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ORIGINAL PAPER

# Of Shifting Economies and Making Ends Meet: The Changing Role of the *Accompagnant* at the Fann Psychiatric Clinic in Dakar, Senegal

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**Abstract** Since 1972, inpatients at the Fann Psychiatric Clinic have been required to have a family member or close friend—an *accompagnant*—stay with them for the duration of their hospitalization. In recent years, however, the role of the *accompagnant* has seen a dramatic transformation. This article considers the emergence of a new kind of *accompagnant* at Fann: the for-hire *accompagnant mercenaire*, who is unrelated to the patient and not employed by the clinic. Against the backdrop of Senegal's neoliberal turn and in light of the growing prominence of the biomedical approach at Fann, the author shows how the idealized *accompagnant* model of family caretaking has given way to this new form of commodified care. At the same time, however, the author argues that *accompagnants mercenaires* regularly draw upon and establish new sets of moral codes, obligations, debts, and expectations in their day-to-day interactions with patients, family members, and staff alike. By way of a careful ethnographic examination of the evolution of the *accompagnant* role at Fann, this article brings into focus a complex and multidimensional picture of the shifting economies—moral and political, as well as therapeutic—within the present-day clinic.

**Keywords** Psychiatry · Care · Moral economy · Therapeutic economy · Neoliberalism

I use pseudonyms throughout the paper to respect the privacy and confidentiality of all of my interlocutors at Fann, including patients, family members, doctors, staff members, and accompagnants.

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## Introduction

Fara was one of the first people I saw each morning as I made my way into the Fann Psychiatric Clinic. I often found him sitting on a bench near the building's entrance, usually with a patient at his side. Sometimes the two were engaged in a heated game of cards, other times they sat listening to Fara's small, hand-held radio. A tall, looming man with huge hands and a kindly face, Fara would shout an enthusiastic greeting, in English, when he saw me, "How do you do?!" or "How do you feel?!" After many weeks of small talk and little exchanges, Fara began telling me a bit about his past. He had worked as a bodyguard for the president of a West African nation during the 1980's, he recounted, until the regime had turned against him. In grave danger, Fara had fled that other country, eventually ending up in Senegal. He made his first visit to Fann in the early 1990's, when he escorted a mentally ill man from Chad to the psychiatric clinic. During his stay as the man's *accompagnant*, Fara showed himself to be as compassionate toward the patients as he was helpful to the staff. After this, he began lending a hand at Fann from time to time, lifting and carrying heavy objects, assisting the patients, and performing odd jobs. Occasionally, he was given a bit of money or small gifts in return.

I admit I was skeptical of Fara's story at first; it was improbable enough to make me question his status at the clinic. Was he himself (or had he once been) a patient at Fann, I wondered? When I first approached the director of the clinic to ask about Fara back in 2002, he confirmed the man's story to be true and added:

> Honestly, I am not sure where [Fara] sleeps or what he does at night after we go home. I do know that he is very kind and very strong, and even the director of the CNHU[1] says that it is good to have somebody like him around here. He does not earn a salary at the clinic, but he does occasionally get a little money from patients' families. He also gets a little money from the administration from time to time. No salary—he does not have a contract. It is more like a bonus or commission.
>
> The nurses are very happy to have him here, too. Sometimes they have trouble with patients, and they can call on Fara to help. And the doctors say, "I need somebody to stay with the patients!" It is better to have a person like Fara than no one. We do not have enough nurses or doctors, not enough personnel. So everyone must find his own way. I see him helping the nurses and doctors, and I think it is good to have him here.

In the past 10 years, Fara has become even more of a fixture at Fann. He has taken one of the storage rooms adjacent to the central courtyard as his own living quarters; it is now known by all as "Fara's room". He carries a *portable* (cell phone) so he can be easily reached by Fann doctors or nurses when they need his assistance. He fills a critical role at the clinic, and I often wondered to myself how things would function there without him.

[1] The CNHU, or *Centre National Hospitalier Universitaire de Fann,* is a large teaching hospital connected to the University of Dakar. It is comprised of a number of specialized medical facilities, including the Fann Psychiatric Clinic (*Service de Psychiatrie–Clinique Moussa Diop*).

Though Fara's story is certainly compelling, many aspects of his situation at Fann are not altogether uncommon. Alongside Fara, there are many other men and women who frequent the clinic in search of odd jobs, errands, or other tasks they might perform for some small compensation. The most remarkable of these informal jobs, and one that Fara himself takes on quite often, is that of *accompagnant mercenaire,* or hired patient attendant. By definition, the *accompagnant mercenaire* is not related to the patient, nor is he an official employee of the clinic. Instead, those employed as *accompagnants mercenaires* at Fann negotiate their payment directly with the patients' families. *Accompagnants mercenaires* have become increasingly common at Fann in recent years; this arrangement represents a dramatic transformation of the *accompagnant* policy that was officially put into place at Fann in 1972. In its original form, the policy required inpatients to have a family member or close friend—an *accompagnant*—stay onsite with them for the duration of their hospitalization with the expectation that this would greatly improve the patient's quality of care and chance of recovery.[2]

In the following pages, I consider the emergence of the *accompagnant mercenaire* at Fann. I begin by providing a few details about the establishment of the clinic before moving on to consider the *accompagnant* policy when it was first instated. From there, I describe the clinic as it exists and operates today, focusing specifically on how the role of the *accompagnant* has changed in the past four decades. Here, I am particularly interested in offering a reading that frames these changes in terms of the shifting economies—moral (Edelman 2005; Griffith 2011; Muehlebach 2012; Prince 2012; Scott 1976; Thompson 1971) and political (Diop 2004; Foley 2008, 2010; Melly 2011) as well as therapeutic (Nguyen 2005; 2010)—within the institution. I argue that as an emerging form of commodified care, the *accompagnant mercenaire* arrangement must be examined against the backdrop of Senegal's neoliberal turn, while also being framed within an understanding of Fann's increasingly biomedical approach to psychiatric care—one that emphasizes pharmaceutical treatment strategies over psychodynamic investigation or therapy.[3] While this article contributes a grounded example to an ever-growing body of literature that describes the impact of neoliberalism on healthcare delivery in sub-Saharan Africa and beyond (e.g., Biehl and Petryna 2013; Farmer et al. 2013; Pfeiffer and Chapman 2010; Rowden 2009), it also aligns itself with recent scholarship that seeks to complicate the assumption that commodified care relations

[2] Though the word *'accompagnant'* may be translated into English as companion, attendant, or escort, I have left the original French word untranslated for the purposes of this paper. According to Gbikpi and Auguin (1978), the term *'accompagnant'* was chosen quite deliberately at Fann as the result of careful discussion and consideration. The word signaled a more active investment in the therapeutics and caretaking of the patient than the word *'accompagnateur,'* which seemed to suggest a less engaged role (1978, p. 7). My decision to keep the original word reflects the intentionality of this choice.

