

# A Foot in Each Camp

**Health Surveillance Assistants  
as mediators in the social interface of child health  
in Malawi**



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All photos used in this thesis are taken by the author.  
The front-page photo is of a child being weight at an outreach under5 clinic.  
Names of people and places discussed in this thesis are fictional.

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# List of Acronyms

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AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
BCG	Bacillus Calmette-Guerin
CHAM	Christian Health Association of Malawi
DPT	Diphtheria-Tetanus-Pertussis
EHP	Essential Health Package
EPI	the Expanded Program on Immunisation
HSA	Health Surveillance Assistant
HCAC	Health Centre Advisory Committee
GAVI	the Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GVH	Group Village Head
HCAC	Health Centre Advisory Committee
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
MA	Medical Assistant
MDGs	Millennium Development Goals
MGDS	Malawi Growth and Development Strategy
MMR	Measles, Mumps and Rubella
MSF	Medicines San Frontier
PMTCT	Prevention of Mother To Child Transmission

PPP	Purchasing Power Parity
REACH Trust	Research for Equity And Community Health Trust.
STD	Sexually Transmitted Disease
TA	Traditional Authority
TBA	Traditional Birth Attendance
UN	United Nations
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
VH	Village Head
VHC	Village Health Committe
WHO	World Health Organization

# Prologue

## The Measles Campaign

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*“So tell him not to fuck with me. I’m being nice!”*

*“Yes, she is scary!”*

*“She is so harsh and she could get him fired!”*

*“Do you think we’re stupid just because we’re black?”*

I am in the Médecins Sans Frontières (MSF)<sup>1</sup> car with Jenny, a northern European nurse in her 20s supervising the measles campaign conducted in an area in southern Malawi. She sits in the front next to the Malawian driver. We drive on a dusty, red road in rural Malawi passing newly harvested maize fields, green hilltops and small clusters of houses made of bricks and grass roofs. Jenny is wearing beige field trousers and a white t-shirt with the MSF logo on. Her hair is greasy and she has dark circles under her eyes partly hidden by her sun shades. She tells me that she has barely slept since this campaign begun three days earlier, and she has literally no time for food or toilet breaks. There has been no time for a proper shower for days now. She is tired and stressed. I ask her about the biggest challenges so far in this emergency measles campaign. She tells me that her biggest concern is the cooler boxes and the neglect of keeping the lid on. This will ruin the cold chain and destroy the measles vaccines<sup>2</sup>. She tells me that she relocates responsibilities when she spots a local Health Surveillance Assistant (HSA)<sup>3</sup> unfit to give injections. Some have bad techniques, she says. Also, she finds it problematic that the HSA-Teamleader is afraid of giving his people instructions. Normally, she says, when MSF assists a vaccination campaigns like this they train one team to be used

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<sup>1</sup> MSF is French for Doctors Without Borders; an independent medical humanitarian organisation.

<sup>2</sup> The measles vaccine need to be kept cold as it is a live vaccine and will die at a certain degree and become useless.

<sup>3</sup> An HSA is a lay health worker responsible for different tasks, among them the vaccination activities in rural areas. HSAs will be thoroughly presented throughout the thesis.

throughout the whole campaign. Now they have to train new teams every week which means having the same beginners' problem at every location. It is the Malawi Ministry of Health who insisted on using the HSAs already working at the different sites in the different districts, she says.

We arrive at a new vaccination site at noon. We stop by a little brick church close to a primary school which is used as the campaign location. Jenny jumps out of the car and hurry over to the church. She passes two women standing outside the church on her way. They are volunteers<sup>4</sup> in charge of organising the line of children and mothers. No children or mothers are waiting in the line at the present. Jenny neglects to see the two male HSAs running towards the church from the Village Head's house next door. They have eaten lunch together, though HSAs were instructed by the MSF to take individual breaks when eating lunch in order to be more efficient. I am greeting the two volunteers when one of the running HSAs grabs my hand when he passes me and says "*Welcome my dear*" as we run into the church together. I laugh and ask him if he is afraid of Jenny, and he replies, "*Yes she is very scary!*" Inside, Jenny is talking to Mr. Mwula, the Teamleader. There are no children or caretakers inside either, only a handful of HSAs and volunteers waiting for patients. Jenny and Mr. Mwula are discussing why so few mothers with respective children have turned up. Mr. Mwula is convinced the administrative target numbers for the location is too high. He is angry and disappointed that no one has consulted the HSAs who are the ones who know the area<sup>5</sup>. Jenny says the MSF is operating according to administrative numbers provided by the Ministry of Health (census data). She agrees, however, that the numbers could be wrong.

We drive back to the site where we started off; at a big, nice Catholic church with a high ceiling and colourful stain-glassed windows. A line of school children are waiting outside the church. (See Photo 1) Inside, the vaccine equipment is located on top of the altar in front of a wall-painting of Jesus and the Virgin Mary (See Photo 2). One HSA is standing behind the altar preparing in advance syringes with anti-measles vaccines. The vaccination session here is running smoothly, and about a thousand children are receiving the measles vaccine today. There is a steady stream of children coming down the aisle, some with scared faces, getting seated at the wooden bench awaiting the injection. Jenny stands next to the HSA behind the altar and becomes aware of his syringes. She loudly tells him that there is a big air bubble in the syringe he just prepared which makes the syringe not full enough. She takes a look at other syringes already prepared and she finds several with air bubbles in them. Many of them thus

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<sup>4</sup> The volunteers are, in this context, community members from the Village Health Committees who accepted to help during the measles campaign for a small fee.

<sup>5</sup> HSAs are responsible for head counting in the catchment area that they serve.

contain too little vaccine. She tells him and the other HSAs that these syringes are useless and then she throws them away. Next she demonstrates how to draw a syringe without making air bubbles. The HSA at display whispers to me that it is impossible to draw all syringes without air bubbles. Jenny hears this and replies that it is in fact very possible, and explains once again, calmly, how to do it.



Photo 1: A line of children outside the Catholic Church.



Photo 2: Cooler boxes containing vaccines and syringes on top of the altar.

The largest measles epidemic in 13 years hit Malawi during my fieldwork spring 2010. In February alone 9000 people received the disease and 44 people died (Doctors without borders). This epidemic also reached the community where I conducted my fieldwork at a rural Health Centre. In May, the fifth month into my stay in Malawi, a nationwide measles campaign was organised. The campaign which was organised by MSF in collaboration with national and local health authorities targeted children between the age of six months and fifteen years in several of the country's districts. Within this group everyone was supposed to receive the vaccine regardless of previous vaccine status. The measles campaign was carried out together with the annual Vitamin-A and Abendazole<sup>6</sup> campaign.

The MSF helped the government with information spread, logistics, vaccine and additional material supply. The MSF-team operating in the district of my fieldwork consisted of one field coordinator, several field supervisors (mostly European nurses), a few Malawian nurses and Malawian chauffeurs. Each field supervisor was responsible for several catchment areas as the campaign moved from health centre to health centre on a weekly basis around the district. They were responsible for distributing vaccines and were supposed to guide and overlook the work of HSAs and local volunteers. The HSAs were the ones performing the vaccination and doing the actual job at the vaccine site, together with the volunteers. The field supervisor responsible for the catchment area described above was Jenny. This was her second emergency case with the MSF. As the excerpt indicates, a lot of tension grew between Jenny and the HSAs during this campaign; issues of race, culture, knowledge and power surfaced on a regular basis.

### *Organising an emergency vaccination campaign*

The MSF team came to Nyanja Health Centre on the Friday before the campaign was started. They held a briefing. More than 40 volunteers had met up at the Health Centre in addition to the HSAs. The volunteers represented all the villages within the Health Centre's catchment area. The nurses and the Medical Assistant attached to the Health Centre were not a part of the campaign. The MSF-team's field coordinator was from Tanzania. She spoke in English during the briefing and a Malawian MSF nurse translated her message into Chichewa<sup>7</sup> since few members of the audience understood English.

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<sup>6</sup> Abendazole is a de-worming drug.

<sup>7</sup> Chichewa, a Bantu language, is the official language in Malawi in addition to English

The MSF needed three teams to conduct the campaign in the area. Each team needed ten volunteers, five HSAs and one Teamleader (a senior HSA). Jenny was the field supervisor for the three teams. An MSF representative hung up a poster showing how the vaccine location should look like. The idea was that two volunteers should control the queue. They should organise arriving people into one queue for children under five years (U/5) and one queue for children over five years. Two volunteers would give out Abendazole to the U/5 children. An HSA would measure the Middle Upper Arm Circumference (MUAC) on children who looked underweight and give caretakers information about food and breastfeeding. One HSA would test salt for iodine (people were supposed to bring a small sample of the salt they owned to the campaign site). Two HSAs would give vaccine injections, and one HSA would prepare the syringes. Four volunteers would work the tally sheets ticking off how many receiving the vaccine and two volunteers would mark the little finger of all the children gone through with permanent marker. The Teamleader was supposed to overlook the whole situation stepping in whenever needed. He was the only one allowed to open the box with all the equipment in, in addition to Jenny. Each team was supposed to cover three locations during the five days of the campaign. Each team had two locations that required a two-day-station. As schools and churches are located very closely in all the villages, often only separated by a football field, the campaign was using the churches as location. This way it was easy to reach the school children.

At the briefing the MSF organised a role-play where the HSAs and the volunteers could play out the scene. The volunteers took turn in playing the children waiting in line, and the role of the volunteers organizing and guarding the line. One HSA demonstrated how the iodine testing should be done. People were enthusiastic and seemed to enjoy themselves. After the role-play everyone was divided into teams, and within the teams they decided the work task of each person, except the Teamleaders; they were already chosen as they were senior HSAs. At the end of the briefing which lasted for a few hours everyone received a Fanta and some cookies. For many this was a nice treat.

The field coordinator from Tanzania asked everyone if they had learned anything from the briefing, and the unison reply was, “*Yes!*” She then gave everyone credit for all the good work they had done that day and emphasised that this was for the children of Malawi, and said they had better do this right. Then she ended the briefing with an appeal for teamwork

and said, “A *TEAM* has only four letters. *T* is for *Together*. *E* is for *Everyone*. *A* is for *Achieve*. *M* is for *More: Together Everyone Achieves More!*”

### *Money issues*

After the briefing it was time for HSAs and volunteers to receive their bonus, and the mood quickly changed in the room. One MSF representative went into a room and asked one by one to come in and receive his/ her money. They started with the volunteers. They each received 350 kwacha (kw) (2, 30 USD<sup>8</sup>) and they were clearly not satisfied, but little could be done since it was much needed money. Next it was time for HSAs to receive their bonuses. In advance there had been rumours about only getting 500 kw a day (3, 28 USD). Normally, at the annual Abendazole and vitamin-A campaign they received 800kw a day (5, 25 USD). The HSAs considered that to be much easier work because now they had to vaccinate in addition. When the first HSA came out and had only received 500kw, people were disappointed. One HSA, a really hard worker, tried to convince everyone to reject the money; to go on strike. The others seemed to like the idea, but when it was their turn to go in, they went and received the 500 kw. HSAs have a meagre average monthly pay of 10.000kw (about 65 USD), therefore most could not afford to reject the money. After they had been given the bonus the HSAs made fun of the TEAMWORK philosophy. They were not satisfied and not motivated to perform their best. However, the field coordinator presented a moral position reminding them this was for the children of Malawi, which seemed to win people over. The bitterness, however, was still showing.

### *Information spread*

It is Thursday the week before the campaign is to start. My assistant, Thomas, and I join Mr. Mphaka, a young HSA, in his catchment area. We are sitting on chairs in the shade outside the Group Village Head’s house. Her front yard is often used for meetings, so she has an outside roof providing shade and there are wooden benches underneath it. Also, there is a big tree providing shade in her yard. We sit down and wait for her to come. When she comes out we all stand up and shake hands. Mr. Mphaka informs her about his errand in her community today and about the up-coming measles campaign. They also discuss a cholera case in her community. The Group Village Head thinks the afflicted is a victim of witchcraft. Mr. Mphaka reassures her that it is cholera. She does not seem convinced. Next we are walking for some 20 minutes to reach the house of the head of the Village Health Committee in the area. She sits in

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<sup>8</sup> Coinmill.com is used for calculating Kwacha into US dollars

front of a small brick house with grass roof and clay floors. There are two other similar looking houses sharing the same yard. We are seated on some tree stumps under a tree in the yard. There are five or six children playing and taking care of domestic animals. None of these children belongs to her; she is just taking care of them right now. She holds a cow, three pigs and some hens. Mr. Mphaka and the woman discuss which one of the volunteers should be involved in this campaign, and how they should divide the money. Simultaneously the pigs are bullying the cow and the children are whipping the pigs with sticks while the cow is trying to kick one of the pigs. Unaffected by the action taking place in the background Mr. Mphaka suggests the committee members divide the money equally. The woman does not agree. She feels some are working much harder than others in the committee, and that some deserve the money more. They discuss the issue for a while. Then they get interrupted when one of the pigs eats a piece of soap. The kids are trying to get a hold of the soap. The pig screams and runs around. When the situation calms down, they go back to discussing the money issue. She says she will do as Mr. Mphaka tells her. He, however, says that the decision is all up to her.

To get a campaign like this to work, the spread of information is crucial. All the people in the community must know about the disease outbreak and what to do about it and where to go to seek help. During the weeks leading up to the measles campaign, the HSA priority was to spread information. Every health talk was about the measles campaign. Health talks were conducted in the morning at the Health Centre and at every outreach- and static clinic. The HSA would have a dialogue with the caretakers regarding symptoms, treatment, danger and prevention of the illness. When it was clear that the campaign would take place, direct information was given about time and location. The HSAs made use of their network. As each HSA is responsible for a catchment area in this community it was his/her responsibility to make sure the information reached the population. Many of them talked to the Village Heads in their catchment area, as the case above describes. The Village Heads would then gather people for a village meeting and give out information. Some of the HSAs attended these meetings. Some HSAs also wrote letters to different congregations to be read out loud during the religious activities of the weekend before the campaign. Members from different Village Health Committees walked from door to door and informed people. In addition, the MSF had a car driving around in the community spreading the information by megaphone.

When talking to caretakers and volunteers during the campaign it was evident that the information spread had been massive. Those I talked to were sure everyone in their

communities had heard the information and were going to participate. This work was pursued before the money issue was raised at the MSF briefing.

### *The MSF, Health Surveillance Assistants and Volunteers*

Jenny, the field supervisor, represented the MSF in this catchment area, and in a wider sense she also represented the 'West' and the 'White'. During the campaign it became clear that the professional level of the HSAs did not live up to Jenny's standards and expectations. She would constantly travel between the three different vaccination sites and report back to the field coordinator and the rest of the MSF team. She would show up un-notified at the locations two or three times a day. Almost every time she came she got frustrated and irritated. This was often due to the HSAs' neglect of keeping the cold chain and using rubber gloves, 'disappeared' vials, air bubbles in the syringes, and crowded benches.

Normally, during under5 clinics<sup>9</sup> HSAs are used to have crowds of mothers and babies in the room where vaccines are handed out. During the measles campaign HSAs would usually wait until the two first benches in the church were filled up before giving injections. Jenny wanted only one person at the time sitting at the bench receiving the vaccine as a precaution against needle accidents. When she arrived she would thus typically enter the church, spot the crowd, and try to 'handle' the situation by waving her arms to move people so that only one person would sit at the front bench. However, as soon as she left, the HSAs would not vaccinate until the benches had filled up again. There were some 'near accidents' with the needles; like when a one-year-old grabbed the needle and pulled it out of his own thigh.

After regular vaccination clinics held at the Health Centre some HSAs would take the empty vials and give them to local glue makers in exchange for a small amount of money. The glue makers use the vials as containers for their glue. At the end of the second day of the measles campaign the vials were missing. The third day Jenny asked the Teamleader, Mr. Mulli, if he had found the empty vials from the day before. Mr. Mulli said no, he had not. Jenny then told him to find them. She wanted the vials because it is MSF procedure to count them up against the tally sheets to secure the numbers of vaccinated children. But it was also important to hinder the spread of empty vials to the black market where they, according to Jenny, were being used to sell false vaccines. One HSA whispered to me that they all knew who had taken the vials and that he had already sold them. The HSA telling me this hoped his colleague

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<sup>9</sup> Settings where children receive vaccines and are weighed at the health centre or at set outreach posts.

would confess so Jenny would give it a rest. When I asked the HSA who told me this why Mr. Mulli, the Teamleader, did not say anything to Jenny to get her off his back, the HSA replied “*She is so harsh and she could get him (the HSA who sold them) fired*”. However, the match between the tally sheets and the empty vials was often false because the HSAs would check the match at the end of the day and correct the tally sheets to make the numbers even. The first day of the campaign a Teamleader and a Malawian MSF nurse at the site figured the numbers out together as the tally sheet showed 717 children vaccinated but only 60 vaccine vials were opened. Only two vaccines were drawn from the last vial and each vial held ten vaccines. This indicated that only 502 children had received the vaccine – if the drawing had been done correctly.

Jenny would sometimes handle situations in a good, professional manner, though this was not always the case. Often, when tired and frustrated she would make gestures and say things which offended HSAs, volunteers or others; including her own staff like the chauffeurs. She, for instance never took time to shake hands with people which is offensive in Malawi. Jenny never took time for this gesture as she probably did not know the importance of it. She would shout out “*hey you*” or “*wo-ho*” to get attention from people she did not know the names of, ignoring the terms ‘*abambo*’ to men, ‘*amay*’ to women and ‘*agogo*’<sup>10</sup> to elders which are proper titling in such situations.

Jenny gave instructions in English. Once I watched her give a group of volunteers instructions where they nodded and said “*yes*” leaving Jenny to think they had received the message when in fact very few of them understood any English. The English skills of the HSAs were also limited. However, when Mr. Mulli started to translate to the volunteers what Jenny had told them, she yelled to him “*Hey, Mulli! Why are you over there when I am trying to talk to you?*” Once she tried to remove people from the crowded bench by waving her arms, as you would do to direct traffic, and she turned to me, did the gesture and said “*This should be international, but they just stare at you!*” She also appointed me to be her witness when handing out money for Mr. Mulli to distribute to his team. This made my assistant very upset. He felt, and was sure the others felt, that they (Malawians) could not be trusted and that she could only trust the other white person in the room. In fact, after she left, Mr. Mulli instantly started to hand out the money. When the final volunteer was getting his money, Mr. Mulli was

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<sup>10</sup> The translation is ‘father’, ‘mother’ and ‘grand person’.

200 kwacha short. He called Jenny, but she refused to turn around the car to come back and give him more money. She said she knew she had given him enough. Mr. Mulli then took 200 kwacha from his own pocket and handed it to the volunteer. Next, Jenny called me. She told me to tell Mr. Mulli that she handed out the bonuses each day to be nice. None of the other field supervisors did that, *“so tell him not to fuck with me, I’m being nice!”*

At one point a young HSA had had enough of Jenny and bluntly said, *“Do you think we’re stupid just because we’re black?”* However, most of the HSAs remained quiet around her saying only things about her behind her back. They wanted to please her and were afraid of making mistakes. This led to the vaccination of adults instead of children during a mobile clinic. It had been a slow day at the vaccination site. Therefore Jenny had organised two teams to go out into the community to look for un-vaccinated children. My assistant and I were in one of these teams. We found no children who had not received the vaccine when going around checking fingers and talking to mothers. The other team found over a hundred in the same area. I know for sure that the other team did vaccinate adults and ticked them off on the tally sheet as children over and under five years, but I do not know how many. We met the other team and saw a line of adults and I also talked to some men who told me they had received the vaccine. When the other team came back to the vaccination site Jenny was very pleased with the work they had done, and she was amazed that they had found so many unvaccinated children!

Regardless of all the tension between the HSAs and Jenny, a lot of children received their vaccines this week and most of the targets were met. However, it became clear that the target numbers the MSF used were not accurate. Several times Jenny would wonder why there were so few people who



Photo 3: An HSA vaccinating children during the measles campaign.

had turned up. As mentioned, one Senior HSA could not understand why they had not been consulted on the target calculations. HSAs are the ones who know the area and they are in charge of counting households in villages and writing down gender and age of all the children each year. During the campaign there were several discussions regarding the turn up. The Teamleaders would often say that most people had shown up. When going into the community searching for unvaccinated children we could find none. Also, when talking to volunteers and community members concerned about the health state of the community they were sure all their friends and neighbours had brought their children to be vaccinated.

# 1

## Introduction

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### *Research question*

Jenny, introduced in the Prologue, was not the focus of my fieldwork; rather on the contrary. In the months before the measles campaign I followed the Health Surveillance Assistants (HSAs) closely. I joined the daily work they conducted at a Health Centre, and in the field, in rural southern Malawi. I observed them in different roles and actions, and I observed patient interaction and handling. I walked with them, cycled with them, talked to them and got to know them.

A lot can be read out from the meeting between the HSAs and the MSF represented by Jenny. On one hand, it is easy to understand Jenny's worries and frustration as a voluntary emergency nurse doing her best to bring proper vaccines out to all the children. On the other hand, it was alarming to witness the disrespect and neglect of local customs on behalf of the MSF. However this will not be a focus. What makes this case interesting for my thesis is the way it illuminates the key role played by HSAs in vaccination coverage and child health activities in Malawi. They did a tremendous job regarding the aspect of turn-up. Yet their role in the emergency measles campaign also reveals dire weaknesses regarding medicine handling. Is it, however, possible that their weaknesses could be the reason for their strengths? It is this paradox I will investigate further throughout my thesis when I argue that the role of HSAs as mediators in crucial interfaces between patients and the Health Centre ensures the large turnout and trust in child health activities by caretakers.

### *Project background*

My thesis is a part of a larger research done by Centre for Development and Environment Medic (SUM Medic). SUM is an international research institution at the University of Oslo which focuses on issues concerning sustainable development.

This interdisciplinary research led by SUM Medic is a comparative project between Malawi and India called *Explaining Differential Immunization Coverage*. They want to identify factors at different levels which lead to good or bad vaccination coverage within the two countries, and they seek to explain social, political and economical aspects that can have an impact on the choice of whether or not to vaccinate a child.

The anthropological research within SUM Medic's project focuses on empirical findings concerning vaccination and vaccination coverage at local levels, with special attention to the mother-child relation, local clinics and the health workers. The aim of the research is to get a group of projects that will provide wide empirically understandings of problems that have to do with deliverance and use of the health service within the two countries. In my research I have focused on the relationship between a local health centre and its surrounding community.

### *Malawi; the country and its state of health*

Malawi is a landlocked country bordering to Mozambique in the southeast/east and the southwest, Zambia in the west and Tanzania in the north. Lake Malawi occupies one fifth of the entire surface area. Within the country there are about 14 million inhabitants, and the capital city is Lilongwe (Europa World). Malawi is a low-income country, and more than half of the population (52%) lives below a national poverty line of 16 165 kwacha (147 US dollars) per person per year (WHO, 2009).

According to WHO (2009) Malawi is facing a growing burden of disease. There is a high prevalence of communicable disease, maternal and child health problems, and an increasing burden of non-communicable (heart disease, asthma, cancer) and neglected tropical diseases. 46% of the population is less than 15 years old and life expectancy at birth in 2005 was 47 for men and 46 for women (although a search on the Internet will provide numbers as low as 36 years). The infant mortality rate in 2006 was 69 per 1000 live births, and under5 mortality rate the same year was 118 per 1000 live births. The maternal mortality ratio is 807 per 100 000 life births which gives an average of 13 maternal deaths a day.

For under5 children, according to WHO (2009), the most common cause of death is malaria, pneumonia, diarrhoea, neonatal causes and HIV/AIDS. Malnutrition is associated with over

half of the deaths. WHO (2009) claims that Malawi has maintained routine immunisation coverage above 80% since 1989 and through this have eliminated measles and neonatal tetanus and reached polio certification level surveillance. However, as described in the prologue, measles are not eliminated in the country. Also, statistical numbers vary greatly based on what is included in the analysis. WHO claims vaccine coverage well above 80%. A study based on data from the Demographic and Health Surveys conducted by the National Statistical Office in Malawi in 1992, 1996, 2000 and 2004 concludes that the proportion of children aged 12 to 23 month fully vaccinated is as low as 51% (Munthali, 2007). The Statistic Central Bureau of Norway (SSB) has collaborated with the National Statistical Office in Malawi since 2004 and their rapport concludes that the vaccine coverage is as low as 33 % if all nine vaccines in the EPI<sup>11</sup> program are included (Nielsen, 2011). However, if only looking at the measles vaccine in children aged 1-5 years the coverage is again above 80 %. The United Nations (UN) only uses statistical numbers on coverage in children between 12 and 23 months, and therefore fully vaccinated children in Malawi, according to their numbers, is as low as 27% if included all vaccines. If viewing the measles vaccine coverage in children between 1 and 5 years it is as high as 87% according to SSB, however for the UN the measles coverage is 72% (Nielsen, 2011). Thus the way organisations or agencies analyse, and which numbers they chose to emphasize, varies between them and gives a difference in coverage numbers ranging from 27% to 87%! In addition, trust in the numbers collected is an issue. Nevertheless, Malawi is considered to be a relatively successful country in providing vaccines to its population when taking into consideration the poverty aspect. Kadzandira and Chilowa (2001), in their rapport on the role of HSAs from 2001, call the EPI implementation in Malawi during the 1990s a success. However, a negative tendency was starting to emerge and the causes needed be documented.

### *Health politics*

The government of Malawi stands for 40 % of the total health expenditure in the country. The rest is made up by several development partners; multilateral, bilateral and non-governmental organisations. The Ministry of Health has the role of formulating policies, regulation and enforcement, ensuring standards, training, curriculum development and international representation (WHO, 2009).

