HSAs and the Wisdom to Handle Knowledge:

A Study of Health Surveillance Assistants' Work in Rural Malawi 2010

Kristin Alfsen

Master's thesis

Department of Social Anthropology

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Kristin Alfsen

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Abstract

Based on five months of participant observation among health workers in rural Malawi, Central Africa, this master's thesis examines how Health Surveillance Assistants (HSAs) with eight to ten weeks of official training handle different traditions of medical knowledge in their work. Main focus is put on mobile health clinics for children under five years of age, so-called Out Reach, U/5 clinics. With this system, basic child-health services are made available on a monthly basis in remote villages by HSAs on bikes. They conduct key HSA tasks like health talk and vaccination in schoolyards, by communal water pumps and the like. Starting from empirical data produced by attendance at fifty-four such U/5 clinics and in a myriad of other settings, the analysis draws on theory from the anthropology of knowledge, medical anthropology and regional studies. The enquiry contributes to the understanding of how child vaccination programs are realized, in addition to contributing to the anthropological literature on knowledge management. Social anthropology student and nurse, Kristin Alfsen, argues that the HSAs' mediation between individual, local, national and international views on health and their locally adjusted, varied and pragmatic methods of knowledge management contribute to the high vaccination coverage found in Malawi, compared with other poor countries. By studying the HSAs' positions of multi-relations, and the knowledge management that takes place at interfaces they thereby are involved in, this thesis also deals with issues of power, resistance and trust. Additionally, "HSAs and the Wisdom to Handle Knowledge: A Study of Health Surveillance Assistants' Work in Rural Malawi 2010" reveals some of the harsh effects of severe poverty on individuals and communities, along with related vulnerabilities in the national child vaccination program.

Preface

More or less willingly, a group of vaccinators in southern Malawi agreed to take on more responsibility. Already overloaded with tasks, they were appointed to introduce a Norwegian master student to their work and life in the countryside. Had the vaccinators not done so in the including, open and caring way that they soon did, this thesis would not have been what it is. Basically, I owe this thesis to them. As an anthropologist, however, I also produced data with the help of many others. I therefore want to thank the patient mothers, Village Health Committee members, traditional healers, district officials and many others who answered my many questions and showed me how they go about. I also want to thank REACH TRUST, especially Lot Nyirenda and Amiya Gondwe who made all this possible to begin with. Still, I would not have been very successful had it not been for the most patient and enduring of them all. Through ups and downs, figuratively and geographically, 'William' stood by my side throughout the fieldwork period. He helped me with much more than language barriers, and wisely alternated between supporting and challenging me. I could not have dreamt of a better assistant, and I hope he will get the opportunity to utilize his many talents and his steadfast dedication to conduct other jobs in Malawi. I also owe many thanks to all members of my extended host family in Malawi. Their caring support and love for discussions made a huge impact on my stay. Every night I learned something new at the dinner table. The head of the family, whose energy and determination seemed never-ending, made an unforgettable effort to make me a fully included member of her family and neighborhood. Thank you! Many people in Norway have also supported me. My supervisor Rune Flikke and the rest of the SUM MEDIC team have offered an encouraging and challenging environment for learning, not to mention the workspace at SUM. I have also benefitted from a scholarship and financial support for copyediting. The obligation to write in English has been an additional challenge for me, and at times, I have felt like I have been working on two master's degrees, one in social anthropology and one in English. Had it not been for the steady support, reading and commenting of Halvor Berggrav throughout the last two years, I might have given up. My hope is that I have, in the end, managed to convey all I have to say clearly and intelligibly. Furthermore, I am proud to submit this master's thesis within the standard time. I see this as part of the test.

