medicine," the approach seeks to enhance healthcare providers' abilities to recognize and listen to patients' stories of their illnesses, stories which are often understood to be embedded in the wider, more complex contexts of their lives (Koen 2009). Attention to and support for this new approach to care provision have been growing steadily since the 1980s, in part due to its dedication to treating "the whole person, not just their illness" (Charon 2004: 863). Narrative medicine thus demands that the holistic individual, rather than a physiological disease, figure as a key actor in the healing process. As such, it emphasizes patients' overall well-being rather than their simple diagnosis and cure. Here, 'well-being' may be broadly defined as the achievement and maintenance of an individual's physical, mental, and spiritual satisfaction, which may be contingent upon economic, interpersonal, or broader cultural contexts, among others (Sointu 2013).

The burgeoning narrative health movement's emphasis on well-being seems to aptly align with traditional health systems' multi-faceted attention to psychological, physical, and spiritual ills. For example, in his extensive study of African traditional healing techniques, Abayomi Sofowora asserts that diagnostic processes are uniquely "person-centred," as they often involve investigation into a patient's "physical, emotional, and social state" (Sofowora 1993: 32). In addition to curing physical ailments, traditional healers may also be called upon in times of distress or misfortune; their capacities thus often extend to contexts that do not necessarily include physiological illness (Sofowora 1993: 29; F. Randimbivololona, personal

communication, June 20, 2014.). These suggest that traditional healing may revolve around deep involvement with and attunement to the complexities of each individual patient. However, much scholarship on traditional healing focuses on the efficacy of prescribed remedies; the patient-provider interactions that precede such prescriptions may be summarized, yet often escape adequate analysis as significant components of a medicinal process (e.g. Selberg 1995; Sofowora 1993; F. Randimbivololona, personal communication, June 20, 2014).

Furthermore, the development of narrative medicine in the United States seems to be overwhelmingly focused on patient-provider interactions in diagnostic, curative, or palliative efforts (e.g. Charon 2004; Adams 2003; Jones 1993). While these are of course key components of care, preventative health contexts also encapsulate a significant arena of modern health care (F. Randimbivololona, personal communication, June 20, 2014). Preventative health efforts are especially salient as international organizations, NGOs, national governments, and other charitable bodies work to stem the spread of communicable diseases, as well as better conditions in a myriad of disenfranchised and underserved communities worldwide (WHO 2014). In addition to the paucity of research on narrative in traditional medicine, then, much of the current scholarship on narrative health has also overlooked the roles that narrative may play in preventative methods of maintaining well-being.

As such, in this paper I aim to offset these neglected areas of contemporary narrative health scholarship. Drawing from research in both urban central-highland and rural eastern Madagascar during June and early July 2014, I first discuss the diverse and nuanced ways in which narrative practices figure in Madagascar's so-called "traditional" health system. I then explore the ways in which narrative is both formally and informally mobilized in preventative health efforts in the region. In clarification of these two research problems, I hope to suggest expansions of what constitutes "narrative medicine" by illuminating extensive networks of actors, engaged in a wide range of practices, that work to maintain well-being through narrative. Indeed, I hope to also problematize Western narrative health practitioners' emphasis on such fields as literary theory and philosophy in their popularization of narrative health; I argue that anthropological studies of traditional medicinal practice may present valuable yet under-

recognized indications of narrative's utility in healthcare provision.

Methodology

Research sites: The first period of research spanned from June 10 to June 27, 2014 in Antananarivo, the island's capital and largest city with a population nearing 2 million (Mongo 2013). Located in the Analamanga region in Madagascar's central highlands region, Tana boasts a sizeable population of the Merina ethnic group, though the city is also home to a diverse array of immigrants and members of Madagascar's 17 other ethnic groups. However, because of the large percentage of Merina in and around Antananarivo, the vast majority of research informants are of Merina descent, and the information gleaned from them is no doubt reflective of this specific ethnic identity as well as other salient social markers such as gender, class, and age.

A second period of research was carried out between June 28 and July 8, 2014 in Andasibe, Antananarivo. A small town of approximately 12,000 nestled in a valley just adjacent to the Mantadia National Park, Andasibe is a frequent stop for nature-loving tourists and a minor hub along the national railway line that links Antananarivo with Tamatave, an eastern port city (Mongo 2013). Despite these contact points, the town's rural tranquility is in stark contrast to Tana's urban bustle; it was chosen as a research site to provide a well-rounded look at Merina medicinal practices at both population extremes. The population is much more homogenous than Tana; all informants are Merina.