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<sup>11</sup> The Expanded Program on Immunization, an attempt to coordinate and expand a number of individual immunisation programs. It was initiated by the WHO.

In 1978 there was held, by WHO and UNICEF, an international conference on the subject of Primary Health Care in Alma-Ata. The outcome of this conference was The Declaration of Alma-Ata who sought the commitment of all member states of the WHO to target health for all by 2000 (WHO, 1978). The declaration suggested that this aim could be reached by the Primary Health Care approach. The Primary Health Care approach belongs to the development discourse of Community Participation which is people centred development (Oakley et al., 1999). In the health section this approach is called Community Involvement in Health. Local communities should be involved in decision making and help to tackle poor health. This could, according to Peter Oakley and Haile Mariam Kahssay (1999) be seen as a reaction against the dominant model of development in the 70s which stressed professionals and external delivery and had no role for the poor in the development process. Now development needed to be more people-centred. “To tackle poverty you need to develop people’s ability to change these conditions” (Oakley and Kahssay, 1999:3).

Primary Health Care could also be viewed as an alternative to the existing health care system. The current system, John J. Macdonald (MacDonald, 1992) argues, should be called *the medical system* and not *the health care system*. Its focus on the curative sides of health hinders the development of the proactive sides of health. It is too focused on ‘the body as a machine’ and the ‘doctor as the engineer’ metaphors and thus ignores the socio-economic conditions creating health. As Macdonald (1992) points out, most diseases which kill people in developing countries are not lethal themselves. It is the combination of them which kills. These are diseases of poverty. Primary Health Care on the other hand is “an approach to the provision of health service which emphasises the *promotion* of health through a partnership between health and other professions and the community, as well as a system of treatment and curative care based on meeting the health needs of the majority of the population to be served” (MacDonald, 1992:9).

According to the WHO (2009) the health care system of Malawi today consists of three levels; Primary-, Secondary-, and Tertiary Health Care. The first level, Primary Health Care, is provided through community based outreach programs, dispensaries/health post, health centres and community hospitals. The second level is provided through district hospitals and CHAM (Christian Health Association of Malawi) hospitals. The third level is provided through central hospitals. In Malawi there are 901 Primary Health Care facilities, 100

Secondary Health Care facilities and six Tertiary Health Care facilities. The staffing of these facilities is the lowest in the region with two physicians per 100 000 population and 59 nurses per 100 000 population (WHO, 2009). For comparison, Norway has 3, 7 medical doctors per 1000 population and 15, 4 nurses per 1000 population (Dagens Næringsliv).

The health policy of Malawi is interlinked with a broader national development strategy called the Malawi Growth and Development Strategy (MGDS). This strategy is a policy framework guiding the achievements of the United Nations' Millennium Development Goals (United Nations Malawi). The Millennium Development Goals from 2000 are “intended to engender national initiatives and strategies geared towards alleviating poverty and improving the standard of living of the poorest of the poor across the globe” (United Nations Development Program Malawi).

The purpose of the MGDS is to serve as a single reference document for policy makers in Government; the Private Sector; Civil Society Organizations; Donors and Cooperating Partners on socio-economic growth and development priorities for Malawi

(Government-of-Malawi, 2006:xii).

A focus in this strategy, as mentioned, is health. In health the focus is on providing the Essential Health Package (EHP) and to develop health infrastructure (IMF, 2007). According to GAVI<sup>12</sup> (2005) the EHP is now seen as the core business of the health sector, and it reflects the realisation that in providing a wide range of health care the government was providing poor health care. Instead the government should provide quality health care to all by focusing on the most important health needs of the people; the EHP. The service provided is supposed to be preventive, promotive and curative (GAVI, 2005). GAVI (2005) claims that the EHP will provide a joint program of work for the Ministry and its partners, and it will lead to transparency and efficiency. The EHP consists of 11 cost effective health priorities that are given free of charge to all people of Malawi:

- 1) Prevention and treatment of vaccine preventable diseases.
- 2) Malaria prevention and treatment.

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<sup>12</sup> The Global Alliance for Vaccines and Immunisation

- 3) Reproductive and neonatal health interventions (including reproductive health, family planning, safe motherhood and PMTCT<sup>13</sup>).
- 4) Prevention, control and treatment of tuberculosis.
- 5) Management of Acute Respiratory Infections (ARIs).
- 6) Prevention, treatment and care for Acute Diarrhoeal Diseases (including cholera).
- 7) Prevention and treatment of sexually transmitted infections (HIV and AIDS, ART and VCT).
- 8) Prevention and treatment of Schistosomiasis and related complications.
- 9) Prevention and management of malnutrition, nutrition deficiencies, and related complications.
- 10) Management of eye, ear and skin infections.
- 11) Treatment for common injuries.

(Pearson, 2010:19)

The Malawian lay community health workers, the HSAs, are at the front line of implementing the Essential Health Package, and thus one can recognise the principles of Primary Health Care and Community Involvement in Health in the health politics of Malawi (Kadzandira og Chilowa, 2001).

### *Social Anthropology and health*

Health and health practices are part of the inmost complexities of social existence, permeating the domains of politics, economics, and religion and always connected with dimensions that go beyond the body, such as interpersonal, family and community relationships

(Kleinman og Petryna, 2001: 6495).

Although the term *medical anthropology* is debated and *health anthropology* could be viewed as more neutral, medical anthropology is the term used internationally (Ingstad, 2007). Benedicte Ingstad is a professor in medical anthropology. She views medical anthropology as a field in the nexus between anthropology and social medicine. According to Arthur Kleinman and Adriana Petryna (2001), what characterises anthropological study of health, is its focus on ethnography to achieve an understanding of health, illness and healing. When

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<sup>13</sup> Preventing Mother-to-Child-Transmission

studying health, most anthropologists focus on the local context since this is where health and illness are recognised and responded to in various forms. By focusing on the local one can also regard the effects of global flows like commodities, information, finance, images and people (Kleinman og Petryna, 2001). As Melissa Leach and James Fairhead put it, in their study of vaccine anxieties, “Vaccines are also special in linking the most global within the most local and personal”...since... “At the needle point, the most global meets the most personal of worlds” (Leach og Fairhead, 2007:2). This aspect is recognised in the prologue where the MSF, representing the global, meets the most personal of worlds in the measles campaign held in the rural community of my fieldwork.

According to Ingstad (2007), the interest of medicine and health within anthropology goes back to the Torres Strait expedition in the late 1800s. On board this expedition was W.H.R. Rivers who was a physician, psychologist and anthropologist. In 1924 he published the book *Medicine, Magic and Religion* where he argues that the three concepts are so closely related that it is impossible to distinguish one from the other. Furthermore, well known anthropologists like Malinowski, Radcliffe Brown and Evans- Prichard were all interested in health and illness, although within their focal point of rituals (Ingstad, 2007). Later, medical anthropology became more and more associated with applied anthropology. Applied medical anthropology is “when anthropologist engage in something directly applicable in different practical measures, be it planning or evaluation of projects or actively participating in the implementation by letting the research result adjust the directions taken” (Ingstad, 2007:22) (My translation from Norwegian). Applied anthropology is further connected to the field of development. As David Brokensha (2001) writes, in the 1970s, when development actors realised that economic development with its ‘trickle down’ effect had limited success, the new emphasis became development for the poor. This developed a need for scholars who knew the poor and thus anthropologists became involved. Anthropology began to play a significant role in development projects. Some scholars, the ‘principled rejectionist’, are very much against anthropology engaged with development. Arturo Escobar was one of them, and he viewed development as a discourse in a Foucauldian way and argued that development gains the developers, i.e. Western donor nations, and it cannot meet the needs of the poor (Brokensha, 2001). ‘Monitorists’ on the other hand, are those who study anthropology of development without wanting to engage actively. The last recognisable category within the field of anthropology and development is the ‘reformers’, those who are willing to be directly concerned with development policies and projects (Brokensha, 2001).

Health, Kleinman and Petryna (2001) state, is a broad concept, and ways to study it vary. Some medical anthropologists, like Paul Farmer, are interested in revealing how social forces alter disease distribution and contribute to the persistence of new microbial conditions. Others are more interested in studying the varieties of local healing traditions coexisting with state institutions. Furthermore, where biomedicine<sup>14</sup> has a tendency to treat health as a separate domain, anthropologist connects health to the larger context of differences in power, social positions, social inequality, particularly as experienced by marginal groups and individuals. Several anthropologists thus address local variations in illness and health and they argue it is important to understand everyday life experience, local knowledge, and social networks influencing personal agency and access to health care (Kleinman og Petryna, 2001).

### *My field and research method*

When going to Malawi my main focus was intended to be the vaccination service and how it was performed locally in a rural area. In addressing the relative success Malawi seemed to enjoy regarding vaccine coverage I primarily wanted to look at the local health workers and the way they interacted with the patient and the community. Therefore I wished to follow the health workers closely when they conducted their duties, and, luckily, I was able to do so.

I was fortunate to be taken under SUM Medic's wings. They had all research permits granted for the project and they had partners in Malawi, REACH Trust<sup>15</sup>, who helped us. Together with two anthropology students from the University of Oslo also engaged in SUM Medic's project, I left Norway the 11<sup>th</sup> of January 2010. We were met by REACH Trust at the airport in Lilongwe, and they had arranged a lodge for us to stay in the coming days. After two weeks in the capital collaborating with REACH Trust to arrange the best location for each of our projects, I was taken to the field. In the period prior to this REACH Trust had also found me a very capable assistant, Thomas. During the two weeks in the capital REACH Trust had taken me to a district south in the country to investigate possible locations for my study. When we were there we went to the District Hospital and introduced ourselves for the Chief Nurse and the District Health Officer. Next we found the District Assembly and introduced ourselves for

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<sup>14</sup> Biomedicine is the term I will use throughout the thesis when referring to the predominant medical theory and practice of Euro-American societies, also known as 'Western', 'Modern' and 'Scientific' medicine. Biomedicine focuses on human biology and physiology and discloses magical and non-rational elements (Hahn and Kleinman, 1983)

<sup>15</sup> Research for equity and community health trust; an independent Malawian health research charity.

the District Commissioner; the Governor of the district. Afterwards we drove into the villages to find Nyanja Health Centre where I was allowed to carry out my research. Here we were met by a senior HSA and the nurse I was supposed to live with. The nurse had heard of my possible arrival, but was now given further information. She showed me her home and welcomed me to stay and said *“as long as you are a Christian we’ll be fine!”* After this we went to see the Traditional Authority to inform him about our task, but he was not there, and we ended up talking to his clerk instead. Finally we talked to the Group Village Head of ‘my’ area of residency and were welcomed by her as well. She looked forward to seeing the ‘azungu’<sup>16</sup> act as a Malawian woman, she said. During this whole process I did not say much. Mr. Lot Nyirenda from REACH trust did most of the talking and explanation. I trusted he knew best who to talk to and how to interact with state officials and local authority representatives.

In Malawi each district is divided into traditional authorities and the ‘ruler’ of each traditional authority is called the Traditional Authority (TA). Within each traditional authority there is a local hierarchy of authorities based on inherency. The traditional authority where I conducted my fieldwork included 70.000 inhabitants. Under the TA in the hierarchy are the Group Village Heads who are in charge of several clusters of villages. Under them one finds Village Heads who have authority in their village. These positions are based on inherency, but pragmatic solutions are also used when someone is unfit to be a Village Head. The TA in this community was a man; however most Group Village Heads and Village Heads I met were women as this society had a matrilineal organisation. The traditional authorities (at all levels) deal with quarrels, disputes, divorces and sometimes witchcraft accusations. When I talked to the TA he told me he mostly handled disputes over land.

I use the term community in my thesis when describing the locality surrounding the Health Centre and its people, though I am aware of the term’s impreciseness. It is a term “usually associated with solidarity, familiarity, unity of purpose, interest and identity” (Rabinowitz, 2001:2387) which overlooks processes of change. I use the term community when addressing actors in the Health Centre’s catchment area who deals with the Health Centre in some way or another. Since everyone, regardless of ethnicity, age, gender and social status at some point in their life have to deal with questions of illness and health they are all part of the community

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<sup>16</sup> Azungu/Mzungu are general terms used to describe ‘white’ people.

revolving health. The community is made up by close to 20.000 people, and it is divided in to numerous villages.

Two weeks after I arrived in Malawi I had moved into the nurse's house located approximately 50 meters from the Health Centre. The Health Centre was located about five km away from the main road. The main means of transportation going between the main road and the Health Centre were bicycle taxis where passengers sat on the carrier. This was the way I would travel when, for instance, I needed to buy water or newspapers or get to the minibus depot if heading for the nearest city. By local standards my residency was a big (approximately 6x3m) and solid house made out of concrete. It had on and off electricity. In a country where only 4% of the population enjoy electricity this was something I had not taken for granted and I was very pleased. I shared the bedroom/food storage room with Nurse Musnga. The house-girl also living with the nurse was a thirteen-year-old girl helping her out with the household in exchange for proper food and boarding, and she slept in the other room on a mat on the floor. The house-girl went to school every day. Behind the house the nurse had a small plot of land where maize grew. In between the maize crops there grew ground-nut- and pumpkin plants. To the left of the house she had three small shacks; the 'kitchen', the 'bathroom' and the pit-latrine. Most afternoons, if not raining, we spent sitting on the front porch cooking, cleansing pies, eating fruits, knitting, listening to the radio or chatting to neighbours passing by.

I was truly welcomed by most actors at the Health Centre. When it became clear that I had no medical experience or training I was not intimidating. The HSAs became eager to teach me and show me how things were done. I had to set some boundaries as I did not wish to be engaged with, for instance, vaccine injections which they were eager to teach me. However, I helped with seemingly easy chores like weighing and plotting weight into health passports. I also helped carrying equipment and I tried not to interrupt in their work too much. In this way I was able to observe closely the interaction between health workers and patients.

HSAs are those actors at the Health Centre providing the vaccine service and other preventive measures in child health. They do not only conduct their work from the Health Centre, they also travel out to remote areas to offer the service in form of outreach clinics. In addition, they engage in community meetings regarding preventive health and they conduct health education. The main means of transportation when performing these tasks are bicycles or foot.

During my time ‘working’ at the Health Centre I sat, together with my assistant, Thomas, in the crowd listening to the health talk and observed patient handling. We walked and cycled and sweated together with the HSAs until I was pink in my face – to everyone’s amusement, and I really got to know them. In addition to the HSAs I also spent much time observing the nurse I lived with in her interaction with patients. Also, I got to know her outside the office. Although living this close to another person was quite challenging, for both I reckon, the closeness gave me greater insight to her life as a Malawian nurse and woman. She was very including and patient with me in explaining and sharing information I did not understand. She taught me how to cook traditional food. After mastering the art of cooking Nsima<sup>17</sup> everyone was very pleased with me as the first question I would get when I met someone new always was if I ate Nsima. Whenever I cooked, washed dishes or did my laundry in the front yard people would stop and comment on how I was becoming a Malawian woman. This was important to me as I portrayed myself as something else than the Malawian rural stereotype of a white woman who paid Malawians for doing her house chores. As I did not master the language this became a way of communicating with my neighbours when Thomas was not around. My main research method was, as just described, participant observation.

Pierre Bourdieu understands participant observation as “the conduct of an ethnologist who immerse her- or himself in a foreign social universe so as to observe an activity, a ritual, or a ceremony while, ideally, taking part in it” (Bourdieu, 2003:281). The inherent problem with this research method, he identifies, is how one can be both subject and object; the one who acts and the one who watches herself acting? I will not claim that I, in my five months in Malawi, was able to immerse myself in a foreign social universe. However, I did my best to participate in daily acts and routines for the sake of bodily experience. I also tried my best to understand the world through ‘their’ logic and not mine, and hopefully to some degree I was able to do so. And doing this gave me good-will from the ones who I spent my days with and they seemingly appreciated my efforts.

In addition, I made use of unstructured interviews ranging from loose conversations with health workers to conversations with Village Heads, patients and others where topic and questions were thought of but rarely written down. I did not want to ‘own’ or guide the interview. I wanted the ‘interviewed’ to guide the conversation, to my assistant’s frustration

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<sup>17</sup> Nsima is stiff maize porridge. It is *the* main food for Malawians, and a person has not eaten nsima during the day he or she will say they have not eaten anything.

who was a journalist by profession. When talking to non-health workers like mothers, committee members, Village Heads and others, I spoke through Thomas. Thomas was not a translator by profession, but he took pride in giving me the correct information as he was afraid he could hurt the outcome of my thesis if not. After some tries and adjustments we worked as a proper team, especially outside the Health Centre when talking to villagers. He was also priceless when it came to access information about interaction and messages through health talks and health songs. He would explain to me what the health workers were talking about, what questions were asked, responses given and etc.

At my second day at the Health Centre there were held a staff meeting where Thomas and I were introduced. Everyone was then informed of the purpose of my stay, and I explained to them about consent and anonymity. Later in my stay I would now and then remind them of the purpose of me being there and I would reassure their anonymity. I would also use my notepad openly as a reminder of the presence of a researcher. The health workers would often have me and Thomas introduced to the patients when they were gathered for health talks before under5 clinics, or Thomas would give us a brief introduction. This introduction was given in Chichewa. At the end of the stay the vast majority of the mothers going to the Health Centre on a regular basis would know me and my agenda.

Before coming to Malawi I had read several places that English and Chichewa were the official languages in Malawi, and both were spoken widely. However, this was truly not the case. In the rural areas very few people spoke any English, and it was absolutely necessary to make use of an assistant. Although I had an assistant to help me with the language barriers, it does not mean I did not have challenges concerning language; on the contrary. As English is a sign of higher education (i.e. secondary school and above) Thomas found it difficult to intervene when HSAs were speaking English to me. I asked him to help them out when they struggled for words without being instructed by me. Thomas did not feel comfortable doing so because it could be insulting for the HSA in question. The level of their English skills varied greatly. For some time I was sure some of the HSAs avoided me and did not like me being there. After a while, though, I understood that they avoided having to expose their poor English skills to me and their colleagues. As a result I usually spent time with the HSAs who spoke well English and this meant mostly men. When realising this I tried actively to join some of the female HSAs when they were conducting their duties. It seemed like most of them were happy to have me joining them. Even though it was somewhat difficult to

communicate with them (mostly in 'yes' and 'no' questions) I could still observe their interaction with patients and feel their workload on my body when climbing hills or travelling far to conduct duties. The female HSAs would also make use of Thomas in a higher degree than the male HSAs when they wanted to explain something to me which I did not understand.

I can argue that in having a male assistant I did not get access to the female sphere to the extent I wanted. Women, especially younger women did not always feel comfortable talking about certain topics in front of, and through a man. I would always get more information when talking to middle aged and elder women on themes like family planning, child health, taboos and traditional practise. However, in having this particular assistant- regardless of gender- I did get full access to the Health Centre. Every employee at the Health Centre really liked Thomas, and they enjoyed talking to him, both men and women. He was easy-going, jovial and professional. If Gerald Berreman's (1962) experience from a Himalayan village has taught anthropology students anything, it is that the assistant is crucial in access to information. If no one had liked Thomas I would have had a much harder time getting invited to join health workers when working outside the Health Centre. In addition to being a translator Thomas helped me in several other ways. He helped me remember, and he was someone who I could discuss findings with. When I wondered if I had misinterpreted something I asked of Thomas' opinion. Because the experience was quite tough on him as well as me, both being strangers in the community and used to more everyday luxury and freedom, and because at times everything went very slow, I tried to come up with 'missions' every day to activate both. Additionally, with him by my side it was easier to make contact with people and to approach traditional authorities. Unfortunately for him, he was also the one who had to put up with me on days when I was sick of smiling all the time, when I was sick of being the Malawian version of me, and when I felt the need to let out my frustration regarding Christian fanatic values and hatred towards gays<sup>18</sup> and etc.

Throughout the thesis I describe several cases of interaction between social actors in the community, like health talks, community meetings and family planning activities, where the language of communication is Chichewa. Information of what is being said relies entirely on

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<sup>18</sup> A gay couple was sentenced to 14 years of imprisonment at the time for conducting a traditional wedding ceremony. The Development Minister of Norway was in the country trying to pledge for their freedom by threatening to halt Norwegian aid. The couple was freed by President Bingu wa Mutharika after Ban Ki- moon paid the country a visit. This was five months after they were put in prison.

Thomas' notes from the situation. During all these sessions he used his notepad actively and wrote down questions and answers, comments and topic of conversations and translated it all to me. In my theses I make use of quotes, and therefore I ask the reader to keep in mind that quotes in this situation are somewhat difficult and cannot be entirely correct.

### *Theoretical backdrop and chapter outline*

The essence of my analysis is a quest to portray the strengths and weaknesses in the lay health workers, the HSAs, and the paradox concerning those opposites in regard to child health activities. The empirical findings are concerned with action taking place in relation to health in a rural setting in Malawi. I have observed numerous interactions between groups and individuals representing different social positions in the community's field of health. The Development Sociologist Norman Long's (1989) perspective on social discontinuities and rural development seems useful for my analysis. In this perspective the researcher should be occupied by looking at the social interfaces; i.e. "a critical point of intersection or linkage between different social systems, fields or levels of social order where structural discontinuities, based upon differences of normative value and social interest, are most likely to be found" (Long, 1989:1-2). This concept implies face-to-face encounters between actors (individuals or groups) who represent different interests and who are equipped with different resources. Therefore, the interacting actors will often be differentiated in terms of power. The aim is not merely to describe what happens in the social interface, but by doing so be able say something about larger institutional frameworks and power fields. By exploring the social interface one should be able to see how interactions are affected by and also influences actors, institutions and resource fields that lie behind the interface situation itself (Long, 1989). Long's perspective is situated in the actor-oriented approach in social research. According to him this approach is a counterpoint to structural analysis, and he argues:

Although it might be true that important structural changes result from the impact of outside forces (due to encroachment by market, state or international bodies) it is theoretically unsatisfactory to base one's analysis on the concept of external determination. All forms of external intervention necessarily enter the existing lifeworlds of the individuals and social groups affected, and in this way they are mediated and transformed by these same actors and structures (Long, 2001:13).

The concept of social interface in this approach is relevant as a way of exploring and understanding issues of social heterogeneity, cultural diversity and the conflicts inherent in processes involving external interventions (Long, 2001).

An important aspect of the social interface is the element of trust. But what is trust? Trust is inseparable from vulnerability, and therefore it has great relevance in medical care as illness leaves the patient vulnerable (Hall et al., 2001). Trust can be studied at different levels when it relates to medicine. One can discuss trust in the institution of health care or trust in the person providing health care. As my thesis is actor oriented I focus on the personal element of trust in the health worker - patient relation. As Mark A. Hall, Elisabeth Dugan, Beiyao Zheng and Aneil K. Mishra (2001) argue, trust is as much directed to motivations and intentions as it is to result in the domain of health care. The personal quality of the health worker matters in the emotional and non-rational component of trust. Trusting views about intentions and motivations can result in forgiveness rather than outrage. “The strongest predictors of trust are physician personality and behaviour. Patient trust is consistently found to be related to factors such as physician’s communication style and interpersonal skills” (Hall et al., 2001:628).

Throughout the thesis I will provide the reader with broad ethnography where social interfaces are carefully described. In the prologue two social actors were presented; Jenny representing the MSFs and ‘the global’ and HSAs representing the rural in the chain of health care providers in Malawi. I revealed HSAs’ weaknesses by viewing their medical skills through Jenny’s eyes<sup>19</sup>. Their poor techniques and ‘ignorance’ of important aspects regarding vaccination must be closely connected to their short medical training- if any training at all. I use this as point of departure for my further arguments unfolding their strengths which were also apparent in the measles campaign in the aspect of the major turn-up.

In Chapter 2 I describe the medical pluralism in the community. By portraying several encounters between patients and health workers, all of different positions, a vivid picture of various logics and interests at play become clear. In this chapter I mainly utilise the concepts of Arthur Kleinman to reveal different clinical realities and explanatory models regarding health and related concepts existing within this community. By doing so I introduce the reader

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<sup>19</sup> I have no medial training and cannot therefore comment on HSAs’ medical skills by referring to own observations.

to the field of my study, and by asking *what influence choice of treatment* I am also able point at factors guiding health seeking behaviour.

In Chapter 3 I reveal existing tension between the health workers and the community. Tension exists primarily between the community and the nurses and the Medical Assistant. Here I provide empirical evidence portraying the authoritarian power dimension at play in the interface. Differences in position, power, knowledge and possibilities are key aspects in this chapter, in addition to resistance. The theoretical perspectives used to analyse these issues are those of Max Weber, Pierre Bourdieu and James C. Scott. I argue there is a gap between people's expectation of the Health Centre and what the Health Centre can and is supposed to provide to the community, and that this gap leads to tension, anger and sorrow.

In Chapter 4 the HSAs play a leading part. By analysing encounters between HSAs and the community I am able to say something about the key role HSAs play in child health activities. In the analysis I position the HSAs in relation to the larger community by further utilising the concept of Bourdieu's capitals, and I argue that much of what HSAs lack in authority or symbolic power they compensate for in their collaboration with the traditional authorities. Closeness between HSAs and the community, which differentiate them from other health workers, is stressed.

In Chapter 5 I present a conclusion. I argue for the larger relevance of my study by contextualising the theme into larger issues of health and health politics. Additionally I discuss HSAs, pro et contra, by utilising the notions of social interfaces and trust.

# 2

## The Social Actors and Medical Pluralism

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By applying knowledge which comes to him as a part of his cultural heritage, man transforms his physical environment to enhance his comfort and improve his health (Paul, 2010:50).