[3] The relationship between neoliberalism and biomedicine (including biomedical psychiatry) has been a variously construed. Along with sharing the basic core concepts of the atomistic and autonomous self, both neoliberalism and biomedicine idealize of individual responsibility, rational choice or action, and productivity. In terms of how one might affect the other, some scholars have highlighted the ways in which neoliberal policies and reforms shape research trajectories, thus fostering and favoring the production of certain kinds of knowledge while limiting others (e.g., Valdiya 2010). Others have argued that the rise of biopsychiatry "help[s] to create the social and cultural milieu favoured by neoliberal policies" (Moncrieff 2008, p. 235) and more pointedly, that biomedicine and its accompanying technologies have been used as a tool of neoliberal expansion (Lock and Nguyen 2010).

are necessarily amoral, mechanistic, cold, or void of "true" care (e.g., Brown 2012; Näre 2011; Glenn 2010; Paerregaard 2012; Stacey 2011). As I relate in the following pages, *accompagnants mercenaires* regularly draw upon and establish new sets of moral codes, obligations, debts, and expectations in their day-to-day interactions at the clinic—with patients, family members, and staff alike. Based on a total of 18 months of ethnographic fieldwork at Fann in 1999 and again from 2001 to 2003, with a follow-up visit made in 2013, this article brings into focus a complex and multidimensional picture of the shifting economies of caretaking at play within the present-day psychiatric clinic.[4]

## The Early Days of the Fann Psychiatric Clinic

The Fann Psychiatric Clinic was established in Dakar in 1956, 4 years before Senegal gained its independence from France. After being run by an interim director for 3 years, a French military doctor by the name of Henri Collomb became the director of the clinic in 1959. Over the next two decades, Collomb and his colleagues at Fann—most of whom were also European—channeled their energy and resources into sociological and anthropological research, clinical practice, and theoretical inquiry. They also trained the first generation of Senegalese psychiatrists. *L'Ecole de Fann,* or the Fann School, as Collomb and his group came to be called, not only positioned itself as a radical departure from colonial psychiatry, it also challenged conventional Western psychiatric models and sought to establish new forms of therapy. Because of this, Fann gained both local fame and international renown during the 1960's and 1970's.

One of the first major changes Collomb made at Fann after becoming director was to "open" the clinic; this he did, according to retired nurse Aissatou, immediately after returning from a visit with a reputable healer in Senegal's Casamance region, where he had seen the freedom of movement that the healer allowed his mentally ill patients. Several years later, a Fann psychiatrist who had worked alongside Collomb wrote that these modifications had been made because conventional psychiatric models simply could not be successful in Senegal; they were just too foreign to what patients were accustomed to in their everyday lives. "The individual [was]…isolated by this structure that was foreign to him. Coming from a collective life, he enter[ed] a world of individual existence. Coming from traditional society, he [was] confronted with a Western way of life" (Bartoli 1968, p. 21). As such, Bartoli explained, hospitalization may itself be a traumatic experience for many of the patients—and thus completely counterproductive to the therapeutic process. In contrast, he described the new "open" model of Fann:

> The clinic is largely open to the exterior, and also on the interior between divisions. Patients go freely throughout the clinic; they come and go as they please. They have constant access to the doctor's offices. Their families almost always have access to

[4] As a sociocultural anthropologist by training, my ethnographic research at Fann has consisted of participant observation (alongside doctors, nurses, social workers, medical students, care providers, patients, and family members), structured and unstructured interviews, and historical/archival research.

> the clinic, as well. There are no longer any 'visiting hours'; some patients' families spend entire days, and sometimes even nights, with them (Bartoli 1968, p. 23).

According to Bartoli, this new model allowed patients to remain connected to their social worlds, which was crucial for the establishment of an effective psychiatric practice in Senegal. Collomb himself agreed, writing that "psychiatric care…must be inspired by the sociocultural conditions specific to each country" (1965, p. 125); and therefore, psychiatry in Africa should be "adapted to the realities of African societies" (1967b, p. 1731; see also Collomb 1975).

The trope—and idealization—of African collective life, which was depicted in sharp contrast to the individualization and atomization of life in the West, would become central to Collomb's project at Fann. "African existence," he wrote in 1967, "is collective; it has not yet submitted to the laws of efficiency and productivity. It is animated by speech, dance and rhythm, and communal meals" (1967, p. 1731). This view resonated strongly with President Senghor's philosophy of Negritude and even earned the Fann Psychiatric Clinic the esteem of that high office. It was, in fact, the basis for all the innovation that took place at Fann during that time. Looking to "traditional" Wolof life for inspiration, Collomb and his colleagues offered communal meals and tea, and organized group activities for patients and staff alike. By the mid-1960's, Collomb and his colleagues had institutionalized weekly *pënc* meetings, or town-hall style gatherings, in each division of the clinic.[5] Likewise, the group came to understand that patients had a better chance of recovery—and were more likely to be reintegrated into their communities after their hospitalization—when they were accompanied by a family member or friend during their hospitalization. Gbikpi and Auguin (1978) recount that the Fann doctors were again inspired by the practices of local healers in this regard: requiring an *accompagnant* to stay with the patient, they explain, "is an old custom utilized by healers. In traditional Senegalese villages like that of Mawa (in Casamance), the patient lives with one or several members of his family" while he is under the healer's care (1978, p. 12).

Dr. Sall, a recently retired psychiatrist who made his career in Mauritania after having been trained at Fann in late 1960's and early 1970's, remembers that the practice of the *accompagnant* began in a very informal way at the clinic, not as a official policy implemented by doctors and thrust upon patients and their families, but rather as springing from the will of patients' families themselves. Especially in the section of the clinic knows as the *Pavillon des Dames* (recently renamed *Division Sud* because in is no longer reserved solely for women), patients' family members often asked permission to—or even insisted upon—staying the night. Collomb and his colleagues encouraged the practice, Dr. Sall told me, and took note of its benefits already before the policy was put into place.

[5] Named after the Wolof word meaning "village meeting or gathering," *pënc* meetings were designed "in the image of the traditional African village" (Dia 1976, p. 373) and served to affirm the ideal of collective African life within the clinic. Though described by many as a unique and distinctly Senegalese addition to the clinical setting, *pënc* were in some ways similar to radical Italian psychiatrist Franco Basaglia's "town meetings," which became a regular part of the psychiatric hospital in Gorizia, Italy at about the same time (Scheper-Hughes and Lovell 1987).

## The *Accompagnant* Policy

The *accompagnant* policy was formalized at Fann in 1972; from that time, patients were required to have a family member or close friend stay with them for the duration of their hospitalization, which at that time tended to be between one and 3 months long. At its inception, the *accompagnant* policy attempted to institutionalize a moral economy of family caretaking and therapy management in the clinic, which it justified by claiming its genesis in "traditional" African ways of life. By moral economy, I wish specifically to reference what Griffith (2009), drawing on the work of Thompson (1971), Scott (1976), and numerous others (e.g., Edelman 2005; Griffith et al. 2007; Striffler 2001) has called the "core idea of propriety", or the "general sense that economic behavior should conform to what is considered proper, just, correct, or fitting" (Griffith 2009, p. 434). Appropriate moral economic behavior, as outlined within the *accompagnant* policy, centered specifically on the moral obligations of kinship. It emphasized the need for an active family presence in the clinic, and demanded the full-time attention of one family member to *the work of care*. This caretaking was, of course, unremunerated; it was a sacrifice the family was expected to make on behalf of the patient.