Information Gathering: Research in Tana and Andasibe primarily consisted of interviews with both allopathic and traditional providers. Interview was chosen as the primary means of information-gathering due to the method's flexibility and dynamism: the myriad of ways in which questions may be constructed and presented allow for diverse and wide-ranging data collection, as well as valuable interpersonal connections with informants (N. Quansah, personal communication, June 16, 2014). This method was especially useful as research was

often conducted in a group setting. Furthermore, interviews may aid in minimizing bias, especially with the use of open-ended questions (ibid.); this is no doubt an important element in subjective, ethnographic research in a country and a culture with which many of us were largely unfamiliar. Interviews were often conducted with the group of other students in the MGH program. Through a translator, students posed questions to the informant, whose responses were in turn translated back. However, some interviews were carried out in either English or French, depending on the informants' command of the language.

In addition to interviews, findings were also gleaned from informal interactions with a diverse array of informants throughout both research periods. These conversations occurred in French, Malagasy, and English--often a combination of the three--without a translator. Their contents were usually transcribed later in my field notes, and are reproduced and discussed with permission to do so from those involved. Despite the utility of formal interviews, these spontaneous and unguided interactions have yielded invaluable insights; the progress of this research in indeed indebted to the power of serendipity.

Informants included officials at Malagasy pharmaceutical companies and the ministry of public health; doctors at regional hospitals, *centres de santé de base* (public community health centers), and *dispensaires* (often privately-owned or -funded health centers, often by religious organizations); *reninjazas*, traditional birth attendants, who both work out of their homes or travel to make house calls; *mpitsabo* or *ombiasa*, healers who, because of their impressive powers, are approached to treat a host of ailments; and ordinary Malagasy in both Tana and Andasibe. In order to respect the identities of those involved, pseudonyms have been adopted where appropriate.

Limitations: As with all research projects, certain limitations arose whose impacts on my findings must be acknowledged. First, the necessary use of a translator, while undeniably helpful in many circumstances, also points to the possibility of any number of miscommunications or misunderstandings. I have tried to triangulate and verify information where I felt it was needed, yet the language barrier--especially with those informants who

communicated in Malagasy--presented a significant hurdle.

Furthermore, while I tried to transcribe interviews and conversations as close to the original event as possible, memory is always fallible to some extent. To offset this, recordings were also made where available, but a sizeable portion of research exists now only as transcriptions. As such, my field notes represent my best attempts to faithfully commit speech to text, though are also contingent on these inescapable weaknesses.

Finally, this paper could have benefitted greatly from longer stays in both Antananarivo and Andasibe, and would ideally represent findings from a wider array of informants. Madagascar, despite its size, is incredibly diverse, and healthcare practices no doubt vary between the island's many peoples and regions (B. Rabarijaona, personal communication, June 19, 2014). Due to informants' homogenous ethnicity and their localization in the Analamanga and Aloatra Mangoro regions, my conclusions are only reflective of healthcare practices among these bounded populations; the findings discussed below may in no way be extrapolated to the larger Malagasy population, nor should they be wholly affixed to the too-nebulous "Malagasy traditional medicine," as they consider only a fraction of the methods and techniques involved in this dynamic, intriguing, and multi-faceted healthcare tradition.

Results

The interviews and interactions that constituted this research process yielded a host of information on traditional and preventative medicinal practices among Merina in Antananarivo and Andasibe. I will first outline response that point to traditional practitioners' understandings of health, then move to the ways in which narrative comes into play in these traditional healing situations. I will then outline results relating to preventative health methods, both formal and informal. These results will be further expanded upon in the following Discussion, with particular comparison to the Western allopathic approach to narrative medicine

Well-Being in Traditional Medicine.