Table of contents

1 Introduction

There are four vaccines, eeh aeeh vaccines.
There are four vaccines, eeh aeeh vaccines.
The first one. The first one.
Is for the big cough, eeh aeeh vaccine.
The second one. The second one.
Is for the cough that pulls the heart, eeh aeeh vaccine.
The third one. The third one.
Is for polio, eeh aeeh vaccine.
The fourth one. The fourth one.
Is for measles, eeh aeeh vaccine.
…
HSAs, HSAs. They fight destructive diseases.
HSAs, HSAs. They fight with preventive medicine for children.
HSAs, HSAs. They fight with vaccines that prevent diseases in children.[1]

Global child vaccination programs have saved lives worldwide for more than thirty years (UNICEF, 2010). Contrary to most predictions, however, coverage levels have proven to be slow-growing and unstable in different contexts, in terms of both supply and demand (Leach & Fairhead, 2007; Muraskin, 2005). The lifesaving potential of and varying struggles over vaccines make vaccination an intriguing topic for research. Furthermore, first-line health workers deliver "the product" to the individual child and caretaker, and doing so realize the goal of various international and national actors locally. They thus operate in relation to and in a meeting point between actors with potentially different desires and intentions: actors that often rely on varying traditions of medical knowledge. That local vaccinators are key actors in the complex chain of processes directed at disease prevention makes an ethnographic study focusing on their work a good approach to increase the understanding of how these processes unfold. Based on five months of fieldwork in rural Malawi in 2010, this master's thesis therefore investigates *how some vaccinators handle different forms of knowledge in their work,* and discusses *how this handling might influence vaccination coverage*. Despite having one of the world's poorest populations, Malawi is presented as a successful country regarding child vaccination (WHO, 2011), making it an interesting site for research.

[1] Two health songs from Malawi, translated from Chichewa. See Appendix 3 for complete record.

Through participant observation and an actor-oriented approach, I have found that the observed health workers mediate between individual, local, national and international views on health, and use locally adjusted, varied and pragmatic methods of knowledge management in their encounter with rural villagers. These findings are highlighted by an identification of different interfaces that the first-line health workers are involved in. Along with their arguably effective knowledge mediation, manifestations and effects of power, resistance and trust become apparent through the focus on their positions of multi-relations. Nevertheless, my research leads to the argument that the way knowledges are handled in this context contributes to the general positive attitude found towards vaccination. By using knowledges, in plural, I want to make it clear that different understandings and different ways of knowing coexist. Furthermore, this means that knowledge are, in practice, often mixed in different ways.

This study is a contribution to anthropological literature arguing in favor of focusing on knowledge management, as a means to show effects, variations and similarities in human interaction and ways of life. My illumination of vaccinators' handling of different forms of knowledge in their work is also a contribution to the SUM MEDIC research project.[2] The overarching goal of this project is "to improve knowledge of why some low-income countries and communities therein are far more successful than others in immunizing children despite unfavourable political and economic circumstances" (Roalkvam *et al.*, 2007:1). This thesis presents processes and effects of a program planned far away from some of the contexts where it is realized, and patterns of strengths and weaknesses in the national child vaccination program are revealed. Additionally, the hardship of individuals living and working in a country severely affected by poverty and its related challenges are illuminated. By approaching child vaccination with a focus on the practices of actors, and by observing and learning from them through participation for a longer period, an important contribution to the understanding of child vaccination programs can be made.

[2] In 2007, the Norwegian Research Council granted funding to the project "Multi-disciplinary approach to Explaining Differential Immunization Coverage." The project is based at Centre for Development and the Environment (thus, SUM MEDIC) at the University of Oslo, and collaborates with international partners.

Empirical data produced through participant observation should, however, never be described and analysed in isolation. The credibility of anthropological studies also relies on thoroughness and openness regarding research circumstances. I therefore include an account of factors that have influenced my studies and methods used to produce data and analyse these in this first chapter. As people's actions always relate to the surrounding contexts, such presentations are just as crucial, and interlinked research contexts, from national to local to social, are presented in chapter two. Further, to qualify as a serious study ethical reflection by the responsible researcher is required throughout the process. Studying human interaction among people living in severe poverty sets additional requirements in this regard, and at the end of chapter two important ethical implications are discussed. All the components above give the reader important background information that makes it possible to evaluate the study's content. One should never forget, though, that what is given are necessarily representations, not descriptions as such, since data are always produced and all observations involve interpretation (Stoller, 1989:39). As such, the derived analyses are based on my own construction of the local reality.