In most societies there is a wide range of treatment alternatives to illness. In the Norwegian society, if a person catches a cold she may try to treat herself by taking vitamin C supplements, eating plenty of oranges or chewing raw milk tablets. If a person suffers from allergy she may visit her medical doctor, her homeopath or her acupuncturist. The medical anthropologist Benjamin D Paul (2010) emphasises the importance of remembering that humans are cultural animals and much of their knowledge comes to them as part of their cultural heritage. People often assume that their way of thinking and acting is the natural way, and it is normal to assume that *others* have more odd beliefs and habits than *us*. Paul also states that it is an insult to imply that just because some areas of the world are technically underdeveloped, their population or their culture must be underdeveloped as well. I mention this because I believe it is important to remember when reading the chapter. Witchcraft is a great part of it the logic in the Malawian community where I conducted my field work and witchcraft is often used as explanation for illness. There are, however, some common denominators between the rationality behind witchcraft and biomedicine, i.e. medicine based on natural science. The biomedical thinking is grounded by a somewhat magical belief in numbers, possibility of explaining, predict and control illness (Frich, 2002), and patients influenced by both rationalities (witchcraft and biomedicine) are caught up in the question “Why me?”

This chapter is an introduction to the medical landscape surrounding Nyanja Health Centre which will be an important backdrop in understanding the complexity of this community. I will look closer at the choices made on medical treatment and I ask what *influences* the choice of treatment. To be able to discuss this question I will introduce the different social actors

involved at Nyanja Health Centre. I will use Arthur Kleinman's theory of The Health Care System, accompanied by Benedicte Ingstad, to illustrate the medical landscape surrounding the Health Centre. The reader will get an insight to the medical pluralism of the community and a better understanding of the clinical realities present which can indicate actions and health seeking behaviour amongst the different social actors. Through various cases the reader will also get an impression of how different health workers handle a range of explanatory models and health seeking behaviours. Lastly, I will compare my qualitative empirical findings relating to factors influencing treatment alternative to the quantitative empirical findings of Karl Peltzer who studied health seeking behaviour in Malawi in the 1980s.

## The Social Actors

### *The Medical Assistant (MA)*

Medical assistants in Malawi handle general complains at health centres in rural areas. Adamson S. Muula (2009) has given a short description of medical assistants. Medical assistants need two years of training in order to earn the Certificate in Clinical Medicine. They are not expected to perform any surgeries. In Malawi there are about 260 medical doctors. This is by far not sufficient with a population of 14 million. Muula further states that the occupation of the medical assistant was established as a temporary solution to this major problem. At the present time medical assistants are very important in bridging government health care to the rural population of Malawi as the medical doctors are in shortage and because most medical doctors stay in the cities. 80% of Malawians live in rural areas (Muula, 2009).

When I conducted my research, Mr. Phiri was the Medical Assistant (MA) at Nyanja Health Centre. Mr. Phiri was a bright man in his late 20s who dreamt of becoming a medical doctor some day. He was not from the community and he had recently begun working there when I arrived. He was easy to spot when he was outside his office in his long white coat, smart pants and shiny black shoes and with a stethoscope around his neck. Everyone knew him as 'the Doctor', and not all were familiar with the term medical assistant. He was in charge of the Health Centre and was very ambitious on its behalf. He wanted everyone there to work hard and organised so they could win the competition of being the best Health Centre in the district.

Mr. Phiri lived a stone's throw away from the Health Centre. His house was one of the nicest in the village; it was owned by the government. It was made of red bricks, had a concrete floor, and tin roof. He also had electricity. When it was dark you could see the house from far away because he had a lamp above this front door. Few houses had such luxury. He also owned a TV, a DVD player and speakers. When his fiancée was listening to Celine Dion's "My heart will go on" you could hear it loud and clear at the Health Centre.

Mr. Phiri was a hard worker. He would see patients in his office every weekday from eight to four or five. He would take an hour lunchbreak at noon. No one else working at the Health Centre worked this kind of hours. I only spent time with him inside his office once when he was seeing patients<sup>20</sup>. During one hour he examined 33 patients. According to the registration forms at the Health Centre between 3000 and 5500 people went to see Mr. Pihri every month. Some weeks, then, he examined 275 patients a day, 39, 2 patients per hour. These numbers seem to fit the long line of patients waiting outside his office every day. As he told me he treated patients with acute illnesses, mostly malaria, and his diagnosis was often only based on the clinical presentation<sup>21</sup>.

### *The nurses*

At the Health Centre, the nurses were responsible for antenatal and postnatal care, child delivery and Family Planning methods<sup>22</sup>. At the Health Centre there were supposed to be three nurses working shifts. However, for a long period during my stay there were only two nurses sharing the workload because one nurse was transferred to another location as there is a shortage of nurses in the country. One of the nurses working at the Health Centre, Nurse Chilemba, was in her 70s and retired, but she was recalled to work due to the shortage.

With only two nurses they worked every other week, day and night. The youngest nurse, Nurse Musanga, was in her 30s and lived in a government house very close to the Health Centre. She was not from the community and had recently been transferred. She would go to sleep in her own bed when she was on duty, and the Watchman would come and wake her up if her assistance was needed at the Health Centre. Nurse Chilemba, on the other hand, had to sleep in the nurse's office on the examination bench when she was on duty. She was from a

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<sup>20</sup> It did not feel ethically right to observe a 'doctor'-patient interaction as intimate as this.

<sup>21</sup> The clinical presentation is the symptoms the patients presents to 'the doctor' (Personal communication with Cecilie Mortensen, MD)

<sup>22</sup> Family Planning refers to birth-control pills, Depo-Provera shots, and referrals for sterilisation.

village within the catchment area of the Health Centre. Her own house was nicer than the government house. It took her approximately 20 minutes to reach the Health Centre on foot. The third nurse, Nurse Mpulula, was away for a long period. She was in her 50s and not originally from the community and lived in a government house close to the Health Centre.

The nurses were always dressed in their white uniforms (a white blouse and a white skirt or a white button dress), nice clean shoes and a traditional chitenge<sup>23</sup> wrapped around their waist. Their uniforms were always shiny white. All of them were big-sized women – or ‘fat’ as they themselves would call it – and proud of it.

My information from the nurse-patient interaction is mainly from Nurse Musanga since she welcomed me to her sessions and got used to my presence. She would start her day sometime around 8 a.m. and let in the women waiting for the family planning injection. The room was crowded. Women sat on the floor with babies on their laps and backs, and the nurse sat on her chair by her desk preparing the syringes while having a health talk with the women. The health talk was often about advantages of family planning, but sometimes about side effects as well. The nurse would ask questions and the women would answer. At times the nurse listened while the women discussed amongst themselves. She would correct or agree with them after a while. Sometimes the spirit during these sessions was high and they would all sing, laugh and giggle. Other times, the nurse would be harsh with the women and complain about smell and call them liars if the women complained about side effects. I will discuss the interaction between the nurse and patients more closely in Chapter 3.

### *The Health Surveillance Assistants (HSAs)*

Close to 20 HSAs worked at the Health Centre, and the division of gender was fairly equal with a small majority being men. HSAs were responsible for under5 clinics; static and outreach. Under5 clinics refer to sessions where mothers take their children to the Health Centre for vaccination and weighing. An outreach clinic is when HSAs bring their equipment and travel into the community to offer the same service which is given during static under5 clinics. They had four different localities for the outreach clinic and the HSAs were supposed to visit every location once a month on a set day. Each HSA had a catchment area (a village or cluster of villages) they were responsible for. They were supposed to prevent disease

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<sup>23</sup> A multi functioning traditional clothing/apron wore by women outside their skirt witch is also used to carry babies in.

outbreaks and do general health promotion in their catchment area. Ideally, an HSA should live in his or her catchment area, though in reality few did. HSAs also did tuberculosis testing, HIV testing, handed out ARV<sup>24</sup> and assisted the nurse. They were supposed to have seven weeks of formal training; however, seven of the HSAs at this Health Centre had not received the formal training.

HSAs who carried out the different testing and handed out drugs had extra training. However, they did not earn more money than the rest of them. These HSAs were all very committed to their work and they spent more hours at the Health Centre, and therefore, naturally, these were the people I spent most time observing and getting to know. The 'quality' or work ethics of HSAs varied greatly. It was not easy to keep track of HSAs as their work did not require them to come to the Health Centre every day. They were supposed to write weekly reports of the workload they had performed, but no one did. The fact that I got to know the more committed HSAs, and thus got invited to join them more often than the less committed, is an important factor in this thesis as it is important for my impression of HSAs.

The HSA activity at the Health Centre was often finished by lunch time, and after lunch (which lasted for at least an hour) many of the HSAs did not return to the Health Centre. The HSAs who were assisting the MA or the nurse, or registered patients often stayed behind. Most HSAs lived at the nearest trading centre approximately 5 km away from the Health Centre. Some HSAs also lived in villages within the catchment area of the Health Centre. They lived in private houses with their families.

When HSAs who were responsible for the catchment areas furthest away were going to outreach clinics, they had to travel quite far. They left 7.30 a.m., and reached the outreach clinic around 9 a.m. Sometimes they walked the whole way carrying vaccines in a cooler box and cotton and forms under their arms. Other times they rode their bicycles up to the point where the journey became steep. Then they left their bikes at a primary school nearby and walked the final distance. Normally they would come back to the Health Centre around noon very tired as the journey was long and hilly. Then it was quite natural for them to end the day at lunch time and when I joined them I understood why. I was often exhausted after this journey. Once, Thomas and I joined a female HSA doing household counting<sup>25</sup> in her

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<sup>24</sup>Antiretroviral (ARV) drugs are treatment of infections by retroviruses, primarily HIV.

<sup>25</sup> Counting houses, number of family members, cooking areas and pit latrines for local statistics.

catchment area. We had to walk up and down several hills and the experience was tiresome. We were done around 3 p.m. and headed back to the Health Centre. By 4 p.m. we reached the Health Centre. Now the HSA was a bit worried as she had to ride her bike for another hour before she reached her home, and she felt it was too late in the afternoon for a lady to be riding her bike alone. HSAs will be discussed more in Chapter 4.

### *The Village Health Committees (VHC)*

In each HSA catchment area there were supposed to be ten volunteers making up the Village Health Committee. In most places, though, it was only a couple of these volunteers who were active. These would assist HSAs at outreach clinics, bringing chairs and benches for them to sit on and help with the weighing of children. A couple of the volunteers were very active and even came to the Health Centre once a week to assist HSAs during under5 static clinic or the nutrition program<sup>26</sup>.

The volunteers were supposed to give information about disease prevention, and they were supposed to run and notify the Health Centre in case of a disease outbreak. They were also supposed to notify the HSA responsible for their area if a village was out of chlorine for the water. On big campaigns, like the measles campaign, the committee members would take turn assisting since it is money involved and not enough room for all the volunteers to join. During the measles campaign two volunteers from each committee assisted.

When I asked different volunteers why they volunteered, they said they wanted to do their part in keeping their community healthy and that they were proud of being a volunteer. They also considered it an honour to be elected as a Village Health Committee member. On election days the whole village would gather and vote for volunteers.

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<sup>26</sup> Every Wednesday undernourished children could come to the Health Centre for physical examination. If in need, the child would receive Plumpy Nut; a peanut butter high in calories.



Photo 4: Members of a VHC building a pit-latrine for an outreach maternity ward.

### *The Patients*

The patients at Nyanja Health Centre were mostly women and children. The only place I saw men was in front of the MA's office, at the Voluntarily Counselling Room, and some came for HIV testing. The rest of the activities at the Health Centre were for women and children: family planning, antenatal and postnatal checks, child delivery, and child health. Women brought children to the Health Centre. I observed men who brought children to the MA, but almost never to child health activities run by HSAs. When I asked about it, people told me that men thought child health was the woman's responsibility. An old man I talked to said that young men were not interested in child health. During the measles campaign one of the volunteers told me that she had only seen three men bringing their children to receive the vaccine. During one of the last static under5 clinics of my stay I finally spotted a man in the crowd. He was tying a baby girl to his back with a chitenge (like the women do). I told him jokingly that he was a rare sight, and asked him if he felt out of place amongst all these women. He smiled and said that men and women made children together, so he had no problem with it.

The Medical Assistant, Mr. Phiri, told me that there had been a campaign called Male Championship where the government encouraged men to come with their wives to the Health Centre. The MSF provided t-shirts to be handed out to men who came. Still, few men showed

up. The Health Centre was a female arena and this was the message brought by the Health Centre through its rhetoric. The women and the HSAs sang different health songs during child health activities, and the message in one of these songs was that the Health Centre belonged to women:

*//Women should be proud of this clinic. It is our (the women's) clinic. The doctors are our own, the vaccination is ours. Let's be happy//*

Twice a week there was a big market not far from the Health Centre. Because women were the major agents at the market, and many had to travel far to reach it, they would combine this with coming to the Health Centre. Therefore, market days were always busy days at the Health Centre. Many women who received family planning injections would do it secretly as their husbands did not approve. To have this done at the same day as the market day was a good 'cover' for them.

In this community there was not a lot of economic wealth. Many lived in small brick houses with dirt floor and mats to sleep on. Some had tin roofs, but most had roofs made out of grass. A few houses had electricity, but none had running water. The clothes people wore around their homes were often dirty, faded and had holes in them, and



Photo 5: An average looking house.

few people wore shoes. However, when people came to the Health Centre they would dress up. As the mothers and their children were not ill when coming to under5 clinics, their appearance was important. Therefore it soon became apparent to me that the women dressed up both themselves and their children for this occasion. This was a day for displaying ones status. Some wore the dress or suit they normally wore to church. Some had shoes with heels, some had white sneakers but others had to come barefoot. Some babies were dressed up in princess dresses or other 'cute' outfits if the family could afford it. The women would bring

nice and clean baby sheets and the chitenge they wore were the newest. In everyday life one did not often see children wearing shoes and white coloured clothes. However, if they had the opportunity, this was the way women dressed up the child at the under5 static clinic. This social aspect of child health will be further discussed in Chapter 4.

I have now given a presentation of the different actors who play a part in my thesis. It is the dynamics and interactions between these actors which will be discussed further. Special attention will be given to the HSAs as these are the key to my main argument. In what follows, I will describe the medical pluralism and different clinical realities existing amongst the actors connected to the Health Centre. I want to illustrate the medical culture of the community. I will utilise Arthur Kleinman's theory of The Health Care System to visualise the medical pluralism and health seeking behaviour found there.

## Medical pluralism

It is early morning and the weather is still cool. I am sitting at the Health Centre waiting for it to fill up with mothers and their children. It is Tuesday, and it is the weekly static under5 clinic where children are weighed and vaccinated. The clinic has an open construction but gives shelter from sun and rain. The walls are painted yellow and baby blue but the paint is peeling off the walls. The women take seat at the stone benches when they arrive and they are awaiting the Health Surveillance Assistants. Some have come from afar, and they all carry a child on their backs. Some are carrying several children. As the clinic fills up, the air is filled with a sour smell of baby wastage. Mothers are cleaning their babies. They remove the nappy and reveal the traditional thread around the babies' waist and the amulet around their neck protecting them. Not all have a waist thread. Some have an amulet with a picture of The Virgin Mary. Others have nothing. The Health Surveillance Assistants arrive, and before everyone will sing health songs, they pray to God asking him to guide them through this session.

### *Theoretical backdrop*

The medical anthropologist Benedicte Ingstad (2007:34) explains medical pluralism as arising "when different medical explanatory models co-exist or are each others' alternatives, either as established options of treatment in the society or inside people's minds as alterative explanatory models for ones own illness experience" (My translation from Norwegian). The medical anthropologist Bradley Stoner (1986:44) puts it somewhat simpler when explaining

medical pluralism as “the existence and use of many different health care alternatives within societies.”

Benedicte Ingstad (2007) shows how medical pluralism further evolved after the Alma Ata conference, when biomedicine was introduced as an medical alternative in many societies. The optimism around Primary Health Care for all by 2000 led to generous donations, and as Ingstad (2007:23) puts it “the optimism was as great as the go-ahead spirit” (My translation). The common belief was that when bringing biomedicine and its truths out to people, they would adapt its practises and forget about old ones. This, however, did not turn out to be the case. Ingstad explains how in most cases people were satisfied with the new healthcare offer and would make use of it when the old way did not work. The new practise and knowledge was adapted and weighed against people’s own knowledge about health. The biomedical treatment was at times cheaper than traditional treatment. People listened to health education and made use of the advice -if convinced. People also made use of the biomedicine when forced to do so (Ingstad, 2007). In many ways she explains the meeting and coexistence of biomedicine and traditional medicine in less developed countries. However, as Stoner (1986) claims, all over the world medical pluralism is the rule and not the exception.

Arthur Kleinman is a psychiatrist, trained in anthropology, who has given great contributions to the field of medical anthropology. In his book *Patients and Healers in the Context of Culture* (1980) he argues that medicine can be viewed as a *cultural system* in the same sense as religion, language and kinship. He calls this cultural system *the health care system*. He defines a cultural system as “a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions” (Kleinman, 1980:24). In many aspects does Kleinman’s notion of a cultural system converge with Clifford Geertz’s notion of culture as “a historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life” (Geertz, 2000:89). Willian H. Sewell (1999) is critical to Geertz’s concept of the cultural system because it argues for a very close connection between publically available clusters of symbols and the moods, motivations, affects, and activities these symbols shape. This deterministic approach to culture is problematic in explaining cultural change and leaves little room for agency and critical reflections concerning the world. Additionally, Sewell criticise how Geertz mainly differentiates between societies of peoples-

between the Balinese, the Javanese and the French -without considering the possibility of cultural differences within these categories; differences of beliefs, wealth, gender, power and status (Sewell, 1999). Although Kleinman's (1980) definition of a cultural system in many ways meets Geertz's definition of a cultural system, Kleinman makes room for the instrumental aspect of culture. In his model a focus is on people's choice concerning health care. Kleinman explains how people's beliefs and actions colours the health care system, and the culture colours people's beliefs and actions. How people act in and make use of the health care system is thus guided by cultural rules. The health care system is locally created by a collective view and shared patterns of usage. However, the health care system is viewed and used differently within the locality depending on social factors such as gender, class, education, religion, ethnicity, affiliation etc. (Kleinman, 1980).

With the health care system, Kleinman (1980) refers to all aspects of health, illness and healing within a society, not only government authorised health care. It includes pluralism and syncretism in health (Stoner, 1986).

Kleinman (1980) further talks about social reality when explaining the health care system. He claims that "social reality is constituted from and in turn constitutes meaning, institutions, and relationships sanctioned by society" (Kleinman, 1980:36). The social reality governs how people act, what they believe, how they view the world, how they interact, and the social reality is perceived through socialisation. When talking about the social reality concerning health related aspects Kleinman uses the term *clinical reality*. Beliefs about sickness and how a sick person should act and respond to healers and family are aspects of the clinical reality. Beliefs about sickness are cultural constructions and are shaped differently in different societies just as the health care system. Cultural beliefs turn *disease* in to *illness*. According to Kleinman (1980:72), disease refers to the malfunction of biological and/or psychological processes and illness refers to the psychosocial experience and meaning of perceived disease. Illness is the social and cultural reaction to the disease. Both are constructed within the clinical reality. Kleinman (1980) talks of explanatory models. As he puts it "explanatory models are the main vehicle for the clinical construction of reality; they reveal the cultural specificity and historicity of socially produced clinical reality, regardless of whether it is based upon scientific medical knowledge" (Kleinman, 1980:110). Ingstad (2007) explains how each individual has his or her own explanatory model based on individual illness experience, but also based on the cultural and social context individuals finds themselves in.

Explanatory models are what construct clinical realities. Such models are held by patients and practitioners in all health care systems. Kleinman (1980) argues that explanatory models must be distinguished from general beliefs about sickness and healing. General beliefs exist prior and independent to the occurrence of illness. Explanatory models are based around the particular sickness episode. This is why explanatory models often changes, and explanatory models can change within the same sickness process (Kleinman, 1980).

Kleinman (1980) developed a model of the health care system which he argues, can be used universally. The content of the model will vary with different cultural, social, and environmental circumstances. The health care system, according to Kleinman, is composed of three overlapping parts; *the popular sector*, *the professional sector* and *the folk sector*. *The popular sector* describes home based care; the care given by family, friends and neighbours. This is the largest sector of the three, and this is where the symptom occurs and where decisions of treatment are taken. The choices taken depends on cultural beliefs and ideas, and I would also add socio economic factors. This is where disease turns to illness. In this sector women are the main agents. Ingstad (2007:53) regards this sector as the nexus for all other treatment since this is the sector you go 'home' to; the place for evaluation, discussion and guidance between community members. This is where future decisions are made. The second sector in Kleinman's model is *the professional sector*. This sector is government authorised and therefore legal healthcare. Dominant in this sector worldwide is the biomedicine. Only in a few countries like India, China and Pakistan are other healing knowledge acknowledge in this sector (Kleinman, 1980). In *the folk sector* you will find different types of healers and practises. Shamanism, religious healing, traditional healing and alternative healing are all found in the *folk sector* (Ingstad, 2007), and it can be closely linked to *the professional sector*, but is most often related to the *popular sector*. The degree of overlapping in this model differs between different societies. However, as Kleinman (1980) argues, the popular sector is the sector which overlaps most into the other two.

A model is an artificial tool used to understand realities, and in this case used to compare societies. I find Kleinman's model of the health care system useful and important as he reminds us that biomedicine is only on part and one truth in the larger system of health care. The model also provides some good analytical concepts when talking about health. I will now present some cases from Nyanja Health Centre and the reader will recognise these closely interlinked sectors Kleinman describes. It will become apparent that the patient and the health

workers draw upon knowledge produced in the different and overlapping sectors. It will also give the reader a larger understanding of the medical culture people base their decisions of treatment on in this particular community.

### *Biomedicine, traditional knowledge and religion*

Nyanja Health Centre is a place where biomedicine is practised, but the Health Centre is also a place where different healing knowledge and clinical realities meet, as the vignette from the under5 clinic portrayed. At the Health Centre one can find biomedicine, religion and tradition

all at the same time and in the same room. Patients and health workers will make use of the different sectors, described by Kleimnan, in this health care system depending on their clinical realities and explanatory models. Often they will also make use of several sectors, maybe all three, during one illness period. To make sure that her baby receives the best possible treatment, a



mother make her child wear the traditional amulets to

Photo 6: A child receiving the measles vaccine while wearing the traditional waist-thread for protection.

strengthen him and protect him at the same time as the mother will bring the child to receive its vaccines and pray to God. Others will only pray, as prayer is the most powerful thing one can do to protect one's child.

The medical anthropologist Byron J. Good (2010) discusses the problem of using the word *belief* as the juxtaposition to *knowledge*, and shows how influential anthropologists like Rivers, Taylor, Frazier and Evans-Prichard have done this, more or less intentionally. They use the word belief to describe the concepts of the *others*, while knowledge is used when describing western rationality. I will, as far as possible, use the word knowledge to describe

western rationality as well as Malawian traditional rationality to avoid contribution to the uneven power relation already existing between western rationality and other rationalities. The dichotomy in this text will thus be between biomedical knowledge and traditional/local knowledge although this is an over-simplification which does not account for syncretism (See Stoner, 1986).

A mother frequently visits the Health Centre with her child. The child looks around three years of age and is undernourished. Mr. Bwanali, the HSA in charge of the nutrition program, conducts follow-up- checks on her child and six others today. She and the other mothers will receive Plumpy Nut if their child is undernourished or suffers from oedema. Mr. Bwanali explains to me that oedema can be caused by poor nutrition, and when you have oedema you swell up. Mr. Bwanali tells me that the woman's child has been referred to the District Hospital but that the woman refuses to bring the child there due to "*personal beliefs*". Her younger child died at the District Hospital. When I ask the woman why she did not bring her child there, she tells me it is due to lack of caretakers to come with her. When I ask her why her child is ill, she tells me that she suspects the child is a victim of witchcraft. This is what the traditional healer told her. She does not know why the child is bewitched, but she thinks it might be because she (the mother) does not have any brothers or other family close by in this society to protect her. She is sure she knows the one who is harming her child<sup>27</sup>, but she does not know who it is. She tells me she cannot afford the traditional healer's treatment. The treatment at the Health Centre, however, is free.

Before I talked to this mother I had listened when Mr. Bwanali had spoken to the seven women at the nutrition program that day. He had asked them for causes of swelling. One replied undernourishment. Another one said it was dangerous to have too many children as it could lead to neglect. When Mr. Bwanali asked about the remedy, the mothers replied nutritious food, and to feed the child food from all the food groups. The women gave answers based on biomedical knowledge they had been taught through health talks and health songs by HSAs. Mr. Bwanali also told the women to encourage each other to rush children to the Health Centre if they swelled, and that they should not waste time on traditional beliefs and remedies. This example shows how the women have knowledge about biomedical reasons for illness and its remedies at the same time as they have knowledge about traditional causes and remedies for the same condition.

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<sup>27</sup> Witchcraft is often associated with close kin and neighbours.

The example also shows how the individual explanatory model guides health seeking behaviour. One of the children in this group was wearing a traditional thread around her foot, and this is traditional treatment against swelling. The mother I talked to listened to the HSA and accepted the medicine, but she was still convinced it was witchcraft rather than neglect or malnutrition that was the reason for the swelling of her child. She also had her own reasons for not going to the District Hospital. Kleinman (1980:106) argues that patients do not share their explanatory model with the health professional, or when asked to do so, only share briefly as they get embarrassed and are afraid of ridicule and criticism.