All of the interviewed practitioners attended to physical illness as well as attempted to plomb the spiritual, emotional, or situational discomforts often implicated in those illness experiences. For example, all three of the *reninjazas* interviewed in Andasibe reported that they

would treat expectant mothers' both physical and emotional toils. Even a reninjaza specially gifted in massage techniques to ease particularly difficult and physically taxing pregnancies and births--her skills could be called upon to turn breech babies, for example--described how she would listen to and attempt to alleviate expectant mothers' myriad worries and fears. This approach seems to reflect the *reninjazas*' conviction that pregnancy is much more than a physical experience--it could trigger any number of bodily, mental, spiritual, or situations complications--and their determination to tend to all elements of this experience. Healers' acknowledgement of the multi-faceted dimensions of health was reflected in their impressive variety of treatment techniques: two healers in Antananarivo described herbal methods to cure physical ailments, as well as various ritual or behavioral means of treating or alleviating spiritual or situational distresses. It seems clear, then, that the majority of traditional practitioners recognized the various ways in which one could experience "ill health" as well as physical events such as pregnancy, and treated these occurrences with methods geared towards overall well-being, rather than simple diagnosis and cure.

Discussions with traditional healers and *reninjazas* also uncovered high levels of interaction with and commitment to patients in a wide variety of healing and treatment situations. All of the traditional practitioners reported that they had lived in the same area their entire lives and for many, their families had been known and respected in the area for a generation or more. This longstanding community presence thus signals pre-existing personal relationships with those who sought out treatment: in the healing process, personal and professional relationships intertwined. Furthermore, practitioners reported an impressive commitment to their patients. For example, one healer based in Antananarivo cited his greatest challenge as "being free...as [he has] to be there always for the sick" (Healer 1, personal communication, June 13, 2014). This was echoed by a priest at the sacred site Doany Kingory outside the city, and by two *reninjazas* in Andasibe, all of whom expressed their willingness to devote copious amounts of time and energy to those seeking their expertise. For example, while interviews with allopathic providers in Antananarivo and Andasibe revealed that pregnant women usually had a maximum of 3 or 4 pre-natal visits and a 3-day hospital stay during

delivery, the *reninjazas* all attested to allowing any number of pre-natal visits ("However many the woman wants," said one (Healer 4, personal communication, July 1, 2014)) and to caring for the newborn and mother for as long as three months after the birth. These findings suggest that practitioners at both research sites may draw upon stores of knowledge built up over a lifetime in their home community to fuel holistic understandings in interactions with patients, as well as devote significant personal resources to patients in need. Here, then, practitioners' attention to many dimensions of health is supplemented by healers' entrenchment in their home communities and their willingness to expend significant time and energy in treating their patients.

Narrative's Role in Traditional Healing

Healers in Antananarivo reported that patients were frequently given space to tell them about their ills, and to address the many elements contributing to or potentially exacerbating their illness or ailment (Healer 1, personal communication, June 13, 2014; Healer 2, personal communication, June 23, 2014). While *reninjazas* in Andasibe often relied on physical methods such as touch and massage to determine a patient's condition, they also indicated that pregnant women were encouraged to share both physical and emotional complaints. Intriguingly, traditional practitioners also reported methods of obtaining information in interactions with patients when their narratives were not sufficient to determine diagnosis or treatment options. Specifically, all indicated that communication with guiding spirits--often the ancestor that had bestowed their healing gift--could fill in such knowledge gaps and aid in deciding successful cures. One healer used light to keep this guiding spirit near (Healer 1, personal communication, June 13, 2014); another conversed with her grandmother in a type of reverie (Healer 6, personal communication, July 3, 2014); others prayed to both God and the ancestors (Healer 2, personal communication, June 23, 2014; Healer 3, personal communication, June 2013, 2014). As such, it seems that practitioners relied on two types of narrative in the treatment process: the patients', as well as spirits', whose involvement could at once supplement and help to interpret patients' descriptions of their ailments.

Furthermore, narrative practices also seemed to come into play in situations preceding

these patient-provider (-spirit) interactions. Specifically, the majority of practitioners reported instances where a third party had summoned them to attend to someone too ill to travel to the practitioner. Only one healer indicated that he only treated in his home (Healer 3, personal communication, June 23, 2014). For example, one *reninjaza* in Andasibe recounted an episode where, as she was going about daily errands, a woman's husband literally ran into her in the street, where, aware of her skills, he alerted her to his wife's difficulty in ejecting the afterbirth and asked her help. She went with him and prepared a remedy for his wife; the woman survived with no complications and, come the New Year, the couple gave her a "nice, fat goose" (Healer 5, personal communication, July 1, 2014). This story, and the attestations of healers and *reninjazas* in Tana and Andasibe, indicate that such third-party narratives may play a significant role in alerting practitioners of cases, especially severe ones, where patients are unable to make the trip to practitioners' homes, and thus jumpstart the patient-provider interaction.