The reader is then presented with empirical findings that constitute a large part of this thesis: The case presented in chapter three describes typical aspects of observed vaccination work, while further patterns and variations are highlighted in a subchapter. Chapter four initiates the main analysis of the vaccinators' handling of different forms of knowledge in their work, with a presentation and discussion of different traditions of medical knowledge encountered during fieldwork. The latter is included because it is central for the reader to gain insight into the culturally complex and ambiguous contexts in which these vaccinators operate. Then the vaccinators' mediation and methods are specifically discussed in chapter five through an identification of different knowledge interfaces that they are involved in. Their positions of multi-relations, revealed in chapter five, lead to a necessary discussion of power, resistance and trust in chapter six.

My empirical findings are analysed mainly within theoretical frameworks of knowledge and power. Literature from the anthropology of knowledge, medical anthropology and regional studies constitute a general foundation for my discussion. By combining theory presented by medical anthropologists, such as John M. Janzen, and social

anthropologists focusing on knowledge management, such as Fredrik Barth, it is possible to decide what *medical* knowledges are, and how one can study them. Relevant regional studies conducted by Malawian researchers are obvious sources to gain insight into this field. Concerning power, a Foucault-inspired *relational* focus makes resistance part of the identified processes. By additional support from Bourdieu it also becomes clear that some forms of power do not need legitimacy, as they are made invisible by presentation as natural phenomena. From empirical examples, trust and hope are additionally identified, increasing the complexity of observed power processes further.

Based on my analysis I conclude in chapter seven that the way knowledges are handled affect vaccination coverage, or more specifically that the claimed, relative, success of the national vaccination program in Malawi (see Chilowa & Kadzandira, 2001; Ministry of Health and Population [Malawi], 2003) can be directly related to efforts of the local vaccinators.

I choose to open some chapters and subchapters in my thesis with relevant empirical vignettes. These short descriptions of episodes, or other forms of produced data, are written in italics to mark them as independent constituents in my text. The purpose is, nevertheless, to invite the reader into the kind of events, products and reflections that I draw on throughout my work.

Research methods and influencing factors

Four months into my fieldwork everyone was summoned for a general staff meeting at the rural Health Centre. Someone from the District Hospital was braving the bumpy road, and "Human Resources" was on the agenda. The morning went by before a car finally appeared, and a man in a black suit turned one of the small examination rooms into an overcrowded meeting room. It was so packed that I was unable to present myself to the newcomer, but the others assured me that I could join in. As someone tried to close the door, shielding us from the view of curious patients, the remarkably dressed man pointed at me and told me to leave the room in a brusque voice. Some 'vaccinators' gave me a pat on the back as I made my way out and sat down with some patients, awaiting a report

about the event. When the session was finally over I met with Mr. Ubwenzi[3] and some others. "Sorry about that, Kristin… He did not know that you are one of us," he said, and my spirits rose considerably. "He probably thought you were from some organization," he continued. "So what was it all about?" I asked, curious to hear of this unusual event. Several 'vaccinators' told me the meeting was a warning, and that they had all been accused of shirking and threatened with dismissal if things did not improve. People looked discouraged. It was only yesterday that their immediate supervisor had listed all the tasks that most 'vaccinators' are required to report on every month. He definitely confirmed that their title, Health Surveillance Assistant, is more appropriate than 'vaccinator.' Sixteen different programs were mentioned altogether, child vaccination being only one of them! Additional programs demand reports on things like how many households in the villages have bedbugs and other vermin, and how many wash their hands with soap. The list of delegated work tasks seemed endless and quite unrealistic. It got me thinking of when I last joined one of the Health Surveillance Assistants for some of her 'additional' responsibilities. I felt so grateful for not being the pregnant one while our sweat ran under the burning sun. It does not help her that she is responsible for only 200 households when they are so remote that she cannot even travel by bike.