### *Sexual behaviour and health*

During my stay I witnessed several encounters between HSA's knowledge of biomedicine and the local traditional knowledge. When I asked the HSAs about the use of traditional healers they would laugh and tell me that people were ignorant. I asked several of them if they would use a traditional healer themselves, and they all said no. However, I noticed small scars on several of them indicating previous use of *mphini* (scarification); a method used by traditional healers. These scars could of course be old and inflicted before they started to work as HSAs. However, it still shows familiarity with and (bodily) knowledge of traditional practise. Knowledge about various practises is important, as I will show, when communicating with the community.

Just before the measles campaign in May I accompanied some HSAs to a community briefing about the campaign and the illness. Normally at this site only women would show up, but today some old men also showed up since the HSAs had told the Village Health Committee to inform and encourage men as well:

It is a sunny day. Some local men sit in the small shade provided by the maize plants close to the shack built by the Village Health Committee to be used as an outreach clinic. The women and children sit at the grass field in front of the shack in the sun. I am sitting together with the HSAs and Thomas on a wooden bench close to the men. Some school kids and women are entertaining us before the briefing starts. The kids play drums and some women dance. A young boy reads a poem he has written. It is about how HIV and AIDS are killing a lot of people and in the poem he encourages everybody to go to the Health Centre and get tested. The briefing about the measles campaign starts and Mr. Mwula, an HSA, stands in the middle of the crowd and asks them what the symptoms of measles are. The crowd replies fever, red eyes, rashes, cough and dark stool. Mr. Mwula then asks how it spreads. A woman replies that

it is an airborne disease. Mr. Mwula further talks about prevention. He tells listeners that the most important prevention is to quarantine the ill person to prevent the spread. Rush to the Health Centre in order to get the patient away from your home, he encourages them. Now an old woman speaks up. She tells Mr. Mwula that back in the days they were taught not to have sexual intercourse if someone in the village got infected with this disease. An old man adds to this that if someone decides to have sexual intercourse the measles will find them! Mr. Mwula smiles and shakes his head. He asks if everyone agrees to this. Many laugh a bit, but nod their heads in agreement. Mr. Mwula does not tell them that this is wrong. He continues with asking the crowd if they know other factors important to have in mind during a measles outbreak. An old man says that you should not bathe the patients because the rashes can burst. Now Mr. Mwula speaks up and tells them that this is wrong. He emphasises how important it is to bathe the patients, and the rashes cannot burst, he says. The old man speaks up again, and this time he tells everyone how important it is to rush to the Health Centre when you recognise the symptoms. After him, the Village Head rises. She thanks the HSAs for their time and she remind people how dangerous the measles are. She condemns churches who will not seek health care from the Health Centre. Then she encourages people to follow the instructions given by the HSAs. At the end of her appeal she encourages mothers to send their children to school. She says, *“some will grow up to be presidents, doctors and HSAs, so let them go to school”*.

The next day Mr. Mwula conducts a new briefing about measles in a village close to his home. There are few men, mostly women and children present:

Mr. Mwula and a volunteer are sitting on a wooden bench under a tree. I sit on the ground with Thomas some feet away from Mr. Mwula and the audience. The women sit on straw mats in front of Mr. Mwula and the volunteer. The women peel dried maize from maize cobs, which will later be brought to the mill, while they listen to the health talk. When Mr. Mwula is finished with the health talk about hygiene and measles, an old woman says that one should not have sexual intercourse when someone is ill with measles. Mr. Mwula agrees in some ways with this statement. He says that sexual intercourse is enjoyment and could be seen as celebration, and one should not celebrate when others are in pain. To abstain is a way of showing sympathy, he concludes. Another old lady says that in the old days you were told that you died if you bathed when you had measles. The wounds will enter your body and you will die. Mr. Mwula replies that this is not the case. The rashes are on your skin, not inside your body. To bathe is important, he reassures. Mr. Mwula asks if anyone wants to comment on anything. A tall woman sitting in the middle, seemingly authoritative, speaks up. *“What you have told us is good. We should follow the instructions so we can have a healthy life. Some of*

*you may neglect it, saying Mr. Mwula is drunk, but what you have told us is very important”.*  
Mr. Mwula and the other women laugh at the ‘drunk’ comment. It is no secret that he drinks heavily in the weekends.

In the situations described above the particular HSA, Mr. Mwula, chose to accept or at least not contradict the traditional knowledge about sexual intercourse and measles. To some extent he agreed. He did not agree to the fact that sexual intercourse attracted the disease, but he made it into an ethical question in that one should not celebrate when others were suffering. However, when it came to the knowledge about not bathing measles patients as they can die, he disagreed and told them this was wrong and stated that not bathing was dangerous. Therefore this was a knowledge that contradicted the biomedical knowledge HSAs had. One important task of the HSAs was in fact to tackle traditional knowledge thought to be of health risk. The next observation I will illustrate concerns a health talk telling women how to behave sexually while pregnant to reduce the risk of HIV/AIDS.

It is Tuesday and static vaccination day at the Health Centre. Today, several HSAs are away on a workshop, so the one performing the health talk, Mr. Ulili, is the HSA supervisor of this and the neighbouring Health Centre. It takes some waiting, but after a while the room is filled up with women and children as usual. The session starts off with some health songs:

*//Whenever I see these children I am happy. Some will become doctors, some will become nurses and some will become teachers. They are our future leaders//.*

*//Women you are loaded with children. One child on the front and one child strapped on the back. Children all over you. This is poverty//*

*//Bravo nurses, help me nurses, the traditional midwife has failed. Nurses carry me//.*

During these songs Mr. Ulili dresses up as a pregnant woman. He borrows chitenges from some women in the audience. He wraps one chitenge around his waist and puts his sweater underneath it resembling a pregnant belly. He also puts a sweater under his t-shirt resembling breasts. The women laugh, sing higher and make high pitched cheering noises with their tongues. They seem to enjoy the show.

Next he performs the health talk. He talks about *do’s* and *don’ts* during pregnancy: “*Join the antenatal group when you find out you are pregnant. Here you will receive knowledge, tests and malaria drugs, and you get to test your blood*”, he says. He encourages the women to bring their husbands to get tested and receive information together. Further he says, “*Keep*

*having sexual intercourse as long as possible when pregnant. Be flexible with your man, if not he will find pleasure elsewhere. Try out new positions; don't just lie on your backs. Discuss sex with your spouses"*

*"Do not drink and smoke, and do not eat clay<sup>28</sup> as this can cause abdominal problems and worms".*

*"Go to the Health Centre six weeks after birth to have the baby checked. Then start with family planning again. Two months after giving birth start having sexual relations with your husband again".* Mr. Ulili also explains to the women that semen cannot get contained in the belly<sup>29</sup> if having sexual intercourse while pregnant.

This health talk focused on very intimate behaviour between pregnant women and their spouses. However, sexuality, pregnancy and mother/child health is closely interlinked in traditional knowledge. In the study of J.W.M van Breugel (2001) conducted amongst the Chewas in central Malawi in the 1970s, he gives a close description of traditional and religious practises. Chewas was not dominant in my area of fieldwork, but the community surrounding Nyanja Health Centre had a great mixture of ethnicities. Still, I recognised many practises van Breugel describes and therefore assume similarities. van Breugel describes *mdulo* taboos and how they always are related to sexual activity. If one disregards such a taboo it can bring death or other disaster on a third person. Adultery during pregnancy is *mdulo*. If broken, the child can die or will remain weakly. If the man disregards the *mdulo*, the woman can also be a victim and die in labour. *Mdulo* is closely interlinked with the notions of 'hot' and 'cold', van Breugel shows. Sexual activity, sexual fluids and menstruation are regarded highly mysterious, powerful and dangerous and is thus classified as 'hot'. People not engaged in such activities, like old people and children, are classified as 'cold'. 'Hot' means danger and 'cold' means vulnerable. The most vulnerable are new-born children. Therefore, only 'cold' people can handle a new-born child. Thus parents and surrounding family need to abstain sexually, remain 'cold', until the child is 'taken' (kutenga mwana). The child becomes 'taken', i.e. ripe as a person, through a ritualised sexual act of the parents with the child placed between them. This happens two to three months after birth. Before the umbilical cord has dried off (5-8 days), the child must remain inside the house where it was born with the

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<sup>28</sup> According to Nurse Musanga many pregnant women in Malawi crave clay during pregnancy, including herself.

<sup>29</sup> When I asked Nurse Musanga about this she explained that some women thought the white substance sometimes covering a newborn were traces of semen.

doors shut in fear of evil (hot) influences. When the umbilical cord falls off, a string of medicine is tied around the waist to protect the child from evil influences and the child is bathed in traditional medicine. van Breugel also pointed out how the fear of hotness make people fear giving birth at the hospital since they cannot be sure the midwife had abstained sexually, and therefore she is potentially 'hot' and a danger to the new-born child.

This detailed account made by van Breugel was made many years prior to my fieldwork. However, several practises I recognise from my experiences. As mentioned, the thread around children waists was very much present and also the traditional medicine bath was common after keeping the child inside the house until the umbilical cord fell off. Additionally many women dreaded giving birth at the Health Centre.

The health talk, although very imperative in its rhetoric, did not necessarily contradict traditional knowledge similar to what was described by van Breugel. Mr. Ulili was trying to convince the women to act according to the biomedical knowledge concerning safe sex which meant *having* sex with your husband. If not, Mr. Ulili told the women, "*your husband will go find pleasure elsewhere and then you and your child are in danger of becoming HIV positive*". Therefore, in addition to the dangers of 'hotness', HIV/AIDS were added to dangers lurking if breaking the *mdulo* taboo.

### *Witchcraft*

Nurse Musanga had a more prestigious position in the community than HSAs, and she was from a city. She took pride in being 'modern', and she would not be identified with traditional healing. This, however, did not mean she only believed in biomedicine. She was a strong believer in God, and she said that "*God heals through medicine*". When it came to reasons for attracting diseases she would refer to poor hygiene and other sources of prevention based on biomedical knowledge, but also she would sometimes use witchcraft as an explanation. Christianity and witchcraft goes hand in hand, she told me, as witches work for the Devil. Before going to bed, Nurse Musanga would often throw holy water<sup>30</sup> at the door and in the corners and cracks of the house to keep witches away at night. When doing this she would say out loud: "*in the name of Jesus!*" (*mu dzina la Yesu*).

Kleinman (1980) argues that it is important to divide a practitioner's explanatory model into theoretical and clinical types. These types can be closely connected or they can diverge. The

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<sup>30</sup> The holy water was water bought at the city supermarket blessed by the nurse's pastor in town.

practitioner's clinical explanatory models can be closely interlinked with the commonsense rationality found in the community, and I will argue, based on the following empirical example, that this was the case with Nurse Musanga.

It is Friday and I have been together with some HSAs in the village furthest away in Nyanja's catchment area attending an outreach under5 clinic. I am exhausted when coming back to my home. Thomas' grey t-shirt is soaked in sweat. I have used my chitenge as shade covering my head when walking back. The terrain was challenging and we walked for an hour and a half coming back in the burning sun. I lie down at the porch and I struggle to get up again. Nurse Musanga has not come home yet; she is away visiting her family in the city. I struggle to make dinner for myself and the house girl. She will soon be back from school. I go to bed in the early afternoon. When the nurse comes back later in the evening she finds me lying in bed. I have fallen ill. She takes a look at me and asks me what is wrong with me. I tell her I am weak and feel nauseous. Next I vomit. Nurse Musanga is now certain it is malaria and makes me take malaria drugs. No tests are involved. About ten minutes after I have taken the drug, the nurse throws holy water at me and in all the corners of the house and prays loudly for the Devil to let go of me. She asks me if I have prayed out loud during her absence, and I tell her no. She tells me this is the reason for my disease. Because I have not prayed out loud, the witches found me and gave me this disease. I fall asleep and relax for the rest of the weekend and wake up fine the following Monday.

What could be read from this episode is that the nurse's explanatory model is based on commonsense (Kleinman, 1980) as well as experience and biomedical knowledge. She is well aware of the malaria's rout of transmission and its symptoms, but this did not explain *why me*. Luise White (2000:19) refers to Monica Wilson who argues that natural science can easily be incorporated in the knowledge system concerning witchcraft as it is easy to agree to the fact that for instance typhus is caused by lice, but that does not explain who sent the lice.

This way of reasoning is well stated in the anthropological theory of witchcraft. Evans-Pritchard (1976, 1935) explains how witchcraft works in the world of the Azande people in Sudan in the 1920s. As Eva Gillies (in Evans-Pritchard, 1976) writes in the introduction, the world described by him, is long vanished. His analysis of witchcraft, however, is still relevant to modern anthropology. He talks about the causation of the notion of witchcraft. In this society misfortune was due to witchcraft cooperating with natural forces. Disease was a natural force and existed in its own right. Witchcraft did not create diseases. However, as

Evans-Pritchard (1935) claimed, witchcraft was responsible for bringing the disease in to a lethal relation with a particular man. A well known example to illustrate the causation between witchcraft and natural forces is the example of the granary. A granary is infested with termites. All Azande know this. The granary is bound to fall down at some point. However, it falls down while some men are sitting in the shade resting underneath it. It kills and injures the men. The explanation for this causality was the presence of witchcraft (Evans-Pritchard, 1935). He further states that witchcraft was present in all aspects of Azande life, and witchcraft was an everyday thing. Azande people expected to come across witchcraft every day. Witchcraft provided the Azande with a natural philosophy where relations between men and unfortunate events were explained (Evans-Pritchard, 1976). Further, Evans-Pritchard (1976) states that it was difficult to get good explanations from people when asking about witchcraft. No one understood it entirely as only witches themselves understood these matters fully.

There are several similarities between Evans-Pritchard's description of witchcraft in Azande society and explanations I got from community members where I conducted my fieldwork. In one village I met an old man who called himself 'The Anthropologist' who wanted to show me a 'book' he had written about witchcraft in Malawi. 'The Anthropologist' had read Evans-Pritchard and wanted to show how Azande notions about witchcraft fitted with the Malawian notion of witchcraft. When I asked people about witchcraft it was hard to get good explanations. I would often get answers like "*Only witches truly know*" or "*It takes a witch to detect other witches*". Nurse Musanga explained to me that sometimes a person would have all the symptoms of HIV but still tested negative. This would be witchcraft. Sudden illness and death could also be witchcraft. Long lasting headache indicated witchcraft because this meant that witches used your body, like a working zombie, when you were sleeping. Also, sometimes, witches would use your head as a ball when playing netball. Harry Englund's (1996) knowledge about the Chewas in Central Malawi and their relation to witchcraft state that witches are considered to inflict all sorts of diseases, to cause unpleasant dreams and unexpected deaths. Additionally, witchcraft can ruin a flourishing enterprise. Witchcraft is an ever-present threat, and Englund describes witchcraft an existential predicament.

When a disease was thought to be sent by witchcraft many people in the community would seek traditional treatment. Nurse Musanga 'believed' the answer instead was God. She would never use a traditional healer she told me. That was unchristian. She believed the traditional

healer was a witch himself as only a witch can know other witches and have the power to hurt them. Since witches were diabolic creatures she refused to seek help from one. The only one more powerful than the Devil, she said, was God. It could seem as, in my illness experience, anti-malaria drugs were the remedy for the actual disease and God was the remedy for the cause of me getting the disease.

Botomani, an HSA I spent much time talking to on the way home from outreach clinics, had a different view on traditional healing. He differentiated between a traditional healer and a witchdoctor. He knew of no witchdoctors in the area, but he knew several traditional healers. He told me that 70%<sup>31</sup> of the Malawian population used traditional healers and that sometimes medical doctors told patients to seek traditional healing since their treatment was not sufficient for some illness. The other HSA accompanying us agreed to this statement. Minutes after we had had this conversation we met a woman with a bandage around her foot. Botomani asked what had happened. She said she had dreamt that a dog bit her, and when she woke up her foot was injured. Since the circumstances were quite mysterious she decided to seek help from the traditional healer. She was on her way back from him now. Botomani nodded when he heard this, and did not tell her to go to the Health Centre, but he did instruct her to keep the bandage clean.

## What Influences the Choice of Treatment?

Karl Peltzer (1987) is a social health psychologist who did a study on psychosocial health care in Malawi in the period between 1982 and 1985. This was 25 years prior to my study, but I can find similar patterns in my empirical data and his findings in health seeking behaviour in Malawi.

As Kleinman (1980) argues each person has his or her own explanatory model and the explanatory model influences the health seeking behaviour. Throughout this chapter, I have presented several illness experiences and handlings of illnesses. The different experiences show that actors in this community have a pragmatic attitude towards treatment, and that the circumstance surrounding a disease is important in a person's decision of treatment. Peltzer's (1987:62) study showed that the professional health care sector was by far most frequently

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<sup>31</sup> This was the number he gave me. This number has not been checked up against statistics.

resorted to for physical disorders/somatic diseases (i.e. coughing, diarrhoea, malaria etc.) and the folk sector was most frequently resorted to for psychosocial disorders (mental illness, impotence, bad dreams, business problems etc.). This seems to be the pattern in my material as well. Peltzer (1987:65) stated that the more the illness, symptom, or problem was attributed to supernatural causation the more likely the person would consult a traditional healer rather than western health institutions. When the woman woke up with a wound in her foot after dreaming of being attacked by a dog, the circumstances guided her to seek the traditional healer as it was clear to her that witches were behind her misfortune. Another example is the mother and her undernourished child. Due to her life situation, her social status, she thought witchcraft was the cause of her child's suffering. She had no close kin in the community to protect her; therefore she was an easy target for witches. Also, Peltzer's research showed that women tended to prefer the folk sector because women were less educated than men and were often contributors to the traditional feminine sphere. However, in this case the mother's financial situation made her seek treatment from the Health Centre as the Health Centre is free of charge. As described earlier, few people had much money to spare, and the fact that the Health Centre was free must be of huge importance for health seeking behaviour.

Peltzer (1987) would categorize Nurse Musanga as a *transitional person*. The expression means that "the person is in a process of crossing from traditional to Western culture and may temporarily turn back, particularly in times of crisis" (Peltzer, 1987:11). Transitional people in Malawi, according to him, are urban, middle class people. More educated people turn to healing churches because higher education is more compatible with Christian healing than traditional healing, Peltzer (1987) argues. Possession by the Holy Spirit is emphasised, and not possession by ancestors. "The Holy Spirit represents the Christian element and spirit possession represents the element from traditional religion"(Peltzer, 1987:55). Furthermore, Peltzer states that such churches are a good place for transitional people that may require traditional healing but are too westernised and christianised to seek a traditional healer. Although Peltzer's description of 'modern' people in Malawi in many ways describe Nurse Musanga, the dichotomy traditional/modern is somewhat outdated as one does not exclude the other, like the various empirical examples from Nyanja have shown. Harrie Englund's (2000) experience from his fieldwork amongst born-again Christians in Lilongwe could provide a vivid perspective on modernity, he says. Being born-again can be seen as severing the bonds of kinship, producing individuals instead. They can be viewed, like Peltzer did, as moving away from tradition by rejecting the village culture. Since born-again christians prefer

biomedicine over traditional medicine and condemn all traditional healers, Englund argues it is easy to conclude with dichotomies like modern/traditional, individual/society, town/village by following meta-narratives of 'modernity'. Englund concludes, however, that the cosmology behind what might appear modern and traditional in Malawi is the same, and the strong connection between village and town in Malawi is still present. The village is always 'home', and this is apparent in how the Chichewa word *mudzi* means both home and village. "The tradition-modern dichotomy... obscures the shared cosmology in the moral disputes between healers and born-again Christians, the abstraction of individualization makes it difficult to appreciate the embodiment of human and spiritual relationships, and so on." Although aware of the difficulties applying the notion of 'modern', I still suggest that how one wants to present oneself can be a factor in health seeking behaviour in Nyanja community. If someone wants to appear 'modern', like Nurse Musanga, he or she would choose treatment associated with modernity which is biomedicine and Christianity.

Gender is also a factor regarding the choice of treatment. According to Peltzer (1987), men seemed to attend the biomedical care more frequently than women because they were more educated and less engaged in the traditional reproductive sector than the woman. At Nyanja Health Centre the vast majority of patients were women and children. Most of the health activities offered at the Health Centre had to do with reproductive care<sup>32</sup> and child health. Because women are the caretakers in the family, women frequented the Health Centre more often than men. When looking at the number of people coming to take the HIV test, the number of women exceeds the number of men. This is of course in correlation with the fact that pregnant women who follow the antenatal program are in many ways forced to take the test. Also, the Health Centre portrays itself as a place for women where women should feel free, as the song shows (see page 24).

## Concluding Remarks

By introducing different social actors connected to the Health Centre and describing how they relate to the pluralistic aspect of health in this community; i.e. how biomedicine coexists and syncretise with other treatment alternatives, the aim is to provide the reader with a good backdrop for further reading. I showed that how health workers (nurses and HSAs) handle different clinical realities and explanatory models varies. I also pointed out how HSAs

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<sup>32</sup> ¼ of all women in reproductive age in this community made use of Family Planning techniques supplied at the Health Centre.

respond differently in different situations. At the Health Centre's nutrition program, Mr. Bwanali told the women not to waste time on traditional beliefs and rather rush to the Health Centre. Botomani, on the other hand, in another situation seemed to agree with a woman's decision to seek help from the traditional healer after being bitten by a dog in her dream. However, he did remind her to keep the bandage clean. Mr. Mwula did not oppose the traditional knowledge about sexual intercourse and measles when he was out in communities talking about the disease. He did, however, contradict the knowledge about not bathing as this opposed his biomedical knowledge. Mr. Ulili tried to convince women to be sexually active during pregnancy. He focused on the danger of HIV/AIDS; a danger witch seemed to fit the 'hot' versus 'cold' classifications of dangers concerning sexuality and pregnancy already existing in traditional knowledge about child health. Although HSAs 'preached' the word of biomedicine, several of the examples reveal an understanding and acceptance of different explanatory models and clinical realities which display a social closeness to the community. The same is symbolised by the scars from previous scarification practise visible on some of their bodies. Nurse Musanga, on the other hand, distanced herself completely from traditional treatment since she was a 'modern', born-again Christian nurse who viewed traditional healers as diabolic creatures. Still, she was well integrated into the commonsense rationality found in the community.

The health care system, as Kleinman explains, is viewed and used differently within the locality depending on social factors such as gender, class, education, religion, ethnicity, affiliation etc. I have addressed some general tendencies in choice of treatment in this community which fit Kleinman's way of addressing health seeking behaviour. In this community, the circumstances attached to disease was important for the perception of the disease, and therefore important for the choice of treatment. In addition I have revealed how gender, economy and social position were important factors in guiding a person's choice of treatment.

In the following chapter I will address the existing gap between people's expectations of the Health Centre and what the Health Centre is supposed to provide. I will illuminate this tension by further addressing face-to-face encounters between health workers and patients.

# 3

## Conflicting Authorities and Witchcraft Accusations

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A couple of months into my fieldwork I joined a community meeting regarding a cholera outbreak in the area<sup>33</sup>. Before this meeting I had only heard positive remarks about Nyanja Health Centre when talking to people in the community (mostly patients). After the meeting, however, it became evident that people did not always paint the whole picture to me. The meeting revealed disgruntlement concerning patient handling at Nyanja Health Centre. Therefore, I will take a closer look at the existing power relations in the community and how they affect patient handling at the Health Centre. I will analyse the dialectic relationship between power and resistance by using empirical examples from face-to-face interaction between health workers and patients and ‘backstage’ resistance from the community. In my discussion of power and resistance I utilise the theories and concepts of primarily Max Weber, Pierre Bourdieu and James C Scott. I argue that there is a gap between people’s expectation of the Health Centre and what the Health Centre actually can and is suppose to provide to the community, and that this gap leads to a lot of tension, anger and sorrow.

### Power and Authority

#### *Theories of power*

“Power is the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests” (Weber, 1968:53). To this classical definition of power, Weber adds that the concept of power is sociologically amorphous and he suggests that domination is a more precise term. Domination, to Weber (2003:311), is the probability of meeting obedience from a group after certain commands. A minimum will to obey, from internal or external interests, exists in every form of relationship of domination. Per Fuggeli, Grete Stang and Bente Wilmar (2010 (2003)), in a report witch seeks to discuss the notion of power in medicine, explain how

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<sup>33</sup> The cholera meeting will be discussed later in the chapter.

Weber divides power into legitimised domination, physical violence and constellations of interests. *Legitimised domination* is power based on acceptance from the subordinates, and this is the ideal form of power as both parties in the power relation appreciate and get advantages from this relationship. The power exercise is almost unnoticeable (Fuggeli et al., 2010 (2003)). Legitimised power/domination is better described as authority (notes in Weber 1963:61). Authority, in Weber's account, is tied to social positions and roles whereas power is tied to the individuals' personalities. Authority is a legitimate relation of domination and subjection (Dahrendorf, 1959:166). Per Fugelli et al. (2010 (2003)) claim that much of the relationship between doctor and patient, and health sector and society builds upon legitimised domination. The patients trust the doctor's knowledge, and because of the social position of the doctor, patients accept and get advantages from being the subordinate; to trust the doctor. This will soon be discussed more closely. In the following empirical example I will view Nurse Musanga at Nyanja Health Centre as an authority, a person with legitimised domination.

### *Nurse-patient interaction*

During my stay at Nyanja Health Centre I observed numerous interactions between Nurse Musanga and patients and neighbours in various settings. I will now present a nurse-patient interaction located in the nurses' office concerning family planning and antenatal examinations. Thomas and I observed six such sessions. The one I have chosen to present here does not represent a generalised picture of patient handling in this situation, but it reveals how it played out a couple of times.