Here, too, ancestral spirits may play a role in illness experiences preceding patients' journeys to care providers. Specifically, a priest at the sacred site Doany Kingory outside of Antananarivo described how spirits may be especially potent in treating particular ailments or illnesses. For example, at Kingory, Nenyraivo, the spirit of a long-gone *reninjaza*, is known to be particularly receptive to complaints from mothers and their children. The priest serves as a liaison between the patient suffering from a given ailment and the ancestral power specializing in that ailment; but patients' knowledge of which ancestor to enjoin for aid is often due to folk stories ("fairy tales," in the priest's words) about their ancestors (Healer 2, personal communication, June 23, 2014). Though these stories may be intended to primarily pass along knowledge of a person's lineage, their description of ancestors' capabilities also imparts crucial medical information. Thus internalized by the living, these types of stories may shape their approaches to healing when the need arises, helping to determine who, when, and where the sick go to for treatment--and may continue to do so for lifetimes.

Finally, narrative practices also play a part in expanding practitioners' client base. All practitioners reported that their expertise is primarily avowed through word of mouth: as those who have been successfully healed recount their experience to friends and neighbors,

practitioners' renown expands. For example, one *reninjaza* in Andasibe reported that she would travel many kilometers to tend to patients, indicating a client base that extended far beyond the confines of the small town (Healer 4, personal communication, July 1, 2014). Another *reninjaza* was unavailable for interview because she had gone to Tana, a distance of more than 70km, to attend a birth. Another noted that patients had come to her from as far away as the Eastern tip of Madagascar, and estimated that it had taken 9 years for word of her skills to spread so far, mobilized by the networks of those she had healed (Healer 6, personal communication, July 3, 2014). A healer in Tana reported that he often treated those who, though they did not necessarily believe in the powers of the spirits that guided him, still came to him for treatment after hearing of his skill (Healer 1, personal communication, June 13, 2014). Here, then, stories about healers' efficacy also influence who the ill seek out for treatment, even in the face of their skepticism. It seems that narratives about the powers of the living, as well as of the dead, play a significant role in peoples' decisions about treatment, and determine the conditions in which a patient-provider interaction may come to take place.

Narrative in Formal Preventative Health Efforts

The importance of narrative practices has also not escaped notice of officials tasked to regulate and implement national health efforts. For example, Dr. Herlyne Ramihantaniarivo, Director of the Ministry of Health based in Antananarivo, described her efforts to bring about "rural transformation" through her organization, Zahana. Zahana employs a three-pronged approach, encompassing efforts among youth, women, and elderly groups. The projects which Zahana develops and supports are, according to Dr. Ramihantaniarivo, born from in-depth discussions with individual community members: "Development must be based on local needs with proposed solutions created by local people" (H. Ramihantaniarivo, personal communication, June 20, 2014). As such, Zahana's members rely on local narratives to determine what measures should be taken to improve community health; local needs, highlighted by inhabitants' stories of their lives and hardships, are privileged, and monolithic, overarching projects are avoided.

Furthermore, Dr. Ramihantaniarivo indicated that supporting communities' traditional

practices is an integral element of Zahana's approach to health. In particular, Zahana works with elderly populations to maintain "tradition-bearing," encouraging a given community's elders to pass on "talk story, folk stories, dances, and traditional values" (H. Ramihantaniarivo, personal communication, June 20, 2014). This element of Zahana's approach thus seems to include maintaining traditional narrative practices as a crucial component in achieving community overall health. While Zahana also works to support improvements in education, sanitation, and economic opportunities, the implication is, should such narrative practices (and other traditions) falter, community well-being will be profoundly impacted. Here, then, is another indication of the ways in which narrative practices are supported and encouraged by government bodies to work toward a given community's well-being by preventing the dissolution of significant cultural elements.

Narrative in Informal Preventative Health Efforts

Interaction with ordinary Malagasy also illustrated ways in which narrative is employed in preventative health efforts, though on a much smaller and more pedestrian scale than Zahana's. These interactions were often spontaneous, and their preventative function often improvised by the speaker. For example, over the course of my time in Antananarivo, one woman repeatedly told me a harrowing story of her pulmonary embolism: her oxygen levels were dangerously low. Her family, gathered haphazardly at her hospital bedside, were prepared to say their goodbyes. She was ready to meet God. But, *grace à Dieu*, she survived. Her doctor was amazed: she'd been a two-pack-a-day smoker, even while pregnant; her illness had been so severe, her lungs so damaged, that she shouldn't be alive. She told me that story, many times over, in attempts to convince me to stop smoking. In stark contrast to the curt, "You shouldn't smoke," I've heard from several doctors, this narrative was earnest, intensely personal, and purposeful in its personality.