The data produced for this thesis are linked to a range of factors, practical, theoretical and personal. I therefore seek to illuminate these initially and show the inter-linkages between method, theory, context and people. I start by accounting for how I got access to local health workers in rural Malawi, and continue with clarifications regarding my dependence upon a field assistant. Further, I present personal factors of influence followed by methods and strategies of data production, before rounding off with a presentation of the analytical framework on which this thesis is built.

Field location and access

As a student of social anthropology, I entered the field of vaccination at the local level, in a southern district of Malawi, Central Africa. For eighteen weeks I took part in the activities of twenty ***Health Surveillance Assistants (HSAs)*** working with vaccination and other tasks from the rural public Health Centre in Mangu. Further elaborations on

[3] All names of people and places in this thesis are fictional to ensure anonymity.

what it means to be an HSA in Malawi are presented in chapter two. SUM MEDIC's Malawian partner, the research organization REACH TRUST, was responsible for the practical arrangements and permissions necessary for me to conduct my study, while ethical clearances from the Ministry of Health and Population in Malawi and the Norwegian Social Science Data Services have been obtained by SUM MEDIC. By use of contacts, REACH TRUST representatives were able to get the required approvals at district level in a certain part of the country, a process I attended for two weeks after arrival. To which Health Centre I would be connected, and with which health worker I would live were decided by the administration at the District Hospital. It is likely that the management chose a location they saw as fulfilling certain criteria, and this can be seen as a restraint in my research. Maneuvering independently of responsible institutions with such errands as health-system-related research is not an option however, and openness concerning experienced effects must hence suffice as compensation.

I lived in Mangu with a senior nurse-midwife in her early 60s and her "extended family." She housed her 31-year-old daughter-in-law, two grandchildren of two and nine years, a 21-year-old niece and 19-year-old nephew, a 21-year-old man assisting her in return for school fees, housing and food, and a housekeeper. Except from the nurse, all others lived in the house sporadically. REACH TRUST paid rent to the nurse for housing me, while I contributed with food. I believe this economic factor has had minimal influence on my research, as household life in this particular family was not one of my main sources of data and the working nurse was not a direct part of HSA work and vaccination as such. Still, my association with this household might have brought additional distance between me – the white foreigner – and poorer individuals in the area. The nurse is the widow of an academic. She had lived in the United States from 1972–75 during her husband's education, and for years in the capital city Lilongwe. She returned to her rural childhood home for financial reasons, after the death of her husband in 1995. Even though her house was falling apart because of leaks and "invasion by rats, ants and cockroaches," as she put it, it was one of a few large houses in the area with windows, a corrugated iron roof, and some electricity. Her standard of living differed from that of most people in Mangu, some of whom could not afford sleeping covers and therefore lit a bonfire inside their house to stay warm on the floor during the cold season. Compared

with many people in the area she also spoke good English, as did most of the household members.

Working with William: interpretation, translation and cooperation

English is one of two official languages in Malawi, though a large part of the population is uncomfortable with or unknowing of it. *Chichewa*, the other official language, is spoken by most people, but is only one of many languages used. In Mangu, *Chilomwe* was another commonly spoken language. This situation made the help of an assistant crucial. REACH TRUST thus appointed William to the task, as he was familiar with the project from earlier work with a Norwegian master student in health economy. Since this fieldwork differed from his previous experience, he received a one-day training and instruction session before we set off to the countryside on our own and learned, by trial and error, how to cooperate and work together in a constructive manner. I use the title "assistant" to indicate that working with William has been of importance regarding not only language barriers, but also discussing data and approaches.