It is Monday morning and several women sit outside the nurse's office waiting to attend family planning. Today, Nurse Musanga arrives 20 minutes too late. When she comes, she attends a neighbour before letting the others in. The neighbour needs to attend a funeral today, so she gets special treatment. When she is done with the neighbour, Nurse Musanga starts to prepare the needles for family planning for the awaiting women when the cleaner, Mr. Shaba, enters the room. He makes a joke telling her she is too early as he has not cleaned the room yet. He cleans and she prepares the needles whilst talking and joking. When he is done Nurse Musanga lets the women into the room.

The room is small, approximately 3x4 m. It contains two desks; one in the middle of the room with chairs on both sides which functions as the nurses' work desk, and another in the corner with an old computer given to the Health Centre "*from America*". Only Mr. Phiri, the Medical

Assistant (MA), knows how to operate this computer, and it is not used for medical records or any work connected to the health centre<sup>34</sup>. The room also contains an examination bench, a chest of drawers and a cabinet. On the wall above the nurses' working desk hangs a chart showing pregnancy measures. The walls are painted yellow and blue.

Thirteen women enter the room and it gets crowded. All of them take seat on the floor. Some carry children on their backs. The rest of the women who have showed up today, eleven in total, have to wait outside the room. Nurse Musanga sits on the chair close to the women on the floor. The desk is behind her, and not in-between her and the patients. She tells one of the women to say a prayer before they start the family planning session. After the prayer, Nurse Musanga talks about advantages of family planning. She tells the women that their and their child's health will be better due to family planning. With family planning they will have time to do more chores than if they are pregnant all the time, she argues. She tells the women about the family planning implant one attaches under the skin of the arm which will work for five years. Some of the women find this very interesting, but some have heard about side effects. Nurse Musanga replies that there are no side effects and that people who claim this are ignorant. She continues to talk about the challenges of bringing many children to this world and asks the women what if they (the mothers) die? "*Your children will become the burden of others*", she lectures them. One of the women on the floor uses herself as an example. She tells everyone that the young child on her back was born eleven years after she had her previous child. She knows of a woman who gave birth at the same time as her who is already pregnant again. Nurse Musanga tells the women that the government wants women to give birth to four children. Next she tells everyone about Norway. She tells them that there are four million people living in Norway and that 14 million are living in Malawi. In Norway they are rich, she says, because they do not give birth to too many children<sup>35</sup>.

Next, Nurse Musanga gives the family planning injections. It takes less than one minute to give out the 11 injections she prepared earlier. The women are prepared and have lowered their chitenge and skirt before they line up for the injection. When she is done, Nurse Musanga leaves the room. Then the women leave the room and a new group of eleven women enters. They sit down and wait. After 15 minutes Nurse Musanga returns and she prepares new needles whilst talking to the new group. This group does not receive a health talk. Nurse Musanga tells one of the women that she is dirty and smelly, and that she needs to take a bath

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<sup>34</sup> Although the MA did practise his computer skills by using health centre statistics to make diagrams etc.

<sup>35</sup> We had talked about Norway and how it was a rich country. I had also told her that Norway had 4, 5 million inhabitants and that an average family had two children.

before coming to the Health Centre. The woman replies that she cannot afford soap. Nurse Musanga tells her that she still has to bathe.

From the health passports<sup>36</sup> Nurse Musanga reads that one of the women present skipped the previous family planning session. Nurse Musanga accuses her of not taking prevention seriously and sends the woman away. Next, she gives the rest of the women their injection, except from the last woman in the line. The woman tells Nurse Musanga that when she is using family planning, be it pills or injection, she bleeds every day. Nurse Musanga calls her a liar, but she ends up giving the woman birth control pills anyway.

The next group of women who enters the nurse's office is pregnant women who have come for antenatal check up. They are eight in numbers, and they all take a seat on the floor. A Health Surveillance Assistant (HSA) enters. He wants to use the Health Centre electricity to charge his phone. He quickly leaves again. Nurse Musanga talks to the women about preparations for giving birth. These women are well into their pregnancies, so Nurse Musanga instructs them in what they need to bring to the Health Centre before giving birth. They need a basin, plastic cover for the bed and a razor blade. She tells them what to and what not to do while in labour. She says that she is the nurse, and she is the one who knows what to do. *"Nurses know when you will deliver, so do not nag and push the nurse"*, she says. *"Behave and respect the nurse. You need to push when it is time to push"*, she goes on, *"as the baby may be retarded if it is stuck in the uterus for too long. Then the baby will struggle with one plus one in the school"*, she laughs. The women also laugh.

Next, Nurse Musanga examines the women's abdomen. This is done more privately with only two or three women present in the room at the same time. The silence in the room is only broken when Nurse Musanga asks questions. The women reply quietly. She also checks if the women have had all their TTV vaccines. If not, they are sent to get it.

A new antenatal group enters. They are early in their pregnancy, new to the antenatal program and have all just done the tests required (STD<sup>37</sup> tests and malaria). When Nurse Musanga examines a middle aged woman, she yells at the woman when she cannot feel a child. Nurse Musanga accuses the woman of trying to fake a pregnancy to get a mosquito net for free<sup>38</sup>. The woman does not answer, but leaves the room quietly. Later, a 23 year old woman leaves the room after her examination and forgets to bring the tablets she just received from Nurse

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<sup>36</sup> All Malawians receive a health passport where all medical history is written down.

<sup>37</sup> STD is short for sexually transmitted diseases.

<sup>38</sup> The MSF provides free mosquito nets for all pregnant women following the antenatal program at the Health Centre. It is meant to be an incentive for women to enter the program.

Musanga. Nurse Musanga then yells after her out into the public “*Hey you! Don’t you have HIV?*” waving the pills at her. The woman bows her head and comes back to collect the tablets.

As I got the translations of the conversations from Thomas *after* the different sessions I could only write down numbers, actions, sounds and smells and try to describe the atmosphere in the room. Today it seemed like Nurse Musanga shifted back and from being funny and being harsh. Thomas agreed to this when I asked him if this was the case. He told me that in his opinion the nurse had been rude several times today and he characterised the episode with the HIV-positive woman as humiliating. Nurse Musanga was occasionally rude to patients, yelling at them in front of everyone, and when questioned, she replied “*I am the Nurse*”. However, I also observed sessions where Nurse Musanga joked with the women and the women felt free to talk about intimate subjects like sexual behaviour between themselves and their spouses; sessions where laughter, giggling and questions were the centre of attention. Still, when talking to people in the community, I sometimes heard complaints about this and the other nurse’s patient handling.

### *Existing power relations*

In a Weberian tradition one can view Nurse Musanga as having authority (i.e. power) because of her position as a nurse. In *Symbolic Power* (1996) Pierre Bourdieu describes hidden power relations. *Symbolic power* is an invisible power which is executed only by acceptance of those who do not wish to know that they are subjects of this power or that they themselves execute this power. *Symbolic power* is the power to constitute the given through utterance, to make others see and believe a world view, and through this view act within the world. *Symbolic power* is almost a ‘magical’ power which makes it possible to achieve what you can achieve by strength, this, thanks to the specific mobilising effect. According to the sociologist Johannes Hjellbrekke (2010 (2003)), the struggle of *symbolic power* is in many ways the struggle of what conception of the social world should be ‘true’, since such power has the possibility to enforce certain classificatory systems and categories of perceptions as social truths. For instance, is biomedical knowledge more valuable than traditional healing knowledge?

Weber and Bourdieu both describe an almost unnoticeable power relation; ‘hidden’ or ‘magical’. They describe a power relation where both parties, the patients and the health

workers, accept the relationship. The medicalisation critiques (loosely named by Deborah Lupton (2000), Professor in Cultural Studies) are those negative positioned to the medicalised society,<sup>39</sup> and they regard power as ‘belonging’ to some social groups. The critique sprung out from the social movement in the 1960s and 1970s influenced by Marxism and liberal humanism advocating individual freedom, human rights and social change. In their opinion, high status occupations have power over others, thus doctors<sup>40</sup> have power over their patients. The medicalisation critique view biomedicine as something negative, as something taking away individual freedom over own health, as something ineffective to many medical conditions, as something providing side effects, as something which, regardless of all this, increasingly amasses power and influence (Lupton, 2000). The motivation behind this oppressive behaviour is greed for more power. The patients belong to a vulnerable group because of their lack of (medical) knowledge (Lupton, 2000).

In the case with Nurse Musanga, I would argue that the view of power as a relationship benefiting both parties (Weber) and the view of power as oppressive behaviour (medicalisation critics), are both present to different extents. When looking at the actual interaction in the room; on the rhetoric used by Nurse Musanga and the subordinate position of the patients, one can recognise the medicalisation critique. However, if one look at the bigger picture and also regard the health benefits given to the patients in the long run, both parties benefit from the relationship, and maybe this explains why patients do come back voluntarily despite risking poor patient handling. Additionally, positive experience of biomedicine helps explaining the demand. However, when health workers behave this directly towards their patients as Nurse Musanga does; refusing to give them family planning injection, telling them that they smell and emphasise how she is the nurse and therefore others must do as she says, it is hard to recognise the *hidden or magical* power relation.

To understand Bourdieu’s concept of symbolic power one needs to understand his notion of capitals. Bourdieu has widened the concept of economic capital, and argues that it exists five recognisable capitals (economic, cultural, social, political and symbolic) which are all important in the field of power (Fuggeli et al., 2010 (2003)) . Symbolic capital is whichever

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<sup>39</sup> Zola (in Kleinman 1980:40) argued that modernization has a tendency to include within the health care system more and more problems traditionally located in other cultural systems. He termed this process mediatisation of modern society.

<sup>40</sup> Medical Doctors did not exist in this community. The MA and the nurses where those with highest bio-medical education present, thus I analyse them in the same manor as doctors have been analysed in western societies.

capital recognised, approved and valued by social actors through the perception-categories provided by those holding the symbolic capital, without being recognised as a capital (Bourdieu, 1996). Why does a person get to dominate and how does a person acquire authority (meaning power through position)? The accumulation of capitals can be invested in the struggle over power (Hjellbrekke, 2010 (2003)). Bourdieu (1986) defines capital as “accumulated labour (in its materialized form or its ‘incorporated’, embodied form) which, when appropriated on a private, i.e., exclusive, basis by agents or groups of agents, enables them to appropriate social energy in the form of reified or living labor” (Bourdieu, 1986:46). The capitals, to him, are what make the games of society something other than the games of chance. “Capitals [...] as a potential capacity to produce profits and reproduce itself in identical or expanded form [...] is a force inscribed in the objectivity of things so that everything is not equally possible or impossible” (Bourdieu, 1986:46).

As further ethnographic descriptions will include the Medical Assistant, Mr. Phiri, I include him to this analysis of *power* and *position* using Bourdieu’s notions of capitals. Fuggeli (2010 (2003)) shows how doctors are well disposed in almost all the capitals recognised by Bourdieu. Doctors have high *economic capital* due to their high wages. In many ways the wage corresponds with their high investment in education- a *cultural capital*. Cultural capital is shortly put as refinements and education, and a doctor has a long education and is often well equipped in this capital. *Social capital* is the power potential you have if you are a member of a powerful group or family or profession which has accumulated money, influence, acknowledgment and network through generations. Doctors inherit social capital through their profession. The last capital is *symbolic capital* which makes a person able to influence others to have the same opinions and views as one self (Fuggeli et al., 2010 (2003)). *Symbolic capital* should be understood as a potential extra dimension of the other capitals if those are unrecognised as capitals (Hjellbrekke, 2010 (2003)). As Bourdieu explains it, “Symbolic capital is to be unrecognised as capital and recognized as legitimate competence, as authority exerting an effect of (mis)recognition” (Bourdieu, 1986:49). Symbolic capital and symbolic power are important notions when talking about doctors. Fuggeli (2010 (2003)) claims the symbolic power is best executed within systems of Weber’s legitimised domination.

Nurse Musanga and Mr. Phiri are close in Bourdieu’s *social space*. They are what the Marxist would classify as actors of the same *class*. Class according to Bourdieu (1995), however, is

not a truth, but a methodological tool to display distinctions in the social room. Nurse Musanga and Mr. Phiri's economical capital is much greater than the majority of their patients<sup>41</sup>. They have technological advantages like electricity, TV and DVD player, radio, freezer and music player which might be recognised as power symbols (Bourdieu, 1996). Additionally, they have nice housing arrangements. The health workers' clothes and shoes, the food they eat and the ability to keep a house-girl, are also a display of their economic- and cultural capital. They have a higher accumulation of cultural capital than most of their patients through a long and valued education. An important aspect of cultural capital accumulation in Malawi is English skills, which most often is acquired through a long education. In Malawi English is the language of the 'connected' and the educated. Without English, people miss a lot of written information one for instance will get through newspapers (although, most villagers could not afford newspapers anyway due to low economical capital, and thus newspapers were not sold in the village). Higher education is their institutional cultural capital. Their education can be cashed out in occupation and their occupation gives them institutional backing (Bourdieu, 1986). As Fuggeli (2010 (2003)) claims, doctors inherit social capital through their occupation since their occupation has a long tradition of being regarded highly by the society's members. The same can be said for nurses and medical assistants in Malawi. Through these capital forms, Mr. Phiri and Nurse Musanga can also be said to possess *symbolic capital*, and in the patient-health worker interaction this is maybe the most important capital. They have symbolic capital because their patients acknowledge, have faith and trust their medical knowledge. The capital relationships are power relationships without being perceived as such, but instead being perceived as something desired. By not questioning the power structures in his society the subordinated uphold his own position (Hjellbrekke, 2010 (2003)). Because of their high accumulation of all the capitals, Nurse Musanga and Mr. Phiri have the opportunity to impose their world view on others. This is symbolic power/ authority. Through this power their knowledge and experience is desired by the patients.

In the following case, I will discuss if one can recognise Bourdieu's notion of *symbolic violence*, i.e. the power to inflict or legitimise a hegemony (through the symbolic systems i.e. tools for communication and knowledge), and therefore secure one class' hegemony over

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<sup>41</sup> They have much more money than most patients, but still they are struggling to make ends meet. For instance, Nurse Musanga has to pay school fees for private schooling for her son as well as for her sisters' son. She has small businesses on the side, like making 'freezies' and knitting baby clothes for sale.

another through the use of one's own strength as backup for those power relations already existing, further contributing to the 'taming of the under classes' (Bourdieu, 1996:42).

### *The Medical Assistant and Agogo*<sup>42</sup>

A young boy suffered from malaria. He was brought to the Health Centre a Friday evening by his Agogo. The Health Centre was closed, but Agogo found Mr. Phiri on his way back to his house. Mr. Phiri, however, did not want to treat the boy. Agogo insisted, but to Mr. Phiri this did not look like an emergency, so he told Agogo to bring his grandson back on Monday during opening hours. Sunday evening the boy died.

Agogo gets angry and disappointed with Mr. Phiri. His grandson is dead because he was refused medical treatment. Agogo talks to the Health Centre Advisory Committee (HCAC) and they arrange a meeting between them, Agogo, Mr. Phiri and Nurse Musanga. The HCAC consists of a handful of respected people from the community and three of them are present; two men and one woman. The meeting takes place one week after the boy was refused treatment. Agogo is dressed in a clean brown suit. The suit is old and faded by the hot Malawian sun and it is a couple of sizes too big for the skinny man. Mr. Phiri is wearing his clean, white medical coat.

The meeting takes place in the nurses' office. Firstly, Agogo explains his side of the story; how he came to Nyanja Health Centre late in the afternoon, met Mr. Phiri who was on his way to his house, and how the grandson was refused treatment because Mr. Phiri did not think the child was ill enough. Agogo ends his explanation by asking Mr. Phiri how it is that he (Agogo), this Monday, had to bury his grandson who, according to Mr. Phiri, was not ill.

Mr. Phiri replies that this is wrong. He says he never said the boy was not ill, he said it was not an emergency and this is why they had to come back on Monday. He goes on saying that this is not a hospital, this is a health centre. They have working hours to follow. Outside working hours they are only supposed to treat emergencies like bone fractures, burn damages, heavy bleedings and labours/abortions. They do not consider malaria to be an emergency if the child is conscious, he says.

Agogo then replies that this cannot be right because in the past (with a different MA) they used to come at night and the MA would help them. Agogo accuse Mr. Phiri of making up new rules. Now Mr. Phiri gets a bit annoyed and raises his voice and says:

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<sup>42</sup> Agogo means Grandfather in this context.

*I am not here to please anybody! I am not here to kill anyone's child. I work according to what I was taught in school, and I am very good at it. I am not anyone's slave. I do not have to work here. My former classmates are working in Blantyre<sup>43</sup> and have nice houses. I love this community and I chose this community. That is why I am here. I am employed by the government and not by you (the villagers)!*

After this speech there is not much of a discussion. Nurse Musanga backs up Mr. Phiri in explaining that the working hour differs at a health centre compared to a hospital. The HCAC concludes that it is necessary to inform people about the working hours and the rules for the health centre. They say that they should go to the Traditional Authority to see if they can gather all the Group Village Heads and Village Health Committees and explain this to them and let them spread the word.

Agogo shakes his lowered head. He says he wants to go home and discuss the meeting with his family and see if they want to bring the case to the District Hospital.

This conflict was obviously a difficult one. Agogo felt his family was wrongly treated since the boy did not get medical assistance. Agogo and others could not understand how a health centre can close when illness can occur at any time, day and night. Even though this had a tragic ending, Mr. Phiri acted according to his job description. The Health Centre had fixed working hours and Mr. Phiri was only supposed to help at night and during weekends if he defined it to be an emergency. Every weekend people were knocking on his door asking for help in the middle of the night. Some situations were emergencies and some were not. As the boy was conscious, Mr. Phiri did not regard it as an emergency. The case showed the frustration of a health worker and of a caretaker who were both victims of the troubling health sector in Malawi, but who were in different position to handle the situation.

Hjellbrekke (2010 (2003)) is viewing the doctor-patient relation in terms of Bourdieu's *symbolic violence relation*, meaning a relation where symbolic capital and symbolic power is dominant. Such relations are based on concepts like trust, duty, honour, prestige, acknowledgment and reputation. Hjellbrekke (2010 (2003)) claims that by the appearance of it, the relationship between a doctor and a patient is a relationship of symbolic violence

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<sup>43</sup> Blantyre is the second largest city of Malawi. It is the centre for finance and commerce and has more than 700 000 inhabitants.

because the patient is in no position to question the doctor's knowledge. The patient finds himself subject to the categories of perception and tool of knowledge the doctor offers. And the doctor is the executer of symbolic power. But is it *symbolic violence* (favouring the dominant part in the relationship)? It is a hard claim to make, he states. If one truly is ill and the doctor presents a correct diagnosis, it will not be beneficiary health-wise to protest against the doctor's knowledge. In situations like this the dominated will harvest from being dominated. At Nyanja Health Centre this is true most of the time. Although patients sometimes are harshly spoken to, experiences humiliation and are in no position to question the MA and the nurses, patients do get medical help which will benefit them and their families. If analysing symbolic violence relation in the same manner as Hjellbrekke, I, however, argue that in the case with Mr. Phiri and Agogo symbolic violence was present. Agogo did not get help from Mr. Phiri when his grandson was ill. He was in no situation to demand anything from Mr. Phiri because of uneven capital accumulations and thus uneven power relations. Agogo had to accept whatever decision Mr. Phiri made. This was, as it turned out, by no means beneficial to the patient. In this case the medicalisation critique's image of Mr. Phiri as a figure of power and Agogo as a helpless caretaker is recognisable.

So far I have argued that Nurse Musanga and Mr. Phiri have a higher accumulation of what Bourdieu recognises as capitals than most of their patients, thus providing them with symbolic power. To what extent this power turns in to symbolic violence varies. In Bourdieu's words (1996) symbolic power is almost magical because it is desired from both parties of the power relationship and almost invisible. Does this mean that the patients are all accepting the nurses' and the Medical Assistant's part in the power relation which is sometimes characterised through threats and acts of violence? Do they not question their behaviour? In the previous case a confrontation was at display. Agogo was questioning Mr. Phiri's medical judgement and he was questioning the rules of the Health Centre. However, his question was soon silenced by Mr. Phiri's knowledge, position and speech.

### *Silenced?*

Using James C Scott's concepts and descriptions of the relationship between poor and rich in Malaysia, I suggest a possible explanation to the question of silence; Agogo became silent to sustain his social insurance. In *Weapons of the Weak* (1985) Scott presents an empirical insight to the Malayan village of his fieldwork and analysis. He portrays the dynamics

between the poor and the rich and the expectations those two poles have to each other. Scott uses the story about a poor man and a rich man, both acting outside the social norm of the society, to illustrate the use of propaganda. The poor man is portrayed in the society as lazy, rude, thief-like and everyone openly looks down on him. The rich man is portrayed in the society as living in the same social manner as the poor man, not allowing himself to spend any of the enormous amount of money he has accumulated, thus being greedy. The way he has accumulated the money is un-Islamic, and he is not handing out anything to charity or giving the society a helping hand. To the rich, all the poor people in the society are heading the same direction as the poor character portrayed in the story. And to the poor, all the rich people are heading in the same direction as the rich character portrayed. The stories embody a critique of how things are, as well as a vision of how things should be. "They are attempts to create and maintain a certain view of what decent, acceptable human behaviour ought to be" (Scott, 1985:23).

If the rich actors in the society portrayed themselves as nothing like the rich character, they would lend money with good terms, be generous and give to charity and feasts and hire more workers. The benefit for the poor is obvious. If the poor actors on the other hand portrayed themselves as nothing like the poor character, they would work hard, not come to feasts uninvited, not beg, and be helpful in general. The benefits for the rich are obvious. If this would become practice, the society would become a utopia. However, this is not reality. Scott asks; how important is it to protect your name, your reputation? In the end, he claims, the unequal power balance plays a large part in answering this question. The rich have the social power to impose what they think is decent behaviour upon the poor. The poor have no power to impose much on the rich. Scott (1985) argues that good behaviour is like a social insurance policy for the poor. Good behaviour will bring everyday-rewards in form of charity and employment offers. The rich need little or nothing from the poor, thus reputation is not as important.

The aspect of good behaviour as a social insurance could be argued to have relevance at Nyanja Health Centre as I suggested with reference to the case with Agogo. Put rather bluntly, good behaviour could give you medical advantages like access. As made clear from my empirical examples, the health workers do have the power to chose who gets treated and who does not. Nurse Musanga threw a woman out from the family planning program with accusations of not taking prevention seriously. Also, who gets treatment after opening hours

seems rather arbitrary, but that is not necessarily the case. It depends on various aspects like the mood of the health worker or acquaintance. Maybe the chances of future treatment will get ruined by arguing with health workers, and maybe to show respect and act subordinate will be a good investment for future emergencies. This could explain why people remain silent when being humiliated or poorly treated during a medical confrontation.

In the following, I will explore the side of the power relation at Nyanja Health Centre illuminating the dialectic relationship between power and resistance. By taking a closer look on the community I will present ways of opposing and resisting. The next case I present shows an arena outside the domain of the Health Centre where the villagers (patients) dare to speak up against poor patient handling.

## The Voice of the Patients

### *The community meeting*

In March, Nyanja Health Centre won a competition held by the Medecins Sans Frontieres (MSF), and now they could call themselves the best Health Centre in the district. The victory was based on activities supervised by the MSF like cleanliness, reports, collaboration etc. All of the workers at Nyanja Health Centre were given t-shirts with prints saying they were winners and they received Fanta, snacks and a trophy<sup>44</sup>. Everyone, especially Mr. Phiri, as he had done his best to inspire the workers, was proud of this achievement. This was during the same period as a cholera outbreak.

A week into the health workers newly found confident and pride due to the competition they won, there was held a large community meeting near the local court to inform everyone about the cholera outbreak. All the village heads, group village heads and other important community members in the catchment area were invited. A representative from the District Hospital was also present. It was an open meeting, and many people from the community gathered underneath the large mango tree across the path by the local court. I would estimate that close to two hundred people were present. The women sat together and the men sat together. Since men and women were so clearly divided I chose to sit together with the female

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<sup>44</sup> The trophy was stolen from the MA's office and a police investigation followed. It turned out to be a patent who had stolen it because it was shiny and nice to look at.

HSAs amongst the other women. Thomas sat together with the men<sup>45</sup>. At the top of the location important people like the village heads and the district hospital representative sat on chairs and benches. The MA and the nurses did not attend, but the Health Surveillance Assistants (HSAs) did. Two senior HSAs, Mr. Mwula and Mr. Mulli, sat upfront with the important people while the rest of the HSAs sat on the ground amongst the audience. Several of the health centre workers wore their new t-shirt to this meeting. The two senior HSAs gave a health talk about what is important when dealing with cholera.

After the health talk, the senior HSAs opened for comments and questions from the audience. It all begun with a discussion about what to do when certain religious groups refused medical treatment. This was of current interest because a man belonging to the Zionist<sup>46</sup> community had just died from cholera.

*Man 1:* How can you help religious groups that don't want to seek hospital help?

*Senior HSA Mwula:* These religious groups were founded in the cities and they are spreading out into the villages. They deny anyone to add chlorine to the water, but in the cities they drink tap water where chlorine is added.

*Man 2:* The Bible encourages us to go to the hospital. Just think of The Good Samaritan<sup>47</sup>!

*Man 3:* The village heads should chase people of such beliefs (those who do not seek medical treatment) from the villages!

*Man 4:* Village heads should get to know beliefs before they are implemented in the village.

*Man 2:* We can't be in conflict with God for going to the hospital. Prayer is good, but you can still go to the hospital.