The two earliest and most comprehensive articles about the *accompagnant* policy (Diop and Dorès 1976; Gbikpi and Auguin 1978) were written by specialists who worked at Fann in the years after its implementation. Diop and Dorès (1976) note that from the policy's inception, female patients were required to have female *accompagnants*; male patients could have either a female or male *accompagnant*. In practice, though, *accompagnants* were usually women, and Diop and Dorès offer several reasons for this. Letting their own culturally informed assumptions about gender, work, kinship, and family life shape their discussion, they assert that female family members were more likely to be available because they were less likely to be working outside the home. Women, they explain, could usually leave their homes in the hands of co-spouses, sisters, or daughters while they were away. In any case, Diop and Dorès tell us, doctors preferred women over men because they were perceived as being cleaner, also, they were more skilled caretakers, they adapted better, and they contributed more readily to the thriving ambiance of the clinic. They were also more willing and better able to perform light domestic duties, such as laundry and cooking (1976, p. 360).

But why require an *accompagnant* at all? First, it was thought that the full-time presence of a family member would keep patients from feeling isolated and estranged; the *accompagnant* would act as a touchstone of sorts. Keeping the patient connected to her social world meant that she would be less likely to experience her stay at Fann as an additional trauma of institutionalization. An interesting point made by Diop and Dorès is that *accompagnants* comprised an important third group in the clinic—a group whom they call "*non-soignants non-fous*"—that were neither caregivers nor patients (1976, p. 360). This was crucially important, as it meant that they brought the attitudes and habits of everyday life into the institution. As Gbikpi and Auguin (1978, p. 8) note, the presence of *accompagnants* helped transform the clinic from a community of patients into one that more closely resembled the world outside. *Accompagnants* spent time not only with the patients, but with each other;

their presence at the clinic created a more relaxed atmosphere. As the *accompagnants* formed relationships amongst themselves, helped one another, told stories, and simply went about their daily tasks, their actions modeled "normal" behavior to the patients and contributed to a sense of community in which the patients could also participate (Diop and Dorès 1976, p. 361).

The *accompagnant* also played a central role in the treatment of her patient. Not only did she bear witness to and support the process of recovery, she also helped the patient accept her hospitalization as well as the course of therapy prescribed by the doctors. Further, the *accompagnant* made sure the patient was eating and sleeping properly and taking her medication as directed; she even administered dosages and helped the patient to bathe, get dressed, clean their room, and use the restroom (Diop and Dorès 1976, p. 360). The *accompagnant* was able to monitor the patient's day-to-day progress and report any problems that might arise. "Things that happen when the staff is not around, especially at night, do not escape [the *accompagnant*]. He can, therefore, intervene to end a dispute, calm an anxious patient, call a nurse or guard" (Diop and Dorès 1976, p. 361). In this sense, the *accompagnant* acted as both an advocate for the patient and an assistant to the staff. And because *accompagnant*s took charge of many of the quotidian responsibilities of the nurses and other staff, the latter were, in theory, better able to devote their time to the more critical problems that arose in the clinic (Gbikpi and Auguin 1978, p. 13).

Another important role played by the *accompagnant* at Fann was that of liaison or link between the clinic and the family. As a translator of sorts, the *accompagnant* was charged with the duty of making sure the rest of the family understood both the terms of the patient's psychiatric diagnosis and also the measures taken to bring about her recovery. The *accompagnant* kept the family involved and aware of the patient's condition; her familiarity with the clinic and the staff helped to demystify both psychiatry and Fann itself. Further, patients' families tended to visit more often when an *accompagnant* was on site (Diop and Dorès 1976; Gbikpi and Auguin 1978).

For the psychodynamically oriented Fann clinic of the 1970's, the constant presence of the *accompagnant* brought with it another important benefit as well. Above all, Fann doctors thought that the careful observation of the patient–*accompagnant* relationship could elicit valuable information about the relational dynamics that existed between patient and family (Diop and Dorès 1976, p. 362). Most notably, in cases where the patient's *accompagnant* was his mother or father, Diop and Dorès write that there was a "strong temptation to privilege the study of early childhood, and in particular, problems of identification" (1976, p. 363). From the doctors' perspective, issues arising during the early psycho-sexual development of the child factored largely in the patient's manifestation of neurosis. Displaying an interesting choice of words given the context of their discussion, Diop and Dorès note that, by way of the *accompagnant*, Fann staff were able to "penetrate" family life ("*Par son intermédiare, il pénètre dans les familles*") (1976, p. 362). Likewise, Gbikpi and Auguin (1978, p. 13) write that the presence of the *accompagnant* allowed the doctors to "penetrate the patient's environment in order to better understand the origins of his illness" ("*Pénétrer l'environnement du malade afin de mieux saisir la genèse de la maladie*"). From this perspective, the presence of the *accompagnant* offered a privileged window into the patient's primary relationships

and thus furnished clues about the very source of the patient's suffering; the *accompagnant* could and should be used as a "therapeutic tool" in and of itself (1978, p. 67).

Although the general consensus among doctors and staff regarding the *accompagnant* policy was favorable from the start, relationships between *accompagnants* and their patients—as well as between *accompagnants* and staff—were not without their problems (Diop and Dorès 1976, p. 361). Gbikpi and Auguin (1978) relate that many unforeseen difficulties had already arisen in the years since the policy had been instated. In cases where the *accompagnant's* relationship with the patient was a central source of conflict (as when the *accompagnant* was the patient's abusive father or mother) or when the *accompagnant* was subjected to the same sources of family conflict as the patient (as siblings often were), for example, treatment was all the more difficult to navigate because doctors and staff had to intervene in these relationships and take great care not to exacerbate existing conflicts. Having these relationships present at the hospital was useful but also dangerous. At the clinic, Gbikpi and Auguin relate, "the *accompagnant* is still too often perceived as a *sane* representative of the family who has come to help the *patient*…get better" (1978, p. 67). In that mental illness likely stems from these troubled relations, they explain, Fann doctors and staff should concentrate their focus on these relationships, and not on the patients themselves, as the site of illness.

Other challenges arose from the new practice as well. *Accompagnants* sometimes experienced difficulties adapting to life in the hospital. In some cases, they became combative or clashed with the staff, making their work all the more difficult (Diop and Dorès 1976, p. 362). Sometimes, the *accompagnants* would just leave. Most notably, Gbikpi and Auguin relate that an unexpectedly high number of *accompagnants* themselves suffered from serious mental disturbances that were revealed during the period of their stay at Fann, and a few even required treatment (1978, p. 56). *Accompagnants* often voiced somatic complaints and suffered from insomnia (Diop and Dorès 1976, p. 362). If not approached with care, Gbikpi and Auguin warned, the practice could result in making manifest a psychiatric condition within the *accompagnant* herself and "sending two ill people (*malades*) back to the family instead of one" (1978, p. 67).

Despite these issues and problems, the *accompagnant* policy became—and continues to be recognized as—one of the trademark innovations of Collomb's Fann. According to Diop and Dorès, there was a substantial difference between the patients who were hospitalized alone and those who were interned alongside an *accompagnant.* For the latter, clinic stays tended to be shorter, relapses occurred with much less frequency, and outpatient check-up appointments were kept much more often (Diop and Dorès 1976, p. 362).