There are of course potentially negative effects associated with the use of assistants during fieldwork (see Berreman, 1962:13), two of them being extension of the chain of interpreters, and the challenges of translation from one language to another. Sørheim (2003) points to several weaknesses and extra challenges after experiencing censorship and deficient rendering. In addition, one inevitably misses interesting data when not fluent in the languages used (Hoëm, 2001). On the other hand, Bourdieu has written that if there exists truth about anything, it is that the social world is subject to contentions (2004:229), and I found it informative and challenging to have someone to discuss all impressions openly with. Being a two-person team and being of different genders were other potentially harmful factors since I conducted fieldwork with an assistant. My experience, though, is that these factors can also ease the pressure in some settings and make people relax. In addition, being male and female, the two of us were able to access both female and male spheres, such as HSA teams divided by gender. I believe that in this case I also got to move around more freely, as people knew I was accompanied by a man. I therefore conclude, from my own experience, that there might be just as many advantages in using assistants as there are disadvantages.

The course of events was a result of the particular contexts and of the personalities of people involved. Most parents and health workers were used to the mix of genders in health-centre-related activities including child delivery, and discussed methods of family planning, sexuality, family life and other matters quite openly in this setting. The fact that William is a married man and father of two was probably a crucial factor as well, since it influences who he is and how he acts and speaks with women and children. He is also the son of an academic, which may have inspired his interests in social life and research. Together we had four eyes and ears to catch interesting occurrences, and we motivated and challenged each other to always do our very best. I additionally learned a lot by being the leader of our anthropological team, and I was forced to keep focus and always try to make reasoned decisions that I could justify.

Nurse and social anthropology student

My own maneuverings in the field as well as the further interpretation and presentation of data in this thesis, are likewise influenced by my background and personality. A Bachelor of Nursing from Diakonhjemmet Høgskole, including four months of clinical studies at a rural hospital in Tanzania, and a Bachelor of Arts in Development Studies from the University of Oslo, have definitely made a difference. I have had an interest in health issues for years, especially in how health is related to culture and poverty, and in the role of health practitioners in this regard. My background as a trained nurse inevitably led me to make certain technical and clinical observations during activities. I also related to the health workers in a different manner than I would have had I not been a health worker myself. Nevertheless, I strained my mind to be aware of how and what I observed and how I documented my observations when conducting this anthropological fieldwork. Such awareness and self-critique are, however, not new to me. Working the last seven years with people diagnosed as psychotic has necessitated regular reflections concerning such challenges with colleagues and patients. Naturally, the fieldwork period itself continuously gave me influential new experiences. Moreover, throughout the process of this thesis Wadel's (1991) classic illustration of how the anthropologist must continuously dance between data, method and theory, allowing discoveries in one area to inform the others, has been an important model.

My relations with people thus evolved throughout the fieldwork period, and different

people responded differently to me, as I did to them. I presented myself as a social science or anthropology student and as a representative of a larger research project. I also explained the project's choice to send me to rural Malawi as the result of Malawi's impressive statistics on vaccination coverage despite economic challenges. After discussions with the research team in Norway, I decided to keep my background as a trained nurse concealed in the field, though I introduced myself as having years of health service experience from adult psychiatry. The fact that I have never worked with child health or vaccination made this self-presentation natural and, I believe, quite crucial for the data collection process. At the rural health centre there was a clear division of labor and movement between nurses and HSAs with eight to ten weeks of training. My role as an observer and curious participant in a wide range of activities and topics might not have been accepted as it was had people seen me as a nurse living with an elderly colleague. I probably would have been expected to teach, not be taught, and to engage in more or less repetitive activities that would have taken a lot of time and focus as well as challenged my ethical boundaries. Nevertheless, that I lived with a superior might have intimidated some HSAs, though my impression is that most relaxed and performed their work as usual as we got to know each other.

As people got used to our presence, my assistant and I were included and counted upon by many people around us. Our both being 30 – with whatever life experience that gives – is also relevant in this regard, since we were considered adults. By the time we left Mangu, most health centre staff referred to William and me as "colleagues." Still, I was always very deliberate about how the two of us were to participate in health related activities. Being in the field as an anthropology student could not disengage me from the ethical guidelines I once signed as a nurse, or from Norwegian legislation on health personnel. This restricted our participation in some activities. I could not help with documentation in health passports and registers of information I knew was not accurately gathered, or give polio drops from vaccine vials I knew had been handled contrary to cold chain and hygiene measures. During activities, I also struggled to not interfere with injection procedures incompatible with my own knowledge or other actions that I *as a nurse* could not partake in. However, I concluded that I had to take the position of a learner, and to draw the ethical line at my own participation. Throughout fieldwork I rather used open and somewhat naïve wondering as a method to understand

and discuss people's procedures as health workers.