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<sup>45</sup> In this case I have used another narrator technique because I could not communicate with my assistant since we had to sit apart because of the female/male divide during the meeting. The quotes are from what he wrote down in his notepad.

<sup>46</sup> Zionists are a religious group who deny any medical treatment.

<sup>47</sup> Luke 10:25-37 in the Holy Bible.

*Man 4:* Often villagers are sick, but caretakers do not take them to the hospital. They speak in tongues, but do not bring them. Village Heads, you have to do something!

*Senior HSA Mwula:* It's true. They are hiding from the HSAs, but you can hear them pray at night!

*Pastor:* Everyone should go to the hospital. It is a loss to any church to lose one of its members.

*Village Head 1:* Thank you all for this message. I will inform the villagers. My own sister was staying with a religious group who did not want to take her to the hospital. So I came and brought her myself, and she became fine. It is the duty of everyone to bring ill people to the Health Centre!

*The District Hospital Representative:* Rush to the hospital! We need teamwork between Village Health Committees. You should share information. This case (the cholera death) was not reported quickly enough!

So far only men from the audience had spoken. Next, the women spoke up and they were clearly not satisfied. They were cheering each other on by clapping and making high pitched cheering sounds with their tongues. The women were not satisfied with the HSAs and the way they were treated by the nurses and the MA.

*Woman 1:* They (the HSAs) do not live in the village they are responsible for. They are pompous. They don't want to live without electricity. The Village Heads should look for houses for the HSAs within the community!

*Woman 2:* The nurses are shouting in the maternity ward. I know a woman who was forced out of bed for not pushing properly!<sup>48</sup>

*Woman 3:* I came to the health centre with three sick children but only two got treatment. Can the MA send back patients?

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<sup>48</sup> I observed a delivery where Nurse Musanga forced the girl in labour to run around and jump up and down. The baby was stuck in the vulva and the situation was critical. Nurse Musanga went from encouragement to threats and physical violence (slapping, pinching and pushing the girl) the more critical it got. Finally, Nurse Musanga threatened to open the girl with a razor blade without closing her afterwards. This was a deliberate strategy to make the girl push. The girl got so scared and pushed so hard that the baby came out and survived....The nurses did not have much equipment to handle difficult deliveries.

*The District Hospital Representative:* Well, sometimes people come to the health centre only for the medicine without anyone being ill.

This comment was not taken well. The women booed and yelled that this was not true!

*Woman 4:* I once came at night and was sent back. I was told that the health worker was tired!

*Woman 5:* I came to the health centre with a child at five in the afternoon and they could not help me. My Village Head had helped me with transportation and everything!

*Village Health Committee:* This particular episode had been discussed, and it was agreed that people who were very ill should be helped regardless of time. But the health workers are human beings, and they do get tired!

*Woman 4:* That doesn't make sense! You have to help the people regardless of time. What about shifts?

Some men are talking amongst themselves and they are commenting on how hard Mr. Phiri is working. The District Hospital representative ends the meeting by telling the HSAs that they have three weeks to find a house to live in within their catchment area. The HSAs find this meeting demoralising, and walk back to Nyanja Health Centre with lowered heads, not acting like winners anymore.

The next week I went to see one of the Group Village Heads to find out what she thought about the meeting. She welcomed me and my assistant and we sat down on a mat underneath a tree in her backyard. She told me that she often got complaints from villagers concerning the Health Centre. Most complaints were about the nurses, the youngest in particular (Nurse Musanga), and the MA (Mr. Phiri). Pregnant women felt badly treated by the nurses. The nurses would shout and be rude to the women, she told me. The Village Health Committee (VHC) in her area wanted to go to the District Hospital and file a complaint against the nurse, but she (the Group Village Head) had stopped them. She wanted to give the nurse a second chance. She had addressed the problem with the nurse before, and she said she would change. The nurse had been working very hard, 90 days and nights in a row, and was tired; hence the yelling. However, the Group Village Head had received complains this week also, so they had to do something soon, she said.

A man who sat on the porch ten feet behind us was following the conversation. At one point he entered the conversation. He wanted to tell me his story with the MA. He had been very ill with malaria and needed a drain. The MA put the drain in and told them to come and get him if something happened during the night. At night the drain stopped dripping, and the watchman went to get the MA. The MA told the watchman to fix the drain for him, something the watchman did not know how to. The patient and the watchman then decided to pull out the drain as they did not know what else to do. The next morning when the MA came to check on him he got furious with them for having taken out the drain and then ignored him (the patient) until lunch time.

The Group Village Head called the medical system Chinese<sup>49</sup>. “*There are many young men and women in the medical system now*”, she said. “*In the past the medical personnel were more mature*”. She asked if maybe the youngness was the reason for the poor quality. The Group Village Head also told us how the MA dismissed her when she wanted to meet him and thank him for letting her and other community members use the static clinic room when discussing human rights. I was there when this happened. He was closing up when she came up to him. He did not look at her, just told her that she had to come back during opening hours.

The man sitting on the porch behind us told me that many people were very furious with the MA, and if he did not change his behaviour, he would get beaten.

The cases described above reveal an arena where the villagers/patients have a voice; an arena where they express or actually yell out what they do not express in the face-to-face relation with the health workers. Also, they bring their concerns to the Group Village Heads. The Group Village Head is another figure of authority in this setting, and is maybe best described by referring to Weber’s notion of *traditional dominance*; an ideal type within the legitimate dominance/authority. To be a Group Village Head means to have legitimacy because of the traditional position one is placed in, and because of this traditional position one exercise authority with acceptance from ones subordinate (Weber, 2003:314). One can, through the empirical evidence, detect an underlying conflict between this dominance anchored in

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<sup>49</sup> Many used the term ‘Chinese’ when something was of bad quality.

tradition, and the authority vested in the health workers which is acquired through their position, role, and capital accumulation. The two wings of authority seem to represent what might be called 'tradition' and 'modernity' since health workers are representing biomedicine and the state, and thus something modern.

The cases show that patients do not accept poor patient handling and being humiliated by the health workers. Where Bourdieu (1996) talks about acceptance of power relations because of a shared world view with the dominant part in the relation, Scott (1985) has taken a closer look on the actual resistance that does take place in, or behind, the face-to-face encounters. Resistance for him is not merely intentional, selfless, organised and with revolutionary consequences. The most common resistance requires no coordination or planning; it often represents a form of individual self-help and avoids direct confrontations with authorities, and does not change much of the power balance. Yet, Scott argues "just such kinds of resistance are often the most significant and the most effective in the long run" (Scott, 1985:xvi).

### *Weapons of the witches*

When talking about the uneven power relation existing in a rural Malayan village, Scott (1985) shows how the rich are not without sanction. Although the rich get away with almost everything, the rich cannot escape gossip. Scott (1985) writes that gossip, slander and character assassination are symbolic sanctions (as apposed to material sanctions). In the following case I will describe how Nurse Musanga reacted when rumours concerning her person and intentions were going around.

During the first months of my stay, Nurse Musanga prayed with a Fellowship every Sunday. They prayed in the maternity ward at Nyanja Health Centre. The newly fledged mothers were asked to join or to leave and come back after the worshipping. In the beginning the Fellowship had around 15 followers, although the number decreased over time.

After the worshipping one Sunday, Nurse Musanga asked if I could run down to the house and place the chickens inside for the evening. I ran down and did my best in chasing the chickens in the right direction. After a little while, Nurse Musanga found me still struggling with the task. She looked upset, but not because of my inability to handle the chickens. She told me that the pastor told her about a rumour going around about her and Mr. Phiri saying they were

satanic people<sup>50</sup>. Two women had lost their babies in labour the previous month and Nurse Musanga had been the midwife of both deliveries. Therefore the women thought she intentionally killed their babies. Nurse Musanga asked if I remembered that she told me about this when it occurred, and I did. She came down after the first stillbirth and explained how the mother failed to push so the baby suffocated. And in the second stillbirth, there was no life in the womb two days prior to the birth. Because of the accusations the Village Health Committee wanted to go to the District Hospital and file a complaint against them, Nurse Musanga told me. Mr. Phiri was accused of being satanic because he did not get up at night to help people. Nurse Musanga said she was a victim because of her membership in the Fellowship. Several people thought the Fellowship was satanic. Nurse Musanga was convinced those who accused her were witches themselves.

The previous week the pastor of the Fellowship's helper, Andrew, had had a dream. He dreamt that someone tried to kill him in his sleep<sup>51</sup>. He woke up and stormed out the door to find and kill the man who just tried to kill him. But he stopped himself and prayed to God instead. A few days later the man who tried to kill Andrew died. The Fellowship read this as a sign from God that He was on their side.

Now, Nurse Musanga told me that although they saw it as a sign from God, others thought that the Fellowship worshiped Satan, and that Satan killed that man. Since Nurse Musanga prayed a lot with the Fellowship, people thought she was satanic too, she explained. Next, she told me that she no longer wanted to make friends in this place<sup>52</sup>. She would go to work, treat her patients, smile to her neighbours, but she would not mean it. You never know what they can do to you, she said. The witches were mad at the Fellowship because they prayed so much that the witches could not hurt them<sup>53</sup>.

The following Tuesday a neighbouring woman, who had brought Nurse Musanga and me fruits and vegetables several times before, came down with a basket of Guavas<sup>54</sup>. Due to the recent accusations, Nurse Musanga had grown sceptical of such gifts, but she accepted the basket. She smiled and said "*Zikomo kwambiri!*"<sup>55</sup> However, when the woman left, Nurse Musanga went out behind the house and threw the Guavas into the maize field. I asked her why she threw away the fruit. She told me that she was afraid of the food because it might

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<sup>50</sup> She used both the word 'satanic' and 'witch' to describe the accusations.

<sup>51</sup> To be killed while one is dreaming means one are killed in 'real' life as well.

<sup>52</sup> Note she is fairly new to this community.

<sup>53</sup> Prayer kept witches away.

<sup>54</sup> A delicious tropical fruit which grew wild in Malawi

<sup>55</sup> It is Chichewa for Thank you very much!

have been poisoned or bewitched. Then she said “*People smile in their faces, but you don’t know what’s hiding underneath*”.

The following week was Nurse Musanga’s week off. I had been out with the HSAs when I came back to the house and found Nurse Musanga sitting behind it. She normally sat on the porch in the front of the house talking to by-passers while she prepared food or did needlework. Today she was hiding from the patients at the Health Centre. The nurse on duty had gone home early, and the patients would come down to Nurse Musanga if they saw that she was home in order to be helped. Nurse Musanga was tired and demoralised from two weeks of accusations, both from the community meeting and the satanic rumours.

At times Nurse Musanga helped patients when the other nurse had gone home early for the day, or if the patients came in late. If one patient came to her house, which was located next to the Health Centre, others would see it and follow, thus making it hard for Nurse Musanga to say no. As she was more educated than the Medical Assistant, Mr. Phiri, she could also assist his patients. Occasionally she had to do his part at the Health Centre if he was attending a funeral etc; therefore people knew that they could also come to her. At night, whenever Mr. Phiri did not get up to help people who needed or wanted his assistant, people would come knocking at our bedroom window begging for help. When people did this, Nurse Musanga would sometimes yell at them and call them stupid because people were supposed to use the watchman. The watchman would wake her up by gently knocking on our window saying “*ody, ody*”, and he would assist her to the Health Centre in the dark. She was afraid of going out without him. On one hand, Nurse Musanga expressed to me that she wanted to help. On the other hand, it was not her duty. And also, she needed to rest and to draw lines so that people did not seek her help in the middle of the night unless there was an actual emergency.

Symbolic sanctions as a result of gossip, rumours and negative talk behind health worker’s backs affect them, as showed in the latter case. Scott (1985) argues that poor and rich need to share a world view for the gossip to have an effect. “Neither gossip nor character assassinations, for example, makes much sense unless there are shared standards of what is deviant, unworthy, impolite”(Scott, 1985:xvii). Through gossip and rumours the patients were viewing Nurse Musanga as a satanic person, as an unholy creature, as something she herself despised. In J.W.M van Breugle’s accounts of witchcraft amongst Chewas in Malawi he says that “one of the greatest insults is to call someone a *mfiti* (witch)” (van Breugel, 2001:223).

van Breugel describes that *mfiti* is the personification of moral evil, and men can 'have evil in their heart'. Scott (1985) further argues that resistance in form of character assassination has the intention to recall the 'offended' to a different standard of conduct or to her social standing and influence.

## Resistance 'Face-to-Face' Versus Resistance 'Backstage'

What is shown through the various cases is that resistance is not done in face-to-face relations with the educated health workers; the nurses and the MA. When only analyzing the face-to-face interaction between the health worker and the patient, it seems like the patient silently accepts poor patient handling. If this acceptance is a result of a shared world view imposed by the health workers dominant position in the power relationship can be discussed. As Scott (1985:287) puts it " Much of the ethnographic material supporting the notion of "mystification" and "ideological hegemony" is, I suspect, simply the result of assuming that the transcript from power-laden situations is the full transcript". When looking at actions on social arenas outside the face-to-face encounters at the Health Centre, the empirical evidence shows that the acceptance is not as silent as it might appear.

The first case (the nurse-patients interaction) at the Health Centre portrays the patients as silently accepting Nurse Musanga's authority. The second case (MA and Agogo) is situated in a formal context with the Health Centre Advisory Committee present, and here Agogo protest and questions Mr. Phiris expertise, but is soon silenced. The latter cases portray the voices and the resistance made by the community members outside the Health Centre. Through gossiping and spreading rumours people affect the health worker when they portray them as something deviant and impolite according to their shared moral standards. The patients are also making use of traditional authorities and public meetings to express their dissatisfaction, occasionally with an effect. After anonymous complains from a village, District Hospital Officials paid Nyanja Health Centre a visit and talked about patient handling, work ethic, and policies with the health workers. They emphasised that the health workers were there to serve the people of the land, and not the other way around. Additionally, people told me that the previous Medical Assistant was chased from the Health Centre. However, if a health worker does not do his or her job in a satisfactory way according to the job-description, the sanction is relocation organised by District Hospital Officials. To fire health workers, especially MAs and nurses, is difficult because of the major lack of them. Maybe this is why the HSAs ended

up being the 'losers' after the community meeting. The public showed dissatisfaction with the nurses, the MA, and the HSAs. Only the HSAs had to sacrifice something in this situation. Many HSAs were forced to move from their families into their catchment area receiving houses with much lower standards than before. Many of them thus had to leave the small business they had on the side, making them suffer financially. HSAs must be easier to replace than nurses and MAs due to the lower level of competence and the shortness of their training; thus filling a different role in the community from the nurses and the MA. This aspect will be discussed more closely in the following chapter.

## Concluding Remarks

In this chapter I have addressed the tension present concerning questions on patient handling and patient rights. By positioning the health workers in relation to community members by using theories of authority and power, I have showed how the uneven power-relation is played out. Throughout this chapter I have argued and showed that there is a gap between people's expectations of the Health Centre and what the Health Centre actually can and is supposed to offer people, and that this gap is very much attached to the question of opening and working hours. This becomes especially evident through the cases of Agogo and Mr. Phiri and the community meeting. People ask why they do not get help, and say it does not make sense that a health centre closes -because people get ill at all times. The helplessness of those patients who do not get helped, illuminates the existing power relationship based on positions in the society which at times becomes a relationship of life and death. Through the various cases I have showed how the resistance is expressed differently at different arenas. In analysing the face-to-face relation between the MA, Nurse Musanga and patients, Weber and Bourdieu's notions of power have been useful. However, outside the domain of the Health Centre, one recognises a resistance which I have analysed through Scott's understanding of resistance.

What more is portrayed in this chapter is the frustration of the two poles (the one demanding service and the one providing service) of the troubling health sector in Malawi. As the empirical examples reveals, the gap between expectation and reality leads to tension, anger and sorrow, which further generates resistance in various forms. Although the resistance is directed and focused on mainly two social actors (Nurse Musanga and Mr. Phiri), these social actors represents the Malawian government, and as such one can read the resistance as a

critique directed at the government which is not able to provide primary health care to its subjects in a satisfactorily manor. Change is the desired consequence to the resistance.

In this chapter I have focused on Nurse Musanga and the Medical Assistant, and I chose to portray the negative tendencies in their relationship with the community. This I have done to illuminate the existing tension present which is real. By making a clear, but also somewhat simplified, division in position and power between the MA and Nurse Musanga and the community, I wish to make my argument regarding the Health Surveillance Assistants and their in-between position in the community clearer. This I will turn to in the next chapter.

# 4

## Health and HSAs

### - Between the formal sector and the community.

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The HSA is the point of contact between the formal health sector and the community. As such, information and new ideas in the preventive health sector that trickle down the ladder from the Ministry and from research has to be implemented at community level via the catalytic functions of the HSA (Kadzandira og Chilowa, 2001:12).



Photo 6: An HSA conducting outreach health talk

In this chapter, health activities related to the Health Surveillance Assistants' (HSAs') job description will be presented. I will discuss several important aspects for achieving successful child health attendance. First, I will analyse the role of HSAs within the local community by portraying challenges, weaknesses and strengths in how they perform their duties. I argue, by analysing their status in Bourdieu's capital terms, that much of what they lack in symbolic power or authority, they might compensate for in their collaboration with the traditional authorities. Next, I address social aspects of child health in the community and I portray other sides to it than the purely medical. I argue that under5 clinics<sup>56</sup> are social arenas for

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<sup>56</sup> As described in Chapter 2, during under5 clinics children are weighed and given vaccination. *Static* under5 clinic is at the Health Centre every Tuesday. Under5 *outreach* clinics provide the same service, but are located at four different locations within the community and each are ideally visited once a month. The idea is to reach those living far away from the Health Centre.

displaying bodily capital<sup>57</sup> which reflects parenthood. Finally, I discuss the entertainment aspect in child health. Throughout the chapter I refer to Foucault's concept of bio-power when analysing the health activities performed by HSAs and other agents, and I suggest that several agents can be seen as 'tools' in the strategies of bio-power.

## Health Surveillance Assistants - The government engaged 'local'

*"We are the only tool whereby we can make someone be good. We prevent disease"*

(Mr. Mwula, Senior HSA)

### *Brief history*

John M. Kadzandira and Wycliffe R. Chilowa (2001) from the University of Malawi carried out a study on the role of the HSA, and they presented their origin. About 50 years ago it was an outbreak of smallpox in Malawi. This created a need for temporary assistants in the field of vaccine. The people trained for this task were called Smallpox Vaccinators. Then, in the early 1970s, the country experienced a large cholera outbreak. The Ministry of Health decided to establish Village Health Committees as a means to fight this and coming outbreaks. The Village Health Committees should consist of volunteers from within the community. However, these committees needed guidance; therefore the Vaccinators were trained to be Cholera Assistants. In the 1980s the preventive section of the Ministry of Health saw the need for primary assistants in the communities and preventive actions to take place before referring people to health centres and hospitals. This was also in the aftermath of the Alma Ata Declaration aiming at providing basic health care for all by 2000. The preventive action task was given to the Vaccinators/Cholera Assistants. This was the beginning of the concept of Health Surveillance Assistants. In 1995 the position was made permanent (Kadzandira og Chilowa, 2001).

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<sup>57</sup> Bodily capital; a term suggested by Lotte Meinert (2004) as an additional capital in relation to Bourdieu's capitals.

## *Bio-power*

In the previous chapter, when addressing the power-relation between the MA, Nurse Musanga and their patients, I analysed the cases in a Weberian perspective on legitimised domination which is better described as authority because authority is tied to social positions and roles (Dahrendorf, 1959:166). Michael Foucault (1995) views power differently. Power does not belong to a person and one cannot acquire, share, or lose power. Power is in every relationship; it is omnipresent. However, as knowledge and power are intimately connected, particular forms of knowledge (like medical knowledge) have direct power as they are put into practice in institutions (Bilton et al., 2002). Foucault's (1995) notion of *bio-power* can be useful when analysing HSAs.

Foucault seeks a shift from viewing power as the oppressive act of a state head like the medieval king with his power over death. Power with modernity, he argues, developed to be more concerned with power over life. The population was, in the nineteenth century, seen as the wealth of the country and this was how the economisation and politisation of gender<sup>58</sup> and sexuality became real. 'Gender' became a public interest. Governments are concerned with its population's health because a healthy population is in the best interest of the nation-state. Foucault looks at power strategies and claims that governments, through various institutions (schools, hospitals, army, and prison), discipline their population for the sake of controlling them to utilise people's potential. A healthy population is important for capitalistic development and therefore health became a political interest. The power over life means that the modern nation-state controls its population to make sure the population's health and reproduction practise gain the country and provides healthy individuals. This power developed through 1) *the politics of anatomy* with its metaphor of the body as a machine; disciplining, gaining of capability, heighten its utility and docility, and 2) *the bio-politics* which focuses on the body as a species, and which supported the biological processes like reproduction, birth, mortality, state of health and life expectancy. This power surrounds life from beginning to end (Foucault, 1995:152). Health thus became a crucial strategy in the power relationship Foucault refers to as Bio-power, and Denise Gestaldo (2000), a nurse and sociologist, argues that health workers can be viewed as government 'tools' in disciplining citizens' in the nations best interest. "In this century, health has become increasingly

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<sup>58</sup> I have read the Norwegian translation of Foucault and the translator uses one term, 'gender' ('kjønn' in Norwegian, which does not distinguish between the biological and the social aspect), when translating the five notions of 'gender' Foucault addresses in one French word; *sexe*. 'Gender' can refer to anatomy, biology, the social, the physiologic, and gender as epistemological and ontological.

important politically as a major point of contact between government and population” (Gestaldo, 2000:114).

The HSAs are seen and suppose to be the point of contact between the formal health sector and the community, and through them information and new ideas from the Ministry of Health should reach community level (Kadzandira og Chilowa, 2001). Furthermore, Gestaldo points out that “... health education can make a contribution to the exercise of bio-power because it deals with norms of healthy behaviours and promotes discipline for the achievement of good health” (Gestaldo, 2000:114).

Leach and Fairhead (2007) address some limitation to Foucault’s notion of bio-power. The image of a unified governmental discourse which Foucault uses as starting point is problematic when the reality often is more pluralistic and involves international institutions, corporations and non governmental organisations in addition to ‘traditional medicine’ and religious institutions. The governance is multi-levelled and thus not only governments institutionalise discipline around medicine. Another critique they aim at bio-power is that its notion has been used (not by Foucault) in a way which deny people agency; that people do not experience and reflect actively on their relationship with powerful institutions. What was shown in Chapter 2 and 3 is that this is a simplification of reality because people do in fact have agency and are choosing actively when it comes to medical possibilities. Although there are challenges in utilising Foucault’s notion of bio-power in an African context where the state structures are weak and the individuals not ‘cared’ for as in societies Foucault refers to, it can still serve to shed light on recognisable bio-medical strategies in providing health care.

## Dealing with the Unforeseen

In this section I describe health activities related to HSAs where the strategies of what Foucault refers to as bio-power are recognised. I will address the job description given to the HSAs by the Ministry of Health and describe how HSAs manage them.

Job description:

- a) Conduct community assessment within an assigned catchment area and facilities in solving health problems in the catchment area.
- b) Facilitate formations of Village Health Committees (VHC) in the catchment areas.

- c) Promotion of hygiene and sanitation through regular inspections, health education and giving feedback to communities.
- d) Supervise VHC and other health committees.
- e) Conduct information, education and communication for the maintenance and improvement of the health status of the community.
- f) Provide immunization, Vitamin A, de-worming drugs, and growth monitoring in children under5, and TTV in women of child bearing age.
- g) Conduct disease surveillance and response on disease outbreaks.
- h) Facilitate provision of safe water supply, chlorination of water at household level, and monitors water quality.
- i) Conduct village clinics on specified days and referral of severe cases to the nearest health facility.
- j) Maintain equipment for the job.
- k) Collect and record data in relevant registers.
- l) Conduct patient / client tracing, follow up, and monitoring.
- m) Inspect public facilities such as schools, markets, public toilets, water sources, restaurants for maintenance of good hygiene.
- n) Motivate communities to utilize health service such as reproductive health services.
- o) Promotes and participates in delivery of accelerated Child survival and Development as follows:
  - i) Environmental hygiene practice.
  - ii) Safe water supply.
  - iii) Food hygiene practice.
  - iv) Good nutrition practice.
  - v) Antenatal care including PMTCT<sup>59</sup>.
  - vi) Infant and young child feeding.
  - vii) Vector and vermin control.
  - viii) Family Health.

Ideally, HSAs receive seven weeks of training before being able to conduct the job description.

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<sup>59</sup> Preventing Mother To Child Transmission.

## *Obstacles*

One of the HSAs' main tasks is to provide immunisation. I observed 15 static under5 clinics during my time in the community. In February 2010 the HSAs had a problem with the BCG vaccine because they ran out of needles designed for BCG injections. The HSAs used another needle to give the BCG injections. They "*improvised*" as one put it, and "*it worked fine!*" In March the main problem was TTV vaccines. For the three first sessions this month (three weeks) they lacked the vaccine. The HSAs could go and get it at the neighbouring health centre, but it was difficult to arrange transportation for this and it was therefore not managed before the 23<sup>rd</sup> of March. At the first under5 static clinic in May no one received vaccines. The gas cylinder keeping the refrigerator for the vaccines cold was empty; therefore the vaccine stock had been transported to the neighbouring health centre. Women were told to come back next week. Next week, however, was the week of the measles campaign; therefore the static under5 clinic was cancelled. The following week a HSA managed to collect TTV and DPT vaccines from the neighbouring health centre, but all the other vaccines were missing. A gas cylinder was provided for the previous week, but the District Hospital had for some reason not filled up the vaccine stock again. The following week, still, only TTV and DPT vaccines were in stock, and unfortunately they soon ran out of DPT during that session. At the staff meeting on the 2nd of June, Mr. Phiri, the MA, reported that the EPI in May had been horrible. 0% received BCG, 27% received DPT, three babies received polio3 and the measles vaccine was out of stock. However, during that day's static under5 clinic all vaccines, except measles, were present.