Another interaction tackled a problem even more pedestrian than smoking: outdoor safety. While on a hike in the forests near Andasibe with a Malagasy friend--I wasn't watching where I was going, and almost walked into a spiderweb--he began recounting a story about his small nephew. The boy had been on a similar outdoor excursion, and had been bitten by a

spider. Unable to quickly access the necessary medical care, he had died. To round out this warning, my friend said, "You've got to be careful, especially out in places like this where there isn't always good medicine." Indeed, a doctor interviewed at the town's community health center reported that it could take more than two months to restock medicines and vaccines. This episode powerfully illustrated the ways that narrative in casual, interpersonal interactions may help prevent incidents demanding medical care, especially in areas or situations where access to such care may not even be an option. In sharing this story about his nephew's death, though, my friend also fueled an interaction of particular bonding and understanding.

Discussion

Narrative Medicine Rhetorics in the US

Narrative medicine's emphasis on understanding and empathizing with patients' stories of their illnesses hinges on a specific understanding of the illness experience. In particular, Anne Parsons and Claire Hooker note that the experience of illness extends far beyond physical discomfort (Parsons & Hooker 2010). Indeed, they suggest that ill health may be especially upsetting as it disrupts a conventional conception of time; illness underlines the striking, and previously unthought, contingency of a person's life (ibid.). Arthur Frank expands on this concept as he points out that all stories--including our life stories--are expected to have a "past that leads into a present that sets in place a foreseeable future" (Frank 1995: 55). Illness wrecks these expectations, as the unhealthy present is not what the past was supposed to lead up to, and the future is made deeply uncertain (Frank 1995: 56). As such, proponents of narrative health suggest that illness narratives are a unique means for the sick to work through this existential suffering and make it known to their healthcare provider. In doing so, the patient-provider interaction is reformulated to involve both physical and more nebulous emotional concerns, whose acknowledgement and discussion may more successfully foster patients' sense of comfort, dignity, and autonomy: *they* are being treated, not just their illness.

In addition to this emotional component, patients' narratives may illuminate more subtle dimensions of health and attune providers to the importance of these individualities in the healing process. For example, Rita Charon, director of Columbia University's Program of

Narrative Medicine, recounts an interaction with a middle-aged patient suffering from back pain (Charon 2004). Invited to talk freely about his illness, the patient's narrative illustrated to Charon that despite their physiological roots, his symptoms were made more insurmountable by "his illiteracy, his failures as a breadwinner, his familial losses, and his life in an alien culture" (Charon 2004: 387). Armed with such knowledge, Charon notes that she was better able to evaluate treatment options as well as generate "deep and therapeutically consequential understandings" with her patient (Charon 2004: 387). Illness narratives are thus understood to encapsulate physical, as well as psychological, spiritual, economic, or cultural concerns. As such, providers' care-ful attention to such narratives, honed by injecting consideration of the humanities into biomedical educational models, may ultimately rework the patient-provider interaction into one which fosters the patient's sense of dignity and autonomy: the patient is made to feel that the ways in which their world works, and the ways it has been made frightening and uncertain, are recognized and acknowledged. (Charon 2004; Jones 1993).

Narrative Practices in Traditional Medicine

While narrative medicine in the United States is primarily geared toward fostering deep understandings and therapeutic relationships between patients and providers to rectify longstanding complaints of distant and impersonal practitioners, narrative practices in traditional healing seem to be integrated into wider situational elements that help lead to patient-provider interactions with a high degree of personality and commitment. In particular, traditional practitioners' longstanding entrenchment in close communities helps account for a degree of familiarity with patients that is often not available in the industrialized, impersonal American allopathic system. While U.S. patient-provider interactions frequently unfold in a professional context only, fettered by the confines of a doctor's office or hospital examination room, the traditional healers interviewed for this research all practiced in their homes: their medical practice occurred in the same location as family celebrations and friendly interactions, and their patients were often also friends, family members, or acquaintances. This blurring of professional and personal relationships enables a patient-provider interaction whose familiarity isn't always wholly dependent on a patient's illness narrative. As such, this pre-existing familiarity could supplement patients' narratives to their traditional practitioners in ways that are not always possible in the United States' system.