Data production

During my five months in the field I produced a wide range of data, mainly by talking to health workers, mothers, traditional healers, people of all ages living in the villages, Malawians with different backgrounds, and some visiting foreigners. Throughout the process inter-subjectivity has been an important goal, meaning that I have strived to account in a clear fashion for the perspectives of several people in addition to the ethnographer's (Stewart, 1998:16). The talks took form as group discussions, individual conversations, semi-structured interviews and more structured questioning of officials at the District Hospital. William and I agreed that group talks seemed particularly successful, since people apparently relaxed, supplemented each other or expressed different opinions while discussing with each other. I met people during health centre related activities, by planned visits and randomly through everyday life in the rural area. Towards the end of my stay, I also gathered information through a questionnaire answered by the HSAs.[4] It was additionally important to observe what people said and how they acted without my direct interference, in accordance with Stewart's (1998:26) point on discrepancies between what people say and what they actually do. I also learned a lot by physically taking part in different activities. The feeling of bicycling long distances in cold rains on muddy roads to conduct outdoor vaccination clinics with no protective gear or place to go to warm up after work, or having to do laundry at four-thirty a.m. after days of rain, to be on time for work, is something which must be experienced. I also tried to follow national news from the rural countryside, which was a challenge in itself since there was nowhere to buy newspapers and it was more popular to listen to Christian radio stations in my household. Further, I have collected song lyrics, documented scenery and reporting systems (not containing confidential information) by photography, and collected different forms of material such as exemplars of health passports. My main focus has been the roles and work of the HSAs as vaccinators, and this focus has helped me to make necessary priorities along the way, while inevitably affecting what I have seen. To focus on how knowledges are handled in relation to vaccination is justified since vaccination is one of the HSAs' key

[4] See Appendix 1.

responsibilities – originally their only responsibility – while this activity is also crucial to child health.

Most child vaccination takes place at the Under Five (U/5) clinic in Malawi. U/5 clinics are operated by HSAs, who are responsible for weighing, registering and – if necessary – referring children under the age of five, plus registering and administering the required vaccines to all children under the age of one, according to the national Expanded Program on Immunization (EPI; presented in chapter two). The HSAs are also responsible for the implementation of health talks at the U/5 clinics. Eleven *Out Reach* U/5 – or mobile bicycle clinics – and four *Static* U/5 located at the Health Centre are conducted monthly by the HSAs in Mangu.[5] This left me, in theory, with five to six workdays a month to learn more about the other work tasks of the HSAs, and to seek out other actors and information related to health care in this rural area. In practice, I still tried to be flexible and to partake in as many events as possible. In total, I participated in fifty-four U/5 clinics during the fieldwork period. During the weekends, market and church activities occupied a lot of time for many people, which made these interesting arenas for me. I was also invited to visit several of the HSAs and other community members at home.

With training in certain research traditions one possesses constituting concepts and values that are in no respect neutral and which remain influential no matter the degree of self-critique and reflexivity. Such pre-theoretical assumptions are central to contemporary anthropological theory and methodology (Moore, 1999:9). Awareness is crucial, yet challenging. To be part of a multi-disciplinary research project with established researchers has been enriching and challenging in this regard. I have also learned a lot by being one of three master students of social anthropology travelling to Malawi in the same period as part of the SUM MEDIC team. We have all done related but separate and differing fieldwork. Our respective backgrounds from journalism, nursing and development studies have made our discussions complex, and I have had an additional forum in which to nuance and challenge my observations, in addition to seeing differences and patterns throughout the process.

[5] Ideally conducted by teams of about six to seven HSAs, but often conducted by three or less.

Analytical framework: What is medical knowledge and how can one study it?