## Today's Fann

In my interviews and informal conversations with many of the doctors, nurses, social workers, and patients who have been affiliated with Fann over the past five decades, I was often told how much the clinic has changed since the 1970's. In

2003, the doctors and support staff working at Fann mostly described the clinic in terms of its problems, lacks, and deficiencies. Serious structural and material inadequacies existed at a number of different levels, they explained. The bathrooms were filthy; toilets barely flushed and overflowed regularly. Patients' rooms often lacked furniture; many patients and their *accompagnants* slept on mats on the floor. At that time, many rooms did not have locks and a few were missing doors altogether. Many patients refused to stay or to keep their belongings in such rooms because they were afraid someone would steal from them if they left. They were also afraid of being harmed by the other patients. The doctors all noted that they struggled constantly to keep up with the day-to-day demands of the place, and sometimes their frustration got the best of them. There were simply not enough doctors and support staff working at Fann to get the job done. Many folks around Fann felt overworked and morale was low. As Dr. Isseu, a psychiatrist who headed one of Fann's four functioning divisions in 2003 intimated at the time, "every person around here is just trying to get by and get through each day."

Between 2003 and 2013, Fann experienced a major shift in personnel. Some doctors and nurses retired, others took more lucrative (or promising) jobs elsewhere. After the Director's retirement in 2012, the doctor who had been working as the head of Division Sud became the new Director of the clinic. Another psychiatrist left Fann to become the Director of a different psychiatric clinic, and two other psychiatrists took jobs with the UN. One of these two, Dr. Mamadou, had been very vocal back in 2002 about how difficult it was to work at Fann. "I am doing the job of three people," Dr. Mamadou had complained to me one afternoon as we sat talking, "and getting paid a fraction of what I would be paid in France or elsewhere!" A similar shift in personnel took place among nurses and social workers, where a wave of retirements and job changes has also led to a flurry of new hires. The new Director of Fann is optimistic about the future of clinic, despite the financial difficulties that continue to face the institution. Fann's unjaded new generation has brought a hopeful energy to the clinic that was not present 10 years ago.

Fann currently has the capacity to take in about 50 inpatients at a time, though many more patients are seen on an outpatient basis. In fact, Fann records show that in 2012, between 300 and 400 outpatient consultations were performed at the clinic each month. Current Fann doctors note that they spend a significant portion of their time each week doing these consultations, and also checking in with patients who were recently released from inpatient care. Additionally, as Fann is a teaching hospital connected with the University of Dakar, the doctors also have their classes to teach and students to monitor. They are expected to publish and attend conferences as well, though they admit that it is difficult to find time to do it all. Many of the medical students and young interns at Fann view their training at the clinic as a means of preparing them to work elsewhere; few express a desire to continue working at Fann over the long term.

## Today's Fann and Senegal's neoliberal turn

An important first step to understanding the many changes that have taken place at Fann since the 1970's is to situate these changes within the context of Senegal's

neoliberal turn. Between 1980 and 2000, in an effort to restructure the national economy, Senegal received 21 structural adjustment loans from the IMF alone (Easterly 2005). These programs spurred numerous social sector reforms that meant significant budget cuts within the domains of both education and health care (Diop 2004; Kelly et al. 1995; Easterly 2005). Fann and the larger *CNHU* were certainly not exempt; according to Dr. Mamadou, these reforms coincided exactly with the start of the clinic's financial hardships in the early 1980's. Moreover, the impact of these reforms—and of subsequent waves of privatization and trade liberalization—had rippling effects on every facet of life in Senegal. Prices of everyday items skyrocketed in 1994, for example, when the currency (FCFA) went through a devaluation of 50 % and controls and subsidies were removed in order to encourage a boom in foreign investment (Diop 2004; Dembele 2005; Kelly et al. 1995). More recently under former President Abdoulaye Wade, the government and its foreign investors prioritized infrastructural development over social service provisions in the march toward modernization, in an effort to attract more foreign investment; this was most visible in the massive road and port construction projects that were undertaken in Dakar during the past decade. Many residents of Dakar, which Melly (2011) has rightfully called a "'structurally adjusted' city," see evidence of the rising prosperity of a select few when they look to the new shopping and entertainment facilities recently constructed along the Corniche. One of the most notable changes that took place in Dakar between 2003 and 2013, in fact, had to do with the ways in which this new wealth, prosperity, and status were put on display, as a matter of distinction, in very close proximity to what others saw to be increasingly desperate living conditions. The wealth of those who have prospered from Senegal's neoliberal turn has come to be upheld by the state as sign of the nation's progress, exhibited as though it were a possibility available to all citizens. For those who struggle to make ends meet, however, such displays affirm the disjuncture between the prosperity of others and the precarity of their own lives. And it is not just in Dakar that people are struggling to get by. Foley (2008, 2010), in her illuminating ethnographic work on Senegal's rural Ganjool region, has drawn connections among the rise of neoliberalism, ecological degradation, newly emerging and precarious migration patterns, increased vulnerability to illness, and new forms of both inequality and structural violence. These issues certainly played a role in the failure of Wade's 2012 reelection bid, which was met with wide-scale protest and opposition throughout Senegal. Macky Sall was sworn in as the nation's fourth president during that same year, and while many are counting on him to ensure a more equitable future for the people of Senegal, others worry that his pedigree, as well as his pro-capitalist, neoliberal stance will likely mean more of the same.[6]

[6] Sall was mentored by former president Wade and played a major role in his government, acting as Prime Minister from 2004–2007 and then directing Wade's successful reelection campaign in 2007. He also stood as President of the Senegalese National Assembly from 2007–2008. In 2009, however, amidst allegations of corruption and foul play on both sides, Sall broke with the Wade's Senegalese Democratic Party (*Parti Démocratique Sénégalais* or PDS) to form his own party, the Alliance for the Republic-Yakaar (*Alliance pour la république-Yakaar* or APR).

By the time of my first visit to Fann in 1999, a flourishing informal economy had already emerged from the gaps created by personnel shortages and material insufficiencies at the clinic. Just as Fann has struggled to stay afloat during the era of structural adjustment, many people outside of the clinic and throughout Senegal have also struggled to get by. In their search for work, many saw an opening—informal and unstable, but work nevertheless—at Fann. It is not an exaggeration to say that doctors, nurses, and social workers depend on this informal support staff to a large degree in order to do their jobs; their presence at Fann fills a critical gap. As Melly (2011, p. 365) notes, Dakar's "so-called informal economy employ[s] a large percentage of the able-bodied workforce…these seemingly 'marginal' activities are, in fact, central to household, urban, and national economies." Fara and others who take part in Fann's informal economy are asked to deliver messages, seek out patients or doctors, run blood samples to the laboratory, pick up prescriptions, take mail to the post office, and watch over patients; for this, they are given a bit of money. From time to time, doctors also ask these workers to run their personal errands. Fann staff are grateful for these unofficial workers, and they feel a degree of indebtedness—even obligation—toward them. They bring Fara and the others food now and then, or give them small gifts when the occasion arises. In turn, these small gifts are a source of pride for the workers who receive them; they are viewed as both tokens of appreciation and a legitimization of their presence within the clinic.