"Narrative Mediators": Problematizing the Patient-Provider Dichotomy

Furthermore, traditional practitioners may also draw on narrative experiences with guiding ancestral spirits in the course of their interaction with a patient. In these situations, such spirits enter the patient-provider interaction as a necessary third, both supplementing and helping to interpret patients' descriptions of their illness. This intervention of ancestral spirits thus complicates the strict patient-provider interaction posited by American narrative health rhetorics, and by Western biomedicine more generally. It also points to the ways in which allopathic and traditional healing systems may sharply diverge: while American allopathic providers may have to rely upon their years of education and a certain degree of intuition to interpret patients' descriptions, Malagasy traditional healers may employ these spiritual connections to deepen their understandings of both a patient and their illness. However, despite these functional differences, traditional practitioners' reliance on ancestral spirit narratives does suggest preliminarily that the enduring allopathic emphasis on a dichotomized patient-provider relationship is indeed too narrow.

While ancestral spirits are inserted into the patient-provider relationship during the course of diagnosis and treatment, other parties--and their narrative practices--may come into play before such an interaction ever takes place. These individuals could be thought of as "narrative mediators," as their actions are necessary preliminary components of the patient-provider interaction. The friends and family members entrusted with information about a sick individual and tasked with seeking out a practitioner to come attend to them are one example. The story recounted above of the man in the street who flagged down the passing *reninjaza* is a particularly potent illustration of this type of narrative mediation, one that, it should be noted, was only made possible by the *reninjaza*'s renown in her community. Narrative mediators, like this man, are thus tasked with beginning a patient's illness narrative in absentia; it is they who speak when the patient cannot. This role may be fleeting, but is significant in its illumination of the many actors who intercede, facilitate, or, if ineffective, complicate the patient-provider interaction. Furthermore, this type of narrative mediation could be particularly important in areas where treatment centers are few and far between, and transportation and communication complicated by geography, thus necessitating the frequent dispatch of a friend or family member to fetch a practitioner on a patient's behalf.

Though this geographical impetus may not always apply in the industrialized West, there may be certain situations where the patient-provider relationship is also mediated by another. Consider allopathic pediatrics, where parents often act as interlocutors and decision-makers for their small children. In this type of situation, doctors must listen at once to their patients and those patients' guardians, juggling the demands of each. There may also be situations in which the patient is not able to speak for themselves, such as end-of-life care, or care for those in comatose or vegetative states. Here, care providers must tend to the patient and the patients' loved ones; in many cases, it is these family members who alert practitioners to the patient's wishes. Practitioners' capacity to acknowledge and internalize narratives delivered by these intermediaries thus has profound ramifications for quality care. However, recent research points out that a startling number of care providers overlook stipulations such as do-not-resuscitate and power-of-attorney forms (Span 2014). Here, then, is indication that sufficient understanding of the many ways in which the patient-provider relationship may be mediated by concerned third parties is also of profound importance in allopathic contexts. These research findings on narrative mediation in traditional healing are thus significant for their illumination of the many others who may be included in patients' interactions with providers: adequate care provision could perhaps be improved by providers' close attention to these various mediators. It seems clear that both allopathic and traditional practitioners must be ready to encourage, acknowledge, and act on narratives from such third parties.

Narrative Influence on Healthcare Decisions

Furthermore, this research yielded findings on the ways in which potential patients use narratives to inform their healthcare decisions. Storytelling about departed ancestors and their particular healing skills endowed members of younger generations with important information about their lineage, as well as valuable knowledge of which spirits to appeal to for help with certain ailments. And storytelling about certain healers' powers and efficacy expanded these practitioners' client base by convincing would-be patients of their capabilities. These findings illustrate the enduring power of storytelling and word-of-mouth, particularly their influence on approaches to maintaining health and well-being. These conclusions are significant in their illumination of the various ways in which people may make decisions about who they seek out for treatment, where, and when. In grasping the power of narrative--stories about both deceased

ancestors and living healers--in these situations preceding a patient-provider interaction, healthcare researchers may be better equipped to understand how would-be patients make decisions about their health.