Once, when I joined three HSAs to an outreach under5 clinic, the small brick house used as vaccination site in that community had collapsed due to bad weather, as the picture illustrates. The HSAs conducted the service outside in light drizzling rain using a nearby tree as a weighing station for the



Photo 7: The collapsed brick house used for outreach under5 clinics.

children. This was not directly the government's fault, but it still reveals unforeseen obstacles HSAs must creatively deal with.

HSAs had generally little equipment. At the village furthest away from the Health Centre the HSA in charge had a clinic for general complaints twice a week where he examined children under 5 and referred them to the Health Centre if he found it necessary. He had antibiotics, malaria treatment and painkillers to distribute to seemingly treatable cases and he used a scheme of symptoms as guidance for illness detection. One of the marks on the check list was to observe the child's breath and count numbers of inhaled/exhaled in one minute. Because the HSA did not own a watch and no one around had one, he assumed that the child had a fast breath because the child had a cough. The HSA filled out a scheme with symptoms and wrote down a number which indicated high breath on the scheme before handing out antibiotics.

For transportation around in the community HSAs had old bikes with no gears. If a bike broke down, the HSA in charge of that bike had to spend his/her money to repair it. If the HSA could not afford it s/he had to walk. Therefore we would sometimes walk to outreach under 5 clinics. Other times an HSA would cycle with another HSA on the carrier which was an exhausting exercise. Since the female HSAs were from the area or from similar rural communities they felt comfortable wearing chitenge over their uniform skirt. They never complained about this to me, but for me it was very hard to cycle with chitenge because I could not move as freely as I could when wearing trousers. Chitenges are wrapped neatly around the body. When I tried to cycle in my ankle long skirt without chitenge, the skirt got caught in the spokes of the wheel staining the skirt with oil.

The weather was a major transportation obstacle, in addition to the bicycles. In the rainy season it rained heavily for longer periods of the day. The dirt roads turned in to muddy roads making it very slippery and potentially dangerous to cycle around in the community. Additionally, the HSAs did not have rubber boots or raincoats to protect them from the rain.

HSAs had everyday-challenges and tried to deal with them in ways they could. There were little communication between the Health Centre and the District Hospital because the radio was out of order, and therefore HSAs had little knowledge about what was going on. In addition to practical challenges, HSAs had other concerns in life forcing them to prioritise.

### *Low attendance*

Performing the job description laid out by the Ministry of Health is affected by factors like gender and family obligations. A female HSA, Mrs. Banda, was a widow. Her husband had passed away five years back. They had four children together (9, 11, 16 and 19 years old). Mrs. Banda was not the most devoted HSA. She would often come late to work and some days she did not attend. However, as the sole provider for the family there were many chores she had to perform. Washing and drying clothes is time-consuming work in Malawi. Because theft was common she did not want to dry the clothes outside when she was away from her house. She had to wait. Preparing food is also time-consuming. Because of the health risk of eating cold food (left-overs) everything should be cooked and eaten while it is still hot. As an HSA one should live by example, being a role model, therefore having a 'smart' and 'hygienic' house was important. Most HSAs had a small business on the side to make ends meet. During market day in the village I at times observed female HSAs prioritising to sell their products instead of being at work. Also, they had gardens to tend to as they, like most Malawians in rural areas, depended on additional subsistence farming. In addition to all these extra chores and responsibilities Mrs. Banda had to commute with her bike to work which took 30 minutes coming in and an hour going back. The sun sets between six and seven p.m. in Malawi and without electricity the day is in many ways over when darkness falls. Therefore, to be at the Health Centre from 8 a.m. until 5 p.m. every weekday leaves little time for other chores and is thus in many ways unrealistic.

Not unexpectedly, then, there was a problem with low attendance amongst the HSAs. The Senior HSA was not pleased when HSAs missed work without giving notice. However, little was done to discipline them. From time to time some of the male HSAs showed up drunk on duty. If they were not too drunk, they were allowed to continue working. One day I saw a note hanging in the HSAs main working station ordering three named HSAs to come and see the Senior HSA as soon as they saw the note. The first was called in because he had been drunk at work during cholera night duty<sup>60</sup>. The second was called in because he had three days of 'unreasoned' absence. The third was called in because the Village Health Committee in his catchment area had complained about him. The complaint was that he had not distributed chlorine in a time of a cholera outbreak. I talked to the Village Head of his catchment area and she was not happy with this HSA. The problem with him, she said, was that he drank too

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<sup>60</sup> A cholera outbreak meant extra work for HSAs in terms of extra nightshift but the pay check stayed the same. To attend cholera patients is also potentially dangerous as the disease is very contagious.

much. She had found a house for him in the community (iron sheet roof, mud floor and no electricity) and she wanted him to move in. He had only been there twice the previous months handling out chlorine. The HSA in question once complained at a staff meeting that they were out of chlorine and needed more supply. He also once expressed to Thomas that nobody enjoys being a HSA because of the lousy pay.

### *Living conditions*

HSAs were supposed to live within the catchment area of their responsibility, though most stayed at the Trading Centre five km away from the Health Centre. In the first months of my fieldwork only three out of 17 HSAs lived within their catchment area. After the community meeting, discussing the cholera outbreak (described in Chapter 3), a few more HSAs moved into their catchment area during the week days, but most tried to dodge the claim. Some ended up living a few days of the week in their catchment area and ‘secretly’ a few days with the family in their old house. To not live within the catchment area was to a large extent economically motivated. Because of the limited pay they received many needed to have a business on the side to be able to give their children a proper education (governmental primary school has no fees, but has poor quality, and secondary education includes school fees). One HSA had invested in a cow and was selling milk, and others produced and sold ‘freezies’<sup>61</sup> and thus needed electricity for the freezer. Few houses in the village had electricity. HSAs recruited by the Global Fund Initiative<sup>62</sup> had been promised three times the pay when applying for the position and was under the impression they would be provided with government houses within the community, and were shocked when they were offered to live in the simplest houses.

Without structural, institutional, social and ‘natural’ difficulties, the job-tasks might have been manageable. However, the health system in Malawi is not running smoothly due to several issues and conditions like poverty, tough rainy seasons, poor infrastructure and few medical personnel. Because of this, though, the HSAs are set out to tackle unforeseen obstacles in their everyday work. All the factors which influences the ability to perform as an HSA; logistic problems, natural obstacles, system flaws, reasons for low attendance and issues of living, which they often have little control over and few means to handle, can in

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<sup>61</sup> Freezies are made out of a berry blended with water and soda extracts. The mix is poured into small plastic bags, frozen and sold as a cold treat on hot days. One piece cost 5 kwacha.

<sup>62</sup> The Global Fund is a public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/Aids, tuberculosis and malaria. (The Global Fund)

some ways be argued to threatening HSAs position and their relationship with the community. HSAs are wanted in the communities and are blamed if not present when disease breaks out.

## The Capitals

The actors providing health care at Nyanja Health Centre are positioned differently in relations to the actors in the community. Bourdieu's notion of capital accumulation can help to shed light on the different positions and the value which lies within them. In the previous chapter I analysed the role of Nurse Musanga and the Medical Assistant (MA) in terms of Bourdieu's notion of the capitals. I showed how, by leaning on Fuglerud et al. (2010 (2003)) account of doctors and capital accumulation, Nurse Musanga and the MA gained symbolic capital in their accumulation of economic-, cultural-, and social- capital due to their occupation. Because of their occupation the patients acknowledged, had faith in, and trusted their biomedical knowledge, and this was important for the power relationship. Different accumulation of the several capitals can imply differences in power. I argued in Chapter 3 that the nurses and the MA gained symbolic power and thus authority over their patients because of the position their occupation gave them in the community.

HSAs on the other hand, did not have as high capital accumulation as the MA and the nurses. Although HSAs had a relatively stable income<sup>63</sup>, the wage was half the MA's wage, and one third of the nurses'. In the community setting HSAs had a higher education than average because all HSAs had to have some secondary schooling in order to apply for the position. In secondary school the language used for teaching is English and therefore all HSAs had some English skills, but the quality of it depended on how many years they participated. In addition HSAs had, in theory, seven weeks of medical training. These aspects can be said to heighten their cultural capital accumulation because education is an important element in Bourdieu's notion of cultural capital. Still, HSAs were far from having the same knowledge as the educated nurses and the MA. Because of low economic capital accumulation HSAs did not have as many artefacts displaying their relative wealth<sup>64</sup> as the MA and the nurses had. HSAs' houses were average, their clothes did not stand out much and to my knowledge most did not possess DVD players and TVs. Still, I will claim that the HSAs, because of their occupation

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<sup>63</sup> In April the Global Fund recruited HSAs did not get their pay check and it was never provided for. They worked a month for free.

<sup>64</sup> All wealth must be seen relatively as none of the actor presented can be categorised as rich. However, some are richer than others in this setting.

and their duties in the community, had some authority. They had a government job and wore (most of the time) a blue uniform which signalled this. Just like the MA and the nurses, people trusted and acknowledged the HSAs biomedical knowledge, which provided them with symbolic power. In fact, many people referred to HSAs as ‘doctors’. This might indicate a general lack of knowledge about differences in skills in the different actors working at the Health Centre, which might possibly make the expectations of HSAs’ competence higher, and thus providing a higher symbolic capital accumulation for the HSAs. People’s expectations of the HSAs were in many ways based on their job description and role given by the Ministry of Health.

HSAs encourage and mobilise mothers to attend child health days and explain how crucial vaccines are for children “*to grow strong*”. The authority HSAs hold might be an important factor in a mother’s decision to listen to their advice. However, when mothers come to the Health Centre not receiving what is promised, like vaccines, and are told to come back next week and again experience a broken promise, HSAs are the ones breaking this promise. The trust needed for upholding the authority is weakened because of the failure to provide the service which they have promised, and thus HSAs’ authority is reduced.

HSAs are recruited from the community, they are not getting a hardship allowance from the government<sup>65</sup> and, as I have argued, they are much closer to the average patient than the nurses and the MA in terms of economic- and cultural capital accumulation, in addition to being more familiar with the community. An illustrating example is how HSAs sit next to women from the community at the market selling a product which often is the same as other women’s products. The nurse might also be selling the same product, but she is sending her house girl to sell it for her. Although HSAs do not have the same medical authority over people as do the nurses and the MA, HSAs’ advantage might, on the other hand, be this closeness to the community in terms of capitals and familiarity which I will now describe more closely.

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<sup>65</sup> The nurses and the MA receive hardship allowance for living in rural areas. The allowance is 8000kw a month, close to what HSAs earn.

## Interaction with the Community

### *The devoted HSA*

Mr. Bwanali, an ever friendly and smiling man in his mid-30s, was an experienced HSA who I spent much time with. His English skills were good compared to many other HSAs. Mr. Bwanali lived close to the Health Centre in a house located within his catchment area. The house did not stand out much from its neighbours. It was made of red bricks and had a tin roof. I was never invited inside; therefore I cannot say much about furniture and flooring. Mr. Bwanali was a devoted HSA who had extra responsibilities at the Health Centre, and he was hired and waged by the Malawian Government. His catchment area had a location for an under5 outreach clinic approximately 20 minute away from his house by bicycle. This under5 outreach clinic was one of the more successful ones. I attended three under5 outreach clinics there, one village meeting and one funeral due to a cholera death where a Senior HSA gave information about hygiene precautions necessary when handling a 'cholera body. In what follows I will describe the interaction between Mr. Bwanali and the community.

It is the first under5 outreach clinic I am invited to join. Mr. Bwanali, Mr. Mphaka (HSA), Thomas and I start off from the Health Centre around 8 a.m. and cycle for 30 minutes before we reach the under5 clinic site. The road which leads us there is quite nice to cycle. It is sunny, so the road is not slippery, and there are not too many hills. At the site there is a small house (approximately 5x3m) made by the local Village Health Committee to be used for vaccination and child health. It is made of bricks and small glimpses of sunlight shines through the roof which is made of grass and plastic sheets. I wonder what they do if it is raining, and Mr. Bwanali tells me that they use the nearby church if rain. Some women are already present when we arrive. They welcome us, take our hand and make a curtsy. Shortly after, I count more than 60 women present with one or more children. They all sit down in the grass field in front of the small house. Before they start to sing health songs, a woman says a prayer on request by the HSAs. One HSA functions as a lead singer while the women repeat or answer back singing. The songs go like this:

*//The child is crying. Let us go to family planning. Family planning is good//*

*//Don't give your baby water or freezies, just breast feed them. Breast milk is the best//*

*//Our children are our future leaders. Children make us happy. Some are going to be nurses and some are going to be doctors//.*

The following health talk is about vaccination and Mr. Bwanali is very interactive in his way of presenting the information. He asks questions and guides the talk, and the women ask him questions as well. After the educational part I help a man from the Village Health Committee with the weighing of children present, while Thomas assists with the health passports. Today, 72 children receive vaccines.

When all the children have been attended to, three women, all members of the Village Health Committee, brings us plates with food. They have prepared Nsima with small dried fish as relish. The Village Head lives close to the site, and the food was prepared in her home. I ask if this is usual treatment. Mr. Bwanali tells me that it is, and that people want to show the HSAs that they appreciate them.

This was the only under5 outreach clinic location where the committee prepared food for the HSAs, and they did so every time. However, other HSAs were also given gestures of appreciation by villagers from time to time. For instance, when visiting a community rarely visited by HSAs because of difficulties to reach, we also received food. They made us Nsima and pumpkin leafs as relish. On our way back, a woman who worked in her garden when we passed by stopped the HSA and gave her a big bunch of Chinese leafs from her garden.

Mr. Bwanali had a good relationship with the Group Village Head in his catchment area. The first time I was introduced to her, Mr. Bwanali brought me. She was in her late sixties and had a slim body. She was doing house chores when we arrived and was dressed like most women in the community are when at home, in a faded t-shirt and an old chitenge wrapped around her skirt. As most elderly women she had a shawl wrapped around her head to cover up grey hair. She had a warm, humorous personality but was direct in her speak. Mr. Bwanali was there to apologise for not attending the last village meeting. She accepted the apology and they talked friendly for a while before we headed back. About two months later I went back to talk to her. This was shortly after the measles campaign. I asked about the campaign, and she explained that Mr. Bwanali came by and informed her about it. He had brought a letter with information. Two of the volunteers in her village was sent to the Health Centre for training (described in the prologue), and they came back and did promotional work. She had also had a community meeting where she informed everyone about the upcoming campaign. She told everyone that when the 'doctor' calls, they have to bring their children to receive the vaccine. She was quite sure that all the children in her community had received the vaccine. I asked her about her

relationship with Mr. Bwanali. She told me that they had a good relationship and that he did a fine job in her community. The communication between the two of them was good, she said. I asked what she thought about the Health Centre in general. She then responded: *“To be frank, there are a lot of problems with the Health Centre. Many people do not receive help and must therefore walk long distances in order to be helped. I receive a lot of complaints”*.

The next HSA I will present is Mr. Mphaka, a man in his 20s. Mr. Mphaka was married and his first child, a boy, was still a toddler. He did not live within his catchment area. Together with his family he lived at the Trading Centre. When I first saw him he was wearing his blue uniform, had white basketball sneakers on and an earplug in his ear listening to the radio. The Global Fund recruited and hired Mr. Mphaka. When he applied for the job as an HSA he was promised three times the pay he received now. He was also under the impression that government houses would be provided for them within the community. He had been an HSA for three years, but had still not gone through the training<sup>66</sup>. Nevertheless, he was one of the HSAs living up to Jenny’s standards during the Measles Campaign (described in the prologue).

In Mr. Mphaka’s catchment area there also was an under5 outreach clinic located 15 minutes away from the Health Centre by bicycle. There were discussions if this should be an outreach clinic or not because of the geographical closeness to the Health Centre. Nevertheless, what follows is a description of Mr. Mphaka’s interaction with the community in his catchment area. Because of a cholera outbreak, Mr. Mphaka wanted to have a health talk in his catchment area. In advance he had discussed this with the Group Village Head and the meeting was held in her front yard.

We follow the main dust road and pass the under5 clinic site in Mr. Mphakas catchment area before we reach a stone on the side of the road with “GVH” painted on it. We take left by the stone and soon we find ourself in the Group Village Head’s front yard. At the front of the yard there is a huge mango tree providing plenty of shade. On the other side of the yard there are several trees providing shade in a ditch which somewhat resembles a tiny amphitheatre with stumps and wooden planks laid out to sit on. Close to the house it is built an outside roof covered with twigs and branches. Underneath it benches and chairs are placed out to be seated

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<sup>66</sup> He had been given informal training by other HSAs when he started working. He had practised injection techniques on oranges before he injected children.

by the Group Village Head, her husband, Mr. Mphaka, Thomas and me<sup>67</sup>. As the place fills up with people, the women take seat on the ground under the huge mango tree and the men take seat on the stumps and planks in the arena. An hour after we arrive the meeting begins, attended by 106 women and 23 men. It is a hot day, and while everyone is squeezed in to the shade, Mr. Mphaka places himself in the middle so everyone can hear him and begins the meeting. A man who sits on the bench close to me says a prayer asking God to guide them through this meeting. Next, Thomas and I introduce ourselves. Then Mr. Mphaka starts the cholera talk. For over an hour he stands in the middle of the yard in the burning sun. He asks questions about cholera and people reply and discuss. He asks: *“What is more dangerous, cholera or HIV?”* Some reply HIV, but most agree that cholera is more dangerous because one dies very quickly from it. Mr. Mphaka asks how one can prevent cholera? A man replies: *“By cleaning the latrine”*. Another reply: *“Everyone should have a latrine and use it properly!”* One man comments that mothers must check the latrine after children have used it. The Group Village Head’s husband gets up and explains how some mothers do not wash their children’s nappies for a week. *“They just pile them up”*, he says. Mr. Mphaka nods his head to this information and explains that this could well be source of cholera. At the end of the talk Mr. Mphaka underlines how important it is to have a latrine. He tells them that he will come back after three months and do a latrine inspection and report back to the Group Village Head. *“The two cholera cases from this area were due to poor latrine hygiene and the lack of a latrine and this can be a source of other diseases too”*, he says.

When Mr. Mphaka is done with the talk the Group Village Head’s husband gets up and talks. He reminds everyone how important it is to give birth at the Health Centre. Traditional Birth Attendances (TBAs) shall not be used anymore<sup>68</sup>. If anyone gives birth at home they will be fined three goats; one from the woman in labour, one from the caretaker and one from the TBA.

The cases of Mr. Bwanali and Mr. Mphaka show how the Health Centre and the traditional authorities are collaborating towards a common goal of a healthier community. In addition to health benefits, there are profits to be made on the Group Village Heads’ part as the TBA example illustrates. A healthier population will benefit Malawi as a nation as defined by Foucault with his logic of bio-power. Due to the collaboration between the Health Centre and

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<sup>67</sup> When I could I would insist on sitting on the ground with the people. Because I came with the HSAs this was, however, sometimes difficult, and most Village Heads and others insisted I sit with them.

<sup>68</sup> TBAs had previous been given training by the government and UNICEF to improve the mother/child death rates. Recently the government made a change of heart wanting everyone to give birth at Health Centres to tackle the mother/child mortality thus making TBAs illegal.

traditional authorities I suggest that traditional authorities (Group Village Heads and Village Heads) in addition to HSAs can be viewed as government ‘tools’ in bio-power strategies. With reference to history, I will now discuss this further.

### *Indirect rule*

As the political scientist Mahmood Mamdani (1996) argues, in many African societies, including Malawi, the colonial legacy of the bifurcated state is still present. He explains that the bifurcated state came about during the colonial period when dealing with the native question; how a tiny and foreign minority could rule over an indigenous majority. The bifurcated state divided the country into urban and rural, into civilised citizens and rural tribes. The British used indirect rule as a strategy for coping with the native question. Indirect rule introduced rural communities within the context of a spatial and institutional autonomy. The tribal leadership should be the hierarchy of the rural/local state, and customary law would exist in the rural communities, as long as they did not directly contradict the civilised British laws in the cities. The state was thus organised differently in rural areas from urban ones as two forms of power under a single hegemonic authority. “Urban power spoke the language of civil society and civil rights, rural power of community and culture”(Mamdani, 1996:18). The local customs was, however, state ordained and state enforced, and “the authority of the chief thus fused in a single person all moments of power: judicial, legislative, executive, and administrative”(Mamdani, 1996:23). Mamdani shows how, in the conservative African states, the hierarchy of the local state apparatus, from chiefs to headmen, continued after independence. In Malawi this was particularly true.

The social anthropologist Peter G. Forester (1994) accounts for the cultural element in recent Malawian history. In 1963 Dr. H. Kamuzu Banda became ‘the Life President’ of Malawi. He ruled the country until he was peacefully defeated in the country's first multi-party election in 1994. Forester utilises Eric Hobsbawm's notion of ‘Invention of Tradition’ when analysing Dr. Banda's rule. Dr. Banda was proud of Malawian traditions and wanted to build a nation based on old traditions; a cultural nationalism. He lived and practised as a medical doctor in Britain for several years and was shocked that Presbyterian cities like Glasgow could have so many public houses and that married men could dance with other women in ballroom settings. When Dr. Banda was growing up in Nyasaland (now Malawi) the Scottish missionaries had

forbidden alcoholic drinks and declared Chewa<sup>69</sup> dancing sinful and primitive. After witnessing the double standards of the British missionary he was ready to re-insert African culture in his motherland when he returned. His 'democracy' became based on old African institutions of chieftainship. Dr. Banda was the country's main chief and his orders were to be obeyed without question as one did with chiefs. He strengthened the roles of the chiefs and their traditional courts because this law system was more appropriate to the Malawians than the British system, he argued. The young should respect elders, especially parents and chiefs. Dr. Banda was not fond of the young educated elite and saw them as a problem to his politics. The wisdom of elders was, for Dr. Banda, of primary importance, and school and colleges existed to supplement this. Forster argues that the importance of culture should not be underestimated when discussing Dr. Banda's long lasting authority, not least the way it has been manipulated to serve as the basis for political legitimacy.

This history of despotism based on the strengthening of traditional authority and old African culture might explain to some extent the importance in collaborating with traditional authorities when dealing with health issues as these collaborations work along the lines of indirect rule. In a bio-power strategically manner, the government makes use of traditional authority and hierarchy and ideas to get people to attend child health activities. HSAs are the government representatives for this relationship, and this relationship might to some extent explain the success of child health activities. If so, the relationship between HSAs and Village Heads is very important. According to Dr. Banda's philosophy, the Group Village Heads are above the health workers in the traditional hierarchy, something which it seems like the HSAs respect through their actions. The HSAs, by adhering to local customs, utilise the authority (i.e. power through social position and roles (Weber)) of the Group Village Heads which strengthen their word. This might compensate for what HSAs lack in what might be recognised as symbolic power when using Bourdieu's notions for analysing. As was shown in Chapter 3, there was an underlying conflict between the Village Heads and Nurse Musanga and the MA, and this conflict might have been about authority and hierarchy and who is above the other. Because HSAs have less authority than nurses and the MA, they might better fit in to the traditional hierarchy and thus being better representatives for the government in providing preventive child health at community level.

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<sup>69</sup> Dr. Banda was a Chewa (Ethnicity)

## The Social Aspect of Child Health Activities

### *Comparing bodily capital*

In Chapter 2, I briefly explained how under5 clinic was a place for public display, how women who could afford it would dress themselves and their children in clean and sometimes matching clothes. I will now go deeper in to this aspect of child health.

Lotte Meinert (2004), who is a social anthropologist, explores the use of Bourdieu's concepts of *capital* and *habitus* to analyse local understandings of resources and strategies for health in Kwapa in rural eastern Uganda. She recognises a problem with using Bourdieu's concepts of capitals and habitus. His theory was developed in a 'Western' society, and thus the capital and habitus are anchored in individuals. This can make it difficult to apply the concepts on the social and inter-subjective nature of an African understanding of health. Still, by using the concepts creatively they will illuminate important aspects of health, she argues.

Meinert (2004) argues that having 'a beautiful home and looking smart' can be recognised as symbolic capital in Kwapa. A beautiful home is big, cemented and has an iron sheet roof. If one cannot afford this, the house should be smeared with cow dung to make it smooth and to reduce dust. To have a 'smart and modern' home, the inside should be decorated with pictures from magazines. Also, the yard should have little brush and have facilities for good sanitation by providing a latrine, a shelter for bathing, a rubbish pit and a plate stand for drying dishes. "Beauty and cleanliness are highly prestigious forms of symbolic capital, which encompasses the other forms of economic, social and cultural capital" (Meinert, 2004:19). Looking 'smart' is a symbol of being healthy. Furthermore, Meinert describes the efforts of producing a strong body where the capitals play an important role. "The development of a child's body as 'strong' or 'fat', able to resist diseases, and lead a good life, is seen as a result of the integration of 'wealth', 'unity', 'learnedness' and 'smartness' in the family" (Meinert, 2004:20). *Wealth* as an economic capital is not just about money in an African setting, but includes also people and livestock. *Unity*, meaning the social relations in the larger family and the surrounding neighbours, refers to social capital. '*Learnedness*', meaning schooling and educating children, is an important cultural capital for the whole family. And finally, '*smartness*' both in the home and in the person is an important symbolic capital, when following Meinert's argument, and can only be acquired through the accumulation of the other capitals. Therefore, Meinert (2004) argues for the importance of the

body in Kwapa and suggest to include the concept of *bodily capital* when talking of health in an African setting. In Bourdieu's theory, capital accumulation belongs to the individual. However, in an African setting where people are regarded as wealth, and the whole family puts much energy in producing a 'strong' body, children are an investment in the future in form of economic-, cultural-, social- and symbolic capital which belongs to the whole family.