## *Accompagnant mercenaire*s: Ambivalence and acceptance

Perhaps the most visible of jobs performed within the realm of Fann's informal economy is that of *accompagnant mercenaire,* or hired patient attendant. Typically, *accompagnants mercenaires* negotiate the terms of their employment—and also their salary—directly with the patient's family. In 2013, their earnings typically ranged from about 2500 FCFA to 5000 FCFA ($5–$10) per day. The clinic provides no guidelines regarding the hiring of these attendants, nor does it provide a set of standards or best practices regarding patient care. *Accompagnants mercenaires* at Fann receive neither training nor support; the care they offer is *ad hoc*, unsupervised, and highly dependent upon the wills and whims of the *accompagnants mercenaires* themselves. Likewise, these hired attendants receive no job security or protection from the clinic. From a certain perspective, then, the *accompagnant mercenaire* might appear to be local a variant of a neoliberal free agent or rational market actor, a "neoliberal self [that] owns itself as a business" and operates as a "conglomeration of skills and traits that can be brought into alliance with other conglomerations" (Gershon 2011, p. 800; see also Cruikshank 1999; Harvey 2005; and Rose 1990), but who is herself charged with balancing risk and reward.

*Accompagnants mercenaires* were not altogether new to Fann when I first visited the clinic in 1999. In fact, earlier versions had been noted by Gbikpi and Auguin already in 1978, but were framed as both an aberration and an object of criticism. They describe, for example, the case of Abasse, whose *accompagnant* was, in their words, "*le boy de la famille*," a pejorative expression for the family's hired help, who had been sent by the patient's father to perform the role (1978, p. 18). Though

this paid *accompagnant* tells the authors in an interview that he cares deeply about the patient's well-being and thinks of him like a son, Gbikpi and Auguin are doubtful about the man's story and dismissive of his intentions (1978, p. 19). The authors were deeply critical about the dangers and limitations of the paid *accompagnant*—in Abasse's case, they explained that the father's rejection and infantilization of his son, which they saw to be at the very heart of the latter's paranoia, aggression, and megalomania, was reinforced by the fact that the father had hired a babysitter to tend to him during his hospitalization. Gbikpi and Auguin warned that such a practice would only be experienced by the patient as an affirmation of the family's rejection (*le rejet*) and would serve to further alienate him (1978, p. 20). In sum, Gbikpi and Auguin offered a scathing critique of the paid *accompagnant*, stating that the practice ran counter to the true spirit of the policy and often had the effect of exacerbating instead of ameliorating the patient's troubles.

While the *accompagnant mercenaire* phenomenon was viewed as an anomaly and an aberrance by Gbikpi and Auguin in 1978, however, it was already an established fact of hospital life by 1999 and has become all the more normalized since that time. Fann doctors and staff, it should be said, frequently express their disapproval regarding this trend. Without exception, every single doctor and staff member I have spoken with over the years has told me that it is always preferable to have a family member stay with the patient. When they speak about *accompagnants mercenaires* in general terms, doctors and staff are quick to note the many ways in which *accompagnants mercenaires* are inferior to conventional *accompagnants* when it comes to the care of the patient. One current psychiatrist at Fann explained to me that because the *accompagnant mercenaire* is a stranger to the patient, he cannot provide Fann doctors and staff with any insight about what the patient was like before he fell ill, nor can he easily recognize the progress the patient is making over the course of his treatment. Several nurses related that *accompagnants mercenaires* do not show the same degree of commitment to the patient and his recovery as traditional *accompagnants* do. These paid attendants, they tell me, do not assist with treatment or monitor the patient's day-to-day progress with the same level of attention. Another difference, described to me by a young but well-respected intern currently working in the clinic, is that when family members act as *accompagnants,* the informal "psychoeducation" they receive enables them to assist their patients even after they leave the clinic; they can help the patient with the transition back to normal life and monitor his condition in a way that *accompagnants mercenaires* cannot. In short, Fann doctors and staff describe the services performed by *accompagnants mercenaires* in purely custodial terms; at best, *accompagnants mercenaires* assist the patient with her daily tasks, report worrisome behavior to the nurses, and make sure the patient does not wander away from the CNHU compound unattended.

Based on these statements, one might be led to conclude that Fann doctors and staff are fundamentally opposed to—or at the very least, ambivalent toward—the presence of *accompagnants mercenaires* in the clinic. In everyday practice, however, *accompagnants mercenaires* are readily accepted as key players at Fann, now more than ever. As the Fann's previous director explained to me in 2002,

"these families now, they all claim to be too busy to send an *accompagnant*. They come in and say to me, 'We are all working or in school; it is not possible for any of us to stay with the patient as an *accompagnant*, but we are ready to pay someone.'" When a family is at a loss about who it can hire to tend to the patient, the doctors and nurses themselves recommend that the family hire an *accompagnant mercenaire* and even arrange for the parties to meet. Fann staff and *accompagnants mercenaires* know each other well and often work side by side, and when doctors and nurses are asked about specific *accompagnants mercenaires*, they have many kind words to say.

That the *accompagnant mercenaire* arrangement is becoming both more common and more readily accepted at Fann, then, points to the needs and desires that have arisen from the intersecting situations of three parties, all of which relate back to the economic shift that has taken place in Senegal in the past three decades. First, families that have been fortunate enough to secure work—or even prosper—in Senegal's new economy find themselves unable to get away from their jobs to do the work of care that, according to the original *accompagnant* policy, would once have been required of them. They do, however, have money on hand to hire somebody for the job, and they have few reservations about paying for this care. Second, there is an available a pool of unemployed or underemployed workers who would be willing and able to accept the job of *accompagnant mercenaire*, like Fara and the others who make ends meet by doing odd jobs within Fann's informal economy. And third, as I shall discuss in more detail below, Fann doctors and staff now see *accompagnants mercenaires* in a new and different light than they did in the past—not as obstacles to care but as a class of "helpers" that can both assist the patient and reduce their workload within the clinic.

Recalling the previous director's statement that, "it is better to have a person like Fara than no one," there is no doubt that the growing acceptance of the *accompagnant mercenaire* role by Fann doctors and staff represents a practical strategy for getting by despite the material insufficiencies and personnel shortages faced by the clinic. Going deeper, however, the acceptance of *accompagnants mercenaires* also signals a shift in attitudes regarding psychiatric treatment at Fann more generally. Doctors and staff currently affiliated with the clinic are not as psychodynamically oriented as their 1970's predecessors were. Recall that Gbikpi and Auguin warned of the dangers of rejection (*le rejet*) that were compounded when a paid *accompagnant* was enlisted instead of a family member, noting that the presence of a paid *accompagnant* was both a symptom and an affirmation of the problems that brought the patients to Fann in the first place. In contrast, reflecting a more global shift, doctors at the present-day clinic are much more biomedically oriented and thus privilege the medicalization—and pharmaceuticalization—of mental illness over a psychodynamic approach. Currently, there are only two psychotherapists working in the clinic; they see only a small fraction of the patients, and very irregularly at that. Psychiatrists rarely refer patients to the psychotherapists as part of their treatment. According to the current head of one of Fann's four divisions, the demand for psychotherapy at the clinic is not great. Patients expect to receive a prescription (or several) for medication during their stay at Fann, but they are much more reluctant to participate in one-on-one talk therapy sessions, and even

less inclined to want to pay for it. In a 2002 interview with Dr. Malick, a psychiatrist working at Fann during that time, he stressed that Fann doctors must "approach the patient with the tools of modern medicine, for that is what the patient will expect." Doctors, he said, should respect this fact. From his perspective, the "tools of modern medicine" are pharmaceuticals.[7]