Narrative as Preventative Health

The findings surrounding formal preventative health efforts, such as those spearheaded by Dr. Ramihantaniarivo and her organization Zahana, also signal the ways in which traditional forms of storytelling may be configured as components of wider community health. Though they also impact individuals' decisions about seeking out treatments, these types of folk stories--chronicling ancestors and their specific powers--also entail a significant cultural practice. In supporting elderly groups' continued transmission of these kind of stories (as well as other practices such as dance), Zahana recognizes the importance of such cultural elements in ensuring overall community health. At the same, then, Zahana and the public health officials involved in its efforts also support a definition of "community health" that extends far beyond physical and economic well-being, but also encompasses indicators of enduring cultural practice. As such, the organization's efforts represent a formal preventative health initiative that, through its encouragement of traditional narrative practices, reframe these practices as a specific element of health.

Furthermore, Zahana develops its community health projects based on in-depth interactions with local community members. This seems to be an iteration of the patient-provider relation writ large: Zahana, in its attempts to "transform" disenfranchised rural communities, represents a government-level health care provider, while the local inhabitants they seek to help collectively represent patients on the receiving end of this institutional care. As such, the organization's efforts to tailor development projects to local needs, as informed by inhabitants' narratives about their lives and difficulties, indicate the importance of narrative practices in such large-scale community health initiatives. Here, then, is indication that the patient-provider relationship may be extrapolated to such government-citizen interactions, and that narrative should remain a key component of these interactions.

Narrative in Informal Preventative Health

Just as governmental public health initiatives could be thought of large-scale versions of the patient-provider relationship, so too could the types of informal preventative interactions

described above be thought of as intimate and spontaneous iterations of this relationship geared toward maintaining well-being. These may be especially necessary and effective in situations where advice or treatment from a trained medical professional may be impossible, such as was illustrated by my interaction with a Malagasy friend in Andasibe's forests, or unproductive, as represented by my interaction with the past chain-smoker. In both situations, informal narrative between two people accomplished efforts at preventative health, thus indicating that such narrative practices may be significant elements of healthcare contexts that both escape diagnostic or curative contexts, and extend beyond the conventional patient-provider relationship posited by American allopathic rhetorics of narrative health. Though these findings are of course anecdotal and not nearly as extensive as I would have wished, they may still point to the power of narrative in maintaining well-being in such informal settings. They also suggest the ways in which illness narratives fuel bonding and understanding between individuals outside of clearly medical contexts; Charon's "deep and therapeutically consequential understandings" need not be limited to interactions between patient and provider within a doctor's office or hospital examination room. Rather, these types of understandings may also be fostered spontaneously and informally, in ways that illuminate how illness narrative might bring two acquaintances closer together.

Conclusion

In order to re-orient allopathic treatment to patients' overall well-being, training in narrative medicine seeks to develop healthcare practitioners' "narrative competency." Narrative competency involves an amalgam of skills--broadly, those required to "recognize, absorb, interpret, and be moved by the stories one hears or reads" (Charon 2004: 864). These skills, then, could include the ability to tease a plot from a larger storyline; the capacity to recognize a storyline's embeddedness in a wider, perhaps merely hinted-at context (for example, the patient's life story); and the ability to successfully communicate and empathize with the tellers of these illness narratives (Charon 2004; Koen 2009). Training in narrative competency may thus involve encouraging medical students to write about their patients in nontechnical language. Students are also assigned literary texts and expected to complete in-depth analysis of

these texts. Providers are ultimately trained to allow patients to write or speak, uninterrupted, about their illnesses, and to recognize the benefits of this process (ibid.). It is hoped that, endowed with such training, future medical professionals will be better able to understand their own feelings toward and knowledge of their patients, as well as to interpret and make sense of the stories the ill tell them.

However, these research findings indicate that such an emphasis on literary theory and analysis may be misplaced. As discussed above, proponents of narrative medicine in the U.S. place significant emphasis on practitioners' awareness of cultural dimensions; it seems an immense oversight that ethnographic literature on traditional healthcare systems is not currently used to fuel these understandings. It seems that students training in narrative medicine and hoping to practice in the American allopathic system may benefit from exposure to the ways in which alternative and traditional healthcare systems successfully employ narrative practices. Not only would students and practitioners be made aware of the many ways in which well-being is approached in different cultures, but a rapprochement could be fostered between the historically at-odds "modern" and "traditional" healthcare systems. This would no doubt help to counterbalanace the deficits of biomedical epistemologies, and, perhaps more importantly, could alert the West to the enduring value of oral practices and traditions, many of which have been long denigrated in favor of written transmission.

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