What Meinert describes as 'smart' in Kwapa is what is considered 'smart' in the Malawian community where I carried out my fieldwork as well. In most homes I was invited into, calendars hang on the walls. In the home I lived in we had calendars going back three years hanging on the walls. This was considered to be modern. Many of the HSAs' health songs and health talks aimed at making people have a clean and hygienic home, as described by Meinert, and to have this can be analysed as being a symbol of high accumulation in economic-, cultural- and social- capital. And at under5 clinics, especially the static ones, the concept of bodily capital in form of a 'fat' child with its investment quality became evident. The rhetoric of "*children are our future worth*" often used in health songs is good examples of the idea of the investment quality (see page 33, 76 and 86 for examples).

At under5 clinics the HSAs or the volunteers had to weigh all the children and plot the weight into the health passport before administer the vaccines. I volunteered to help with the weighing from time to time. The first time I imagined it was a simple task, however I was wrong. Weight can be understood as an important measure on bodily capital which reflects the family's symbolic capital. The mothers were asked to remove the clothes from their children, including the nappies, but most women tried to remove as little as possible. And the children were dressed in many layers of clothes. Some women "*made excuses*", as the HSAs put it, when asked to remove more clothes saying the child had diarrhoea or had a bad cough. The mothers wanted their children to weigh as much as possible. When the weather got cooler many women protested loudly and booed when they were told to remove the children's clothes. They were afraid the child would catch pneumonia. This, in addition to the pressure of having a 'fat' baby made the weighing procedure much more difficult than first imagined. An HSA jokingly yelled out once that the women had to remove the child's nappies as well as the clothes as "*some of you are hiding rocks in them*". One time when I weighed some latecomers at an outreach clinic, the last woman complained of me. She told me that I made her remove more clothes from her baby than the women before her. The previous baby weighed 6, 8 kg, and her weighed 6, 5kg. The woman pointed at the other baby and claimed

that his real weight was 6, 3 kg, thus weighing less than her baby. Also, when I asked different members of the community (mothers, grandparents and a traditional healer) what was considered a healthy baby the common answer was “*a fat baby*”.



Photo 8: Women in line at an outreach clinic. An HSA sits in the foreground registering the weight of the children in the health passports.

### *Parental morality*

Another aspect of bodily capital can be how it reflects on the morality of the family. Leach and Fairhead (2007) uses material from The Gambia to show how ideas about the body are important and connected to the social and political aspect of vaccine anxiety. They show how health and strength are relationships drawn between strength, growth, breastfeeding and sexual intercourse. “How strong and plump, or how weak and sickly, a baby is becoming very much linked with moral and social issues concerning the timing and appropriateness of sexual activity, in ways which, as we shall see, can have important bearings on mother’s social experiences of vaccine clinics” (Leach og Fairhead, 2007:110). There is a widespread ‘belief’ in The Gambia that women can damage the baby’s health if engaging in sexual intercourse again too soon after the birth because the man’s sperm enters the milk and this can lead to diarrhoea or malnutrition and the baby will lose strength. A good weight indicates parental abstinence. Also, if a mother becomes pregnant while breastfeeding she will stop to breastfeed

as fluids from the foetus, including residual semen will enter the breast milk and potentially harm the suckling child.

In Malawi, at least in the community where I conducted my fieldwork, there are aspects resembling the Gambian example. Unfortunately, but understandably, I did not get a lot of such intimate information from mothers at the Health Centre. However, I will still argue that bodily fluids and child health are connected here as well. In Chapter 2, I presented a health talk about sexual behaviour relating to child health and pregnancy. Also, there were several health songs about the importance of breast milk. The first woman I met at the Health Centre was a woman pregnant again who had stopped to breast feed her toddler, and the toddler was now treated for oedema (the child had swollen legs) caused by malnutrition, according to the HSA. I once asked a young mother why some Malawian mothers oppose breastfeeding when pregnant again. The mother then said, without elaborating, that because of changes in the body, the milk was no longer suitable for a child. Many children I saw at the Health Centre had a thread around their waist to strengthen and protect them from *sempho*<sup>70</sup>. HSAs explained in their health talks that *sempho* was caused by malnutrition, but the mothers had another explanation as well. Because the parents had to abstain from sexual intercourse for a period after giving birth, the thread protected the child from the parents' infidelity. If any of them were cheating and came home and played with the child, the child could get *sempho*. A healthy baby; not thin, not swelling, but fat, reflected the parenthood positively, and the under5 static clinic was an ideal place to display this bodily capital which also captured the morality of the parents.

However, the social aspect of child health related to the display of bodily capital can work against its purpose. If one is very poor or has an ill child one can experience ridicule in this setting by other mothers. One mother who had a suffering child told me that other mothers commented the baby and accused her of having HIV and passing it on to her child. This was not the case. The baby had a congenital chromosome abnormality. Nevertheless, for the mother it was stigmatising to attend such child health days. Leach and Fairhead (2007) argues for similar aspects in The Gambia where the social display is an important part of child health, and they suggest that those less integrated in the community, immigrants and poor, felt excluded by other mothers. Taking a sick child to the clinic could be worrisome for mothers

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<sup>70</sup> Chichewa word for a condition recognised by symptoms of swelling

as it reflected poorly on them. On the other hand, as a volunteer woman in a Village Health Committee pointed out to me, it was easier for the very poor to attend outreach under5 clinics than the static ones because the display aspect was less prominent here as some mothers would come straight from the gardens in their everyday outfit. This illuminates how important it is to have outreach clinics as well as static ones, not only to reduce the distance and time mothers have to spend on child health, but also to reach all children regardless of social status and bodily capital.

### *The aspect of entertainment and Community Involvement in Health*

In this society there was not much entertainment and few activities for youth other than football and netball. At the market place there was a 'cinema', but this was by many considered to be a "bad place". Nurse Musanga did not want me to go there. At the market there were some pubs (kiosks selling alcohol), but this was "no place for ladies". For entertainment, families could visit their church. In church people found amusement in songs and dances. Some aspects related to child health at the Health Centre and its under5 clinics also provided amusement. In addition to dress up, meet people and participating in health songs, people would sometimes get theatrical entertainment as well at the Health Centre. A youth group, The Drama Group, made health related plays and acted them out at the Health Centre. Three times during my stay, after the rainy season, the group performed at the static under5 clinic. The play was a substitute for the health talk, and the second time I observed a health play more than 200 spectators were gathered. The play was acted out outside the Health Centre. Caretakers and children attending static under5 clinics, women present for family planning and antenatal checks, and patients in line for the Medical Assistant all saw the show. Also, people who passed by, they stopped and sat down to watch. Before the play started, an HSA engaged the spectators in health songs.

Mr. Bwanali gets in front of the audience and starts to sing and the audience sings back: "We don't ridicule each other or shout at each other. Everyone here is married", but people are not enthusiastic. The singing is 'slow'. Mr. Bwanali stops the singing and asks the women to "sing and enjoy yourselves, and leave your problems at home". A woman from the audience gets up in front of everyone and sings while she dances and makes a show: "Let's take care of our children, they are our future worth!" The other women enjoy this and are encouraging her. The woman is dancing more and makes high pitched cheering sounds. After her, another woman from the audience gets up and makes a show. The audience loves it, and they all sing:

*“Some fathers run away from their children. Too many to take care of. Let’s go to family planning. Some sugar daddies run away from their children. Let’s go to that room (points at the nurses’ office) and have family planning”*. Next, The Drama Group appears. They enter the ‘stage’ in a row singing and shaking their behinds to the audience amusement. A woman gets up, runs over to a male actor while he is dancing, and she pretends to slip money down his shirt. The group is singing about breast milk and cholera.



Photo 9: The Drama Group enters ‘the stage’ while they dance and sing.

The group has very few props, in the first play only a branch. A man and a woman are running around chasing something while trying to hit it with the branch. This is done in a comical way. After a while of chasing the man argues that the virus is gone now, so they can do as they please (making a gesture which makes it obvious that he is aiming at sexual intercourse). They were chasing away the Human Immunodeficiency Virus. The audience laughs. Next a third actor is entering. She explains to the couple that people cannot see the virus with the naked eye, and instruct them to go to the Health Centre to get tested.

The group presented three plays that day. It took 45 minutes. They asked the audience if they could perform one last play, but the women waiting for the under5 clinic agreed it was enough. This might indicate the time pressure the caretakers are under.

David Kerr, (1989) professor of theatre at the University of Malawi, links performing arts to primary health care communication in Machinga and Zomba districts of southern Malawi. Although community theatre as a means of information and education goes as far back as the 1930s, Kerr argues that present development theatre is more efficient and more in contact with the spectators than the old “well-meaning, but clearly manipulative colonial agents”(Kerr, 1989:472). In 1985 the Drama at the University of Malawi engaged in health issues. A small group did research and developed plays aiming at current health issues and other community issues. The plays had little or no props and had to stimulate the imagination of the audience. They also wanted the audience to participate actively during the play making the form highly improvisational. The play was well received by the audience and was, for instance, used to introduce Village Health Committees. Kerr says there was no tradition of spoken drama in that part of Malawi (with a fully developed story and roles), but there existed several cultural traditions very close to the drama. To some extent did the Theatre for Development draw upon these, for instance when using the call and response, and repeated songs. Also the loose structure of the play which made the audience able to affect the outcome and enter the discussion is found in traditional story telling (Kerr, 1989).

The plays I observed were acted out 25 years after the development of ‘modern’ health plays in Malawi, but traces of the original idea is still found. If combining the health songs and the play to one performance one can recognise the openness in audience participation when the women felt free to go on ‘stage’ and sing. The play described was aiming at an important health issue in this society, namely HIV and its myths. Other plays I observed during my time in the village were plays about hygiene, cholera and promiscuity. Common for all was the use of humour, song and dance. John Hubley (1984) pins down the characteristics of effective health education and argues that “the word of mouth is perhaps the most valuable way to influence action...” because “...oral traditions in many rural societies are strong and people enjoy communication conveyed by means such as puppets, drama, story telling and music”(Hubley, 1984:1056). However, while the origin to the health play was driven by incentives of ‘producing’ a healthier population, the incentives for the actors in this Drama Group were divided. Community health benefits were of course a positive outcome, but the actors mainly joined the Drama Group because they were bored, and because getting a job in Malawi is difficult for youth they hoped being active in the Drama Group would give them an edge; that it could be their ticket out of the village.

In development politics, *Community Involvement in Health* became a philosophy guiding strategies from the mid 1980s onwards. One saw a change from politics where development programs were imposed on people, to politics where people were invited to join the development in a bottom-up experience which would ideally empower the majority, i.e. the poor. This was a deliberate strategy supported by the WHO which promoted community involvement in bettering health conditions *for* the majority of the people by bettering *with* them. People participation became an additional ingredient in health care delivery (Oakley og Kahssay, 1999). Concrete activities like Village Health Committees, Community Health Workers, Health Campaigns, discussions and local meetings, drama, dance and songs were important for the Community Involvement in Health strategy (Oakley et al., 1999), and all these activities are recognised in this Malawian setting.

Denise Gestaldo (2000) views the issue of *participation* or *Community Involvement in Health* as a double edged sword because it can mean both empowerment and control. Participation can be viewed as a new approach in the exercise of bio-politics. Now, everyone should be involved in promoting health based on government directions, like Village Health Committees and Drama Groups in Malawi. When asking if health education is good for you, Gestaldo answer that health education can be subjugation because many practises involve imposing ‘truth’ about health. Patients risk losing control over their own bodies. Health education is also widening the clinical gaze and contributing to management of social and individual bodies, she argues. On the other hand, she claims that health education is good in the sense of empowerment and helping people to make informative choices regarding own and their family’s health.

## Concluding Remarks

The reader should now have a better understanding of the intricate aspects attached to child health activities and primary health in this community. As Gestaldo (2000) argues, health is a major point of contact between government and population. And in Malawi, through HSAs, information and new ideas from the Ministry of Health should reach community level (Kadzandira og Chilowa, 2001). Because HSAs do not possess the same medical authority as the MA and the nurses, HSAs have to make use of other strengths when interacting with the community, and closeness to the community, both geographical and social, is a major strength. Government ideas reach community level because of the natural relationship HSAs

have with various traditional authorities. Gestaldo (2000) further argues that health workers can be viewed as government 'tools' in disciplining citizens in the strategy of bio-power. The MA, the nurses and HSAs are such 'tools'; people who work for improving the health of the population. Due to the particular role of the HSA as a government (or Global Fund) engaged 'local', who collaborate with the community, other members of the community can also be viewed as such government 'tools'; like the traditional authorities (i.e. Group Village Heads and Village Heads), members of Village Health Committees, and actors in the Drama Group. They all work, more or less, together for the common goal of a healthier population (driven by different incentives) and they turn to HSAs for guidance. Child health and primary health are closely related to social networks and roles of authorities, it reflects parenthood and social statuses and provides aspects of entertainment while involving a wide range of actors in the process of providing health care.

# 5

## Strengths and Weaknesses; a conclusion

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### *The universal value of the thesis*

'Health for all by 2000', the slogan from the Alma Ata declaration in 1978, reached Malawi and its health politics. HSAs are health workers conducting their work according to the Primary Health Care approach and Community Involvement in Health, which dominated development health politics after the declaration. In 2000 member states of the United Nation agreed to adapt the global action plan of the Millennium Development Goals. The Goals sought to achieve eight anti-poverty targets by 2015. Target 4 is to reduce by two thirds the under5 mortality ratio. Childhood vaccines are regarded a cheap and manageable means to this end. Target 5 is devoted to reduce by three quarters the maternal mortality ratio and achieve universal access to reproductive health (United Nations Millennium Goals). At Nyanja Health Centre one can recognise the priorities from targets 4 and 5 in the everyday work at the Health Centre and at outreach posts. The nurses are concerned primarily with target 5 and HSAs deal with the preventive side of target 4. In this thesis, I have commented on health activities related to both of these goals at Nyanja Health Centre. However, such global health ideologies and aims are acted out locally in distinct and often varying ways.

Negative rumours and local interpretations of biomedical preventive methods are not uncommon. "We believe modern-day Hitlers have deliberately adulterated the oral polio vaccine with anti-fertility drugs and contaminated it with certain viruses which are known to cause HIV and AIDS" (Leach og Fairhead, 2007:1). This quote, found in Leach and Fairheads' account of vaccine anxieties, it is taken from Datti Ahmed, a doctor and president of Nigeria's Supreme Council for Sharia Laws. With this, Leach and Fairhead wish to indicate how different ideas about vaccines varies around the globe, and they also show how a teacher in Guinea worried that vaccination had created a strengthened but more violent generation, as he considered it to be a connection between children's vaccination and the behaviour of child soldiers. Also, Leach and Fairhead analyse the anxiety for the MMR

vaccine in contemporary Britain where parents mobilised against the vaccine, being afraid it could cause autism.

In her article, Amy Kaler (2004) shows how in Malawi, family planning projects and the introduction of the condom led to conspiracy theories saying that America or the Malawian government wanted to exterminate the Malawian people because they were tired of the population's demand for aid. Therefore, allegedly, the government introduced the condom as a 'tool' to spread HIV. Kaler's study shows how some places in Malawi there were a lot of scepticism towards health workers, because they were seen as acting on behalf of the State against the people. This scepticism, Kaler argues, can transmit to other health policies. An example of this was an anti-polio campaign that took place in Malawi. Many people was worried that the polio vaccine was a malevolent sterilisation injection that would make the children sterile (Kaler, 2004).

Although my study concentrates on a distant rural location in a small African nation, the theme of my study is universal. All over the world local interpretations of global health incentives can be found. Sometimes these interpretations work against biomedical implementations with forceful results, and other times they collaborate. If one assumes that parents in The Gambia and Malawi or Malawi and the UK react in similar manner to biomedical offers, one might be taken by surprise as diverse clinical realities can vary enormously and therefore lead to very different interpretations of the offers. As mentioned by Kleinman and Petryna (2001), everyday life experience, local knowledge and social networks influences personal agency and access to health care. Sceptics to biomedical influence were found in Malawi, as Kaler shows, and in my area of study the sceptics were mainly the Zionist who wanted nothing to do with biomedical interference. However, most people made use of the biomedical health offers; especially child health offers. I have in this thesis looked at the part HSAs play in child health.

### *Trust in the interface*

The lack of biomedical skills among HSAs, which was recognised by Jenny, the MSF representative, is closely connected to the time limited training HSAs receive. In a report presented by A. Katsulukuta, the National EPI Manager of Malawi, one can read that 17% of all HSAs lack pre-service training (Katsulukuta, 2010). The report recognises the lack of pre-

service training as one of the greatest challenges in the institution of HSAs, in addition to the ever increasing duties assigned to them.

At Nyanja Health Centre, 7 of 17 HSAs lacked training. However, as Senior HSA Mr. Mwula told me, lack of training is not his biggest concern. He argues that the largest difference between HSAs is found between those who have completed secondary education before applying for the position and those who have barely finished first grade of secondary school. Based on the aspect of short training one can ask if the biomedical health system is undermined due to the lack of competence among HSAs. However, if trust and experience are identified as important factors in the biomedical health system, can HSAs, despite their lack of training, be important agents in supporting the system?

“It is essential that parents trust the quality of the service on offer” P.H Streefland, A.M.R Chowdhury and P. Ramos-Jimenez (1999:722) argue when studying the quality of vaccination service and its social demand in Africa and Asia. They document the fact that “parents are willing to invest considerable effort in having their children vaccinated; however, there are a number of serious shortcomings in the quality of the routine vaccination service and strains are apparent in the interface between the vaccination providers and the users” (Streefland et al., 1999:722). Throughout this thesis I have depicted various social interfaces between health workers and patients, and I have showed how these meetings have been characterised by differences in authority, position, rationalities and knowledge. Strains have been apparent, particularly in the interfaces I have selected to display between Nurse Musanga, Mr. Pihri (both educated health workers) and their patients.

The two educated health workers described in this thesis were both strangers to the community, and they had recently moved there. They worked for the government and they enjoyed luxury like electricity and other symbols of wealth and power. This created a social distance between them and the community. In addition, they socially distanced themselves further by to some degree ignoring traditional authorities. In Chapter 3 I described how Mr. Pihri ignored a Group Village Head when she came to thank him, and how Mr. Pihri told her, without looking at her, to come back the next day during opening hours. By doing so, Mr. Pihri showed her disrespect. The Group Village Head also told Nurse Musanga to start acting differently towards her patients, but no change had been detected in her behaviour according to the Group Village Head. Nurse Musanga thus ignored the reprimand given to her from

traditional authorities. Both the Mr. Pihri and Nurse Musanga were accused of having evil intention when they were accused of being satanic or witches. As health workers they were involved in situations concerning life and death, and much of witchcraft revolves around death and illness (van Breugel, 2001). As Mark A. Hall et al. (2001) argue, interpersonal trust is important in the doctor-patient relation, and my empirical examples have shown that many people were sceptic towards the educated health workers. Trust is not always rational, Hall et al. state, and often people trust a health worker as long as they know that his or her intentions are pure and honest. Trust is very much connected to the health worker's character and personality. Therefore an excellent but rude health worker can receive a low degree of trust from her patients. Furthermore, Hall et al. stress, trust is consistent with different patients' personalities. In addition to the sceptics in the community, I talked to several people who said they had received good treatment from both of the educated health workers and who recognised the intense work pressure the nurses and the MA were facing.

When discussing traditional knowledge and alternative rationality existing in the community regarding health, I have shown how health is closely connected to a person's morality. Witchcraft revolves around the images of the person as a moral being (Englund, 1996). Thus, by accusing the educated health workers of being satanic or witches, the accusers are criticising their moral being. van Breugel (2001) explained the logic behind Chewa notions of 'hot' and 'cold'; of vulnerability and danger, in the 70s. Because hotness could harm or kill a new-born who was considered to be 'cold', trust was crucial. To produce a healthy toddler the whole family needed to behave in a very strictly moral way to protect the child from evil. Because one could not be certain of the midwife's morality, if she was 'cold', hospitals were feared. Today, as the Government has forbidden Traditional Birth Attendances, and together with traditional authorities is making it compulsory for women to deliver at the Health Centre, a situation is developed where nurses might be in a very exposed situation regarding trust and witchcraft accusation if something should go wrong.

The relationship between HSAs and the community in the interface is not characterised by as large a gap in position, authority, rationality and knowledge as is the case with the nurses and the MA. HSAs are positioned differently towards the community than the MA and the nurses. While the educated health workers sit in their office and have the patients come to them, HSAs actively seek their patients within the community. HSAs purpose, in addition to provide preventive health care and spread biomedical knowledge, is to form a link between

the community and the formal health service delivery (Katsulukuta, 2010). HSAs engage actively with the community through outreach services, community meetings, health talks and by participating in funerals where hygiene precautions are needed. Health precautions in funerals are needed when someone has died of cholera and action must be taken to hinder the spread of the disease. Moreover, many HSAs uphold a good relationship with the village heads and cooperate with them, which enable HSAs to reach the community. By being a part of the community in this way, HSAs have to succumb on a daily basis to traditional authorities, rules of conduct and social relations. I never heard of any serious accusation of evil directed towards HSAs. I witnessed, however, how HSAs received complains in face-to-face interactions. In Chapter 2, I refer to a case where an authoritative woman makes a joke on Mr. Mwula's behalf referring to his love for alcohol by saying "*Some of you may neglect it, saying Mr. Mwula is drunk, but what you have told us is very important*". People laughed, and Mr. Mwula laughed. Although a joke, it was a criticism which I never observed being directed towards the nurses or the MA in a similar manner. Being an HSA means one is part of the community. Therefore one is adjustable by local sanctions and authority which makes the level of trust in HSAs generally high. As stressed before, an important non-rational/emotional component of trust relates to the personality of the health worker and not the quality of his knowledge and experience (Hall et al., 2001). As long as parents trust that HSAs are benign and want to help their children resist disease and help them grow strong, they will continue to bring their children to child health activities.

### *Pro et contra HSAs*

In the prologue I described what went on during a massive measles campaign carried out in 2010 in the area of my fieldwork. The case illuminated the strengths and weaknesses of the HSAs as servants of Primary Health Care in Malawi. To me, though, it seemed like the weaknesses and strengths they possessed were carefully interlinked and thus presented a paradox which made me ask: *Is it possible that HSAs' weaknesses can be the reason for their strength?* From this question I presented an argument claiming that *the role of the HSAs in this community has a mediating effect between the patients and the Health Centre which ensures the large turnout and trust in child health activities by caretakers.*

When looking at the situation from Jenny's perspective, a nurse, it becomes clear that HSAs medical skills and techniques do not live up to her expectations and this is something she is

worried about. She observed and commented on several incidents of vaccine abuse, and it is crucial that vaccines are handled correctly for having a full effect. The lack of medical skills is a serious weakness. Additionally, the increasing duties assigned to HSAs are a problem. As I have shown, some HSAs found it difficult to perform all their job tasks because they had a low payment and needed to engage in other return tasks to make ends meet. Moreover, some, especially female HSAs, had other roles to fulfil like, for instance, the role as a housewife or mother. Senior HSA Mr. Mwula pointed to the low pay as a major obstacle for HSAs. However, because of the low pay HSAs engage in similar activities to other community members who are also struggling to make ends meet. This signals equality. In addition to low wages, poor housing arrangements and transportation are major concerns pointed out by Mr. Mwula.

Limited biomedical training, in addition to the large workload and poor housing and transportation arrangements, are the factors which characterises the negative sides of the institution of HSAs. On the other hand, Malawi has the lowest number of medical doctors and nurses in the whole region, and the country suffers from 'brain-drain'. The saying 'there are more Malawian medical doctors in the city of Manchester alone than there are in the whole of Malawi' may no longer be the case, but it is a common quote used to describe the situation in Malawi. However, between 1998 and 2000 Malawi lost over 100 nurses to countries in the 'West', and such figures have far-reaching consequences in an already nurse-constrained environment (Muula et al., 2003). Prior to 2006 there were 5000 HSAs in the country. In 2006 additionally 6000 HSAs were recruited, and today there are approximately 10,500 HSAs in Malawi; 1:1,200 population. Therefore, HSAs, despite their weaknesses, are crucial in bringing preventive health care to the Malawian rural population. Despite their lack of training they do contribute to the local community. By looking at the high turn-up during the measles campaign and generally at under5 clinics, the HSAs' work must be described as successful since the high turn-up is due to the promotion work they carry out.

As I have shown throughout this thesis, HSAs are not positioned in the same manner as nurses and medical assistants. HSAs are positioned in-between the Health Centre and the community; with a foot in each camp. I have shown how tension was present between the Health Centre and the community, mainly because of the social and material distance between the educated health workers and the community. This social and material distance further contributed to strains between conflicting authorities, trust issues, interactional difficulties and

misunderstandings of the health offer. The in-between position of HSAs mediates the social distance between the Health Centre and the surrounding community. By cycling into the communities, HSAs bridge the Health Centre to remote areas and they become familiar with the 'local ways'. This aspect of their job description, together with the personality and position of HSAs, ensures a large turnout and trust in child health activities by caregivers. Despite HSAs biomedical weaknesses, through them biomedical aid reaches people living in places far away from hospitals and health centres. HSAs are the bicycling remedy against the disease of 'brain-drain' of which Malawi suffers.

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