The growing acceptance of the *accompagnant mercenaire* role at Fann, then, signals a shift in the clinic's therapeutic orientation as much as it represents a practical strategy for getting by. For the psychodynamically oriented Fann of the 1970's, the presence of the *accompagnant* in the clinic did much more than keep patients connected to their families and ease the workload of the staff. It offered important clues about the relational dynamics that were thought to be at source of the patient's suffering and allowed doctors to not just observe but intervene in these relationships. In contrast, the current doctors and staff at the clinic are much less likely to view family dynamics as a primary source of a patient's suffering. From their perspective, mental illness is not a product of these relationships; rather, as the biomedical model affirms, it is located in the patient himself. It is not that troubled family dynamics and dysfunctional social relationships are seen as unimportant, but rather that they are understood to be secondary problems that will be ameliorated once the patient has been cured. In fact, in the present-day clinic, relational problems between patients and family members are often read as the very *symptoms* of the patient's illness, and the mending of these problems is taken as a sign of recovery. As Fann's current head nurse explained to me, she can tell a patient is responding well to his medication when she sees him getting along better with his family members. From this perspective, the custodial care offered by an *accompagnant mercenaire,* while perhaps less desirable than the care offered by a patient's family member-*accompagnant*, is nevertheless viewed as an passable substitute when there is no other option available.

## New Economies at Fann

I have argued that the growing acceptance of *accompagnants mercenaires* at Fann indicates a turning away from the original *accompagnant* policy, which institutionalized a moral economy of family caretaking and therapy management, while at the same time offering the psychodynamically oriented doctors a window into the very relationships that were thought to be at the source of the patient's illness. As a form of commodified care that has become more common in recent years, the *accompagnant mercenaire* may be read as a symptom of the larger economic changes that have taken place in Senegal (as well as the therapeutic changes that have taken place at Fann) over the past three decades. Understood in this way, *accompagnants mercenaires* appear to be unattached actors involved in simple

[7] The waxing of the biomedical model has been noted in the North America, Europe, and throughout the world (Lakoff 2005, Luhrmann 2000, Petryna, Lakoff and Kleinman 2006). As Fann has embraced a biomedically oriented approach and the clinic has relied more heavily on pharmaceuticals, however, the high cost and short supply of medications has never ceased to present problems for both patients and doctors alike.

market transactions; they are hired to provide custodial services for the term of their employment, and after their contractual obligations have been filled and they have been paid, the relationship between the patient (and family) and the *accompagnant mercenaire* is, in theory, terminated.

In contrast with these assumptions, my ethnographic research at Fann has made visible a much more complex picture of the investment and level of care offered by *accompagnants mercenaires*, as well as the kinds of relationships they cultivate with patients, families, doctors, and staff. Particularly helpful here is Nguyen's (2005) discussion of therapeutic economies and his reminder that "[t]herapy always involves a form of exchange and is embedded within 'regimes of value.' Exchange may be monetary…or it may constitute 'moral economies' as individuals call on networks of obligation and reciprocity" (2005, p. 126). Likewise, exchange may be multivalent, comprised of many coexisting (and sometimes competing) regimes of value at once, as is the case within current therapeutic economy at Fann. It would be incorrect, then, to say that a purely moral economy of family caretaking has been supplanted by purely amoral set of market transactions via the *accompagnant mercenaire* at Fann. As Griffith's (2009) insightful work on the moral economy of tobacco farming in North Carolina illustrates, all economies—even those of the advanced capitalist or neoliberal ilk—have their moral dimensions. In his view, the dichotomy often made between moral and political economies is a false one that may serve to obscure more than it clarifies. Even more recently, Andrea Muehlebach's evocative look at the rise of voluntarism in northern Italy has shown that neoliberalism's stronghold may actually *depend upon* the production of a specific and "highly moralized kind of citizenship" (2012, p. 6).

The present-day Fann should not be imagined as a space devoid of moral economic behavior ruled solely by impersonal market forces. In their daily interactions with patients, families, and staff members alike, *accompagnants mercenaires* create new webs of social relations that are often maintained long after the patients are released. Further, the unpaid (and yet critical) assistance they offer to Fann staff takes the form of a gift that binds the *accompagnant mercenaire* and the staff together in a relationship of debt and reciprocal exchange. I turn now to consider Coumba's story in order to illustrate these points.

Coumba came to Fann looking for work as an *accompagnant mercenaire* in 2009. Her sister had fallen ill in 2005 (due to stress caused by her husband and his family, Coumba told me), and Coumba had been her *accompagnant*, so she would had plenty of experience. She found the work with her sister hard but very interesting; she came to learn a lot about mental illness, and she felt good about the role she played in her sister's recovery. She got along very well with the nurses and doctors, and she remembers them telling her that she showed a certain knack for dealing with the patients. After explaining all of this to the Director, Coumba was put in contact with her first patient and has been working at Fann ever since. Coumba is in her mid-thirties and divorced; her four children are currently living with her mother in a town outside of Dakar. This is a good arrangement, she told me, because she must sleep at the clinic most nights. She takes trips to visit them as often as she can.

"The work is very difficult," Coumba confided, "but I am good with the patients. I understand them; I know how to talk to them and how to calm them." Most

patients accept her quickly and easily, but others take time, she explained. Coumba told me many stories about bodily injury caused to her by patients: she has been pushed, hit, and bitten numerous times. One morning she showed me deep teeth marks on her forearm left by a woman who had been brought to Fann the night before. But, Coumba told me, she has patience and she is good at winning patients over. In many of our conversations together, Coumba described what she saw to be the three qualities that made her an excellent caretaker: her ability to endure, her loving patience and kindness, and her empathetic understanding of what patients themselves are going through.

Coumba has formed long-lasting relationships with many of her patients, and their families as well, though she admitted that some families "have treated her more like a servant than an *accompagnant*." Mostly, though, she gets along very well with families, and when they visit the clinic, they often bring her food or small gifts. Indeed, in these cases, the families see the care offered by Coumba as greatly exceeding their expectations; Coumba's caretaking overflows the boundaries of obligation that are drawn into the caretaking arrangement, and the families feel a deep gratitude for her commitment. Here is a sign, perhaps, that the *accompagnant mercenaire* relationship is not fully commodified or unattached, but that it involves building moral and affective relationships. Coumba goes to visit many of her past patients regularly, just to say hello and catch up. "After all, we get to know each other well during all the time we spend together here!" She has even, on several occasions, taken patients to visit her children and mother for the weekend.

Coumba is skilled at keeping track of which medications her patients take and when, and she is a great help to the nurses in this capacity. One Sunday morning, while I sat in Division Sud with Coumba, a few patients, and another *accompagnant mercenaire* named Mbaye, a nurse came in to dole out patients' medications. On weekends and evenings, there are only two nurses and one doctor on duty to serve the entire clinic, so this particular nurse, normally stationed in another division, was not familiar with this particular group of patients. I watched as Coumba and Mbaye took on the work of sorting through the medications, matching them with patients, pouring the proper quantities and cutting pills when needed, not just for their own patients, but for all the patients in the Division. I also watched as they got cups of water ready, brought the patients in one by one, and got them take their medication.

Coumba's assistance is also crucial to—and acknowledged by—Fann doctors, even the Director of the clinic. She told me the story of a young man named Modou, who was brought into Fann last year. His mother stayed on as his *accompagnant*, but Modou acted very aggressively toward her–he hit her, he insulted her, and he would not even let her into his room. After 3 days, the situation had only gotten worse. Dr. Ly, the head psychiatrist of the Division Sud, told the mother to go home and asked Coumba to take her place. When Modou's mother came back several days later, Modou greeted her warmly and, happy to see her, invited her into his room. The mother just did not understand mental illness, Coumba explained. But she does.

Dr. Ly gives her a bit of money from time to time, for getting the patients their breakfast (usually coffee or tea and bread with butter), and helping out in general. Sometimes, when she is on her way to visit her family, Coumba told me, Dr. Ly or

the head Division nurse will slip her 10,000 FCFA ($20) or small gifts to take to them. This is a nice gesture, she said. It makes her feel like her work there is important. When she gets back after a weekend away, the staff all tell her that they missed her, and that the clinic just does not run as smoothly without her. Although Coumba did not say as much, it is worth noting that 10,000 FCFA ($20) is twice or even four times what patients' families usually pay her for a full day of work. As such, these spontaneous payments are more than just a symbolic token of appreciation; they actually represent a significant amount of money and ultimately help Coumba make ends meet.

One morning as I sat talking to Coumba, her cell phone rang. It was the Director of the clinic himself, telling her that a new patient would be arriving at the clinic within the hour—a French woman, employed at the embassy, who had fallen ill. Coumba had been planning to leave later that morning for a weekend trip to see her children. As she hung up the phone, she shrugged. The Director needed her, she said. She would have to wait for the following weekend to make the trip.

In action, Coumba's work is that of a heath care professional, though her work is not officially recognized as such. Because she has worked with numerous patients and knows the clinic so well, she is capable of performing tasks (like doling out medications) that family member—*accompagnants* are not. At the same time, by force of living with and caring for the patients over a period of several weeks, the relationships she forges with them are deeply personal, even intimate. Oftentimes, *accompagnants mercenaires* bridge or blur this very distinction between professional and personal/familial. As Fann's current head nurse explained to me, Coumba works hard to "*tisser les relations*" (literally: weave relationships) with her patients, to earn their trust, to become familiar with their habits and behavior, and to encourage them along the path of recovery. Certainly, *accompagnants mercenaires* like Coumba do not remain entirely detached or unaffected by these relationships; though they are hired caretakers, they are involved with the intimate, quotidian processes of illness and recovery; they do *take care* in a very powerful way (Mol et al. 2010). On this point, my ethnographic observations find much in common with recent writings that touch upon the oftentimes intimate relations that are forged and negotiated within the domain of paid domestic care (e.g., Brown 2012; Näre 2011; Glenn 2010; Paerregaard 2012; Stacey 2011). One key factor that sets the *accompagnant mercenaire* model apart from these other examples is that it exists as a form of paid caretaking not within the domestic sphere, but within the psychiatric clinic itself, alongside and yet distinct from and subordinate to other forms of institutionalized (paid) care.

## Conclusion

Central to my argument is that there has been a significant shift in what constitutes appropriate moral-economic behavior when it comes to patient care at Fann. Whereas the original *accompagnant* policy invoked the moral obligations of kinship to promote its specific form of family caretaking, the growing acceptance of *accompagnants mercenaires* signals the emergence of new regimes of value,

exchange, and meaning within the clinic. Within this new configuration, the core idea of propriety is not at all centered on the family's obligation to take part in the work of caring for the patient. Instead, it has been supplanted by a different core idea of propriety—one that stresses the right and also the duty to work and earn an income, which by extension may enable one to provide for one's family. For the families who hire an *accompagnant mercenaire*, the core idea of propriety has shifted from a "caring for" (direct caretaking) to a "providing for" (earning money that will allow family members to be taken care of by others). It is now "right" to pay somebody to do this work of care, and families may justify their absence from the clinic without a second thought.

From the perspective of Coumba and the other paid *accompagnants*, the core idea of propriety at the heart of Fann's new moral economy also revolves around their desire and even right to work, to make ends meet, and to provide for their families. However, while Coumba's paid caretaking at Fann allows her to "provide for" her children, it also keeps her from being able to "care for" them on a daily basis, which, she says, is difficult. For the *accompagnants mercenaires*, there is an added dimension to this core idea of propriety within this new configuration of care as well: these paid caretakers see it as their rightful claim that they should be treated fairly, by Fann staff and patients' families alike, and recognized as skilled therapy managers.

What has emerged with the *accompagnant mercenaire* at Fann is not just a new arrangement that meets the intersecting needs of three different parties—the doctors and staff, who insist that the patient have an *accompagnant* of some sort (and who benefit greatly from the additional help offered by *accompagnants mercenaires*); the families, who cannot send an *accompagnant* but are ready to pay somebody to do the job; and the *accompagnants mercenaires*, who are themselves trying to eke out a living in difficult times—but a commodified caretaking relationship that is nevertheless heavy with intimacy and expectation, obligation and indebtedness. As a role that blurs the professional and the personal/familial but may alternately be accepted or denied as one or the other, the status of the *accompagnant mercenaire* is itself constantly shifting. The ambiguous status of the *accompagnant mercenaires* is made apparent by the fact that *accompagnants mercenaires* like Coumba receive both money and gifts, at different times, from patients' families and Fann staff alike. By way of the patients' families, the gifts given to Coumba alongside her (usually meager) salary communicate that she is more than the patient's hired custodian, but is also a caretaker and even a friend, an acknowledged part of the families' web of social relations. In this way, Coumba's work is given value beyond the payment she receives. Likewise, in the absence of the formal recognition of a contract with the hospital (and the status, stability, and full-time salary that go with it), the occasional money given to Coumba by Fann doctors and nurses legitimizes her work as being worthy of payment, while the gifts are an expression of the gratitude they feel for the work she does. Ultimately, however, these gifts do little to fix the ambiguous status of the *accompagnants mercenaires* within the clinic; they may actually reinforce and perpetuate the structural inequalities and exclusions that keep Coumba and the others from being recognized as official clinic employees in the first place. Despite the precarious work arrangements that *accompagnants mercenaires* must

navigate, however, and despite the fact that their work is a form of commodified care, *accompagnants mercenaires* like Fara and Coumba provide more than mere custodial services to the patients in their charge; they cultivate and "weave" relationships with patients, families, doctors, and staff that exceed their contractual obligations, and that cannot be reduced to a simple market transaction.

I have insisted in these pages that the shifting economies at work within the Fann Clinic have not ushered the end of care or of sociality, but have instead opened a space in which new forms—sometimes fraught, oftentimes precarious—of both care and sociality have emerged. Against the backdrop of Senegal's neoliberal turn and the clinic's increasingly biomedical approach to psychiatry, the changes that have occurred at Fann in recent years can certainly be read as symptoms or side-effects of these larger transformations. Beyond this reading, however, I would suggest that these changes not only index but provide a more nuanced understanding of the larger social and economic transformations that have taken place in Senegal in recent years, specifically by demonstrating how these broader transformations are experienced by actors on the ground. Looking closely at the emerging role of the *accompagnant mercenaire* at Fann, then, not only offers us a glimpse of the large-scale transformations taking place at Fann and in Senegal more broadly. It also demonstrates how real people both assess and negotiate what it means to be a moral actor as they attempt to make ends meet amidst these shifting conditions.

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## References

Bartoli, Daniel
1968 Aménagement de l'Environnement des Malades Mentaux à Dakar. Etudes Médicales: 18–25.
Biehl, João, and Adriana Petryna, eds.
2013 When People Come First: Critical Studies in Global Health. Princeton: Princeton University Press.
Brown, Tamara Mose
2012 Who's the Boss? The Political Economy of Unpaid Care Work and Food Sharing in Brooklyn, USA. Feminist Economics 18(3): 1–24.
Collomb, Henri
1965 Assistance Psychiatrique en Afrique (Expérience Sénégalaise). Psychopathologie Africaine 1(1): 11–84.
Collomb, Henri
1967 Methodological Problems in Cross-Cultural Research. International Journal of Psychiatry 3: 17–19.
Collomb, Henri
1967b Les Problèmes Psychiatriques en Afrique Noire. La Gazette Médicale de France 3(3):1723–1732.
Collomb, Henri
1975 Histoire de la Psychiatrie en Afrique Noire Francophone. African Journal of Psychiatry 2: 87–115.

Cruikshank, Barbara
1999 The Will to Empower. Ithaca: Cornell University Press.
Dembele, Demba Moussa
2005 The International Monetary Fund and World Bank in Africa: A "Disastrous" Record. International Journal of Health Services 35(2): 389–398.
Dia, Alhousseynou
1976 Une Communauté Thérapeutique: Le Pinth de Fann. African Journal of Psychiatry 2(1): 147–151.
Diop, Momar-Coumba
2004 Gouverner le Sénégal: Entre Ajustement Structurel et Développement Durable. Paris: Karthala.
Diop, Babacar, and Maurice Dores
1976 L'Admission d'un Accompagnant du Malade à l'Hôpital Psychiatrique. Perspectives Psychiatriques 59(5): 359–368.
Easterly, William
2005 What did Structural Adjustment Adjust?: The Association of Policies and Growth with Repeated IMF and World Bank Adjustment Loans. Journal of Development Economics 76(1): 1–22.
Edelman, Marc
2005 Bringing the Moral Economy back in … to the Study of 21st-Century Transnational Peasant Movements. American Anthropologist 107(3): 331–345.
Farmer, Paul, Arthur Kleinman, Jim Kim, and Matthew Basilico, eds.
2013 Reimagining Global Health: An Introduction. Berkeley: University of California Press.
Foley, Ellen
2008 Neoliberal Reform And Health Dilemmas: Illness, Social Hierarchy, and Therapeutic Decision-Making in Senegal. Medical Anthropology Quarterly 22(3): 257–273.
2010 Your Pocket is What Cures You: The Politics of Health in Senegal. New Brunswick: Rutgers University Press.
Gbikpi, Paul, and Roselyne Auguin
1978 Evaluation ́dune Pratique Institutionnelle à Fann, ÍAdmission ́dun Accompagnant du Malade à ÍHôpital. Psychopathologie Africaine 14(1): 5–68.
Glenn, Evelyn N.
2010 Forced to Care: Coercion and Caregiving in America. Cambridge, MA: Harvard University Press.
Griffith, David
2009 The Moral Economy of Tobacco. American Anthropologist 111(4): 432–442.
Griffith, David, Manuel Valdéz Pizzini, and Carlos Garcia Quijano
2007 Entangled Communities: Socioeconomic Profiles of Fishers in Puerto Rico. Miami: NOAA Southeast Fisheries Science Center.
Harvey, David
2005 A Brief History of Neoliberalism. Oxford: Oxford University Press.
Kelly, Valerie, Thomas Reardon, Bocar Diagana, and Amadou Abdoulaye Fall
1995 Impacts of Devaluation on Senegalese Households: Policy Implications. Food Policy 20(4): 299–313.
Lakoff, Andrew
2005 Pharmaceutical Reason: Knowledge and Value in Global Psychiatry. Cambridge: Cambridge University Press.
Lock, Margaret, and Vinh-Kim Nguyen
2010 An Anthropology of Biomedicine. Oxford: Wiley-Blackwell.
Luhrmann, Tanya M.
2000 Of Two Minds: The Growing Disorder in American Psychiatry. New York: Vintage Books.
Melly, Caroline M.
2011 Titanic Tales of Missing Men: Reconfigurations of National Identity and Gendered Presence in Dakar. Senegal. American Ethnologist 38(2): 361–376.
Mol, Annemarie, Ingunn Moser, and Jeanette Pols, eds.
2010 Care in Practice: On Tinkering in Clinics, Homes and Farms. Bielefeld: Verlag.
Moncrieff, Joanna
2008 Neoliberalism and Biopsychiatry: A Marriage of Convenience. *In* Liberatory Psychiatry:

Philosophy, Politics and Mental Health. Carl I. Cohen and Sami Timimi, eds., pp. 235–255. Cambridge: Cambridge University Press.

Muehlebach, Andrea

2012 The Moral Neoliberal: Welfare and Citizenship in Italy. Chicago: University of Chicago Press.

Näre, Lena

2011 The Moral Economy of Domestic and Care Labour: Migrant Workers in Naples. Italy. Sociology 45(3): 396–412.

Nguyen, Vinh-Kim

2005 Antiretroviral Globalism, Biopolitics, and Therapeutic Citizenship. *In* Global Assemblages: Technology, Politics and Ethics as Anthropological Problems. Aihwa Ong and Stephen Collier, eds., pp. 124–144. Malden: Blackwell.

2010 The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS. Durham: Duke University Press.

Paerregaard, Karsten

2012 Commodifying Intimacy: Women, Work, and Care in Peruvian Migration. The Journal of Latin American and Caribbean Anthropology 17(3): 493–511.

Petryna, Adriana, Andrew Lakoff, and Arthur Kleinman, eds.

2006 Global Pharmaceuticals: Ethics, Markets, Practices. Durham: Duke University Press.

Pfeiffer, James, and Rachel Chapman

2010 Anthropological Perspectives on Structural Adjustment and Public Health. Annual Review of Anthropology 39: 149–165.

Prince, Ruth

2012 HIV and the Moral Economy of Survival in an East African City. Medical Anthropology Quarterly 26(4): 534–556.

Rose, Nikolas

1990 Governing the Soul: The Shaping of the Private Self. London: Routledge.

Rowden, Rick

2009 The Deadly Ideas of Neoliberalism: How the IMF has Undermined Public Health and the Fight Against AIDS. London: Zed Books.

Scheper-Hughes, Nancy, and Anne Lovell, eds.

1987 Psychiatry Inside Out: Selected Writings of Franco Basaglia. New York: Columbia University Press.

Scott, James C.

1976 The Moral Economy of the Peasant: Rebellion and Subsistence in Southeast Asia. New Haven: Yale University Press.

Stacey, Clare L.

2011 The Caring Self: The Work Experiences of Home Care Aides. Ithaca: Cornell University Press.

Striffler, Steve

2001 In the Shadow of State and Capital. Durham: Duke University Press.

Thompson, E.P.

1971 The Moral Economy of the English Crowd in the 18th Century. Past and Present 50: 76–136.

Valdiya, Shailaja

2010 Neoliberal Reform and Biomedical Research in India: Globalization, Industrial Change, and Science. Ph.D. dissertation, Science and Technology Studies Department, Rensselaer Polytechnic Institute.