It was Saturday afternoon and the REACH TRUST vehicle had just left my backpack, washtub, mattress and me in what felt like the middle of nowhere. There I was, planning to study 'the multi-relations of vaccinators' in some way or the other… My new host was proudly giving me her "geographical tour," while I could barely believe it was actually not a dream. She told me she looked forward to my participating in and sometimes leading the family's evening prayers, and pointed to where it would all be happening. On the wall, I noticed a white shiny banner with black letters: "A cheerful heart is good medicine. Prov. 17 22" *"It's from the Bible," my hostess explained, and my confidence increased a little. There seemed to be some multi-relations going on.*

Knowledge can be defined as culturally constituted views of reality, springing from music, dance, emotionally laden settings and the like, as much as from words (Janzen, 2002:191). Three dimensions or perspectives can be said to shape *medical* knowledge of illness and health around the world, according to Janzen (2002). The first constitutes ideas of *causes* and *cures* of illness, linked to views of "the way elements and forces in the world act upon one another" (Janzen, 2002:192). Furthermore, cures are always linked to people's causal explanations, and when studying this one should also bring the specific contexts and historical changes into the perspective. The second shaping dimension is "[t]he *scale*, *scope* and *focus* of ideas of cause and cure" (Janzen, 2002:194, my italics). Janzen exemplifies with how western medical thinking, or biomedicine, used to be founded on more or less single-cause theories based within the individual physical body, while many other traditions have relied upon different cosmic, natural and/or social aspects when explaining illness. The third and final dimension concerns how the first two dimensions are believed to *play upon and situate the body or person*, depending on how body or personhood is defined. For instance, a lot of western medical thinking has been based on a cultural dichotomy between mind and body, and between individual physiques and society. Anthropological studies have, however, contributed to a nuance of this view and to the repeal of such absolute dichotomies by presenting people as mind *and* body, and the body as shaped by lived experience in a social world (see Sheper-Hughes & Lock, 1987). The subject is thus both shaping and shaped by culture (Ortner, 2005) – an argument which will be elaborated later. According to Janzen (2002:150), where suffering – and, I would add, the *cause* of suffering – is said to

lie, the experience of sickness is defined. In other words, different definitions have different effects and consequences. Studying definitions of personhood and body, human nature and disease thus reveals that these concepts also have to do with moral and dominating social values, though medical culture consists of vital and no longer vital knowledge (Janzen, 2002:214).

Janzen's definition and dimensions of medical knowledge highlight how knowledges of illness and health evolve and change as cultural constructs, and thus demonstrate that no system can lay claim to a final truth. Nevertheless, our classifications have the power to shape reality – stigma following from our definitions of disease does, for instance, feel very real – and it is up to us to strengthen and enhance human dignity (Janzen, 2002:209). Anthropological studies of medical knowledge, rituals of healing with the use of symbols and metaphors, or more generally the creation of meaning through social interaction are thereby valuable. In this thesis, the focus of analysis will be on the syncretism, hybridity, creolization and pluralism – with its asymmetry – of different medical knowledge, identified by use of Janzen's three perspectives. Eriksen (2007:114) distinguishes between *syncretism* and *hybridity* as non-reflexive and self-conscious amalgamations or mixes of worldviews, respectively, and defines *creolization* as an interchange leading to "new forms [of cultural phenomena] with varying degrees of stability." Finally, *pluralism* can in this context be defined as "the existence and use of many different health care alternatives within societies" (Stoner, 1986:44). The way power is part of this un-static picture of co-existing elements, themes and values is of course central, and analytical approaches to power will be discussed shortly.

As a contributor to the anthropology of knowledge, Barth has presented a model for studying *traditions of knowledge*, to understand how they "are configured and how they are variously reproduced and changed" (Barth, 2002:3). This analytical framework partly overlaps with Janzen's three dimensions above, but Barth (1999, 2002) specifically calls for a comparative perspective to see how knowledge is produced, distributed, and more or less shared and contested. He argues that three faces of knowledge can be analytically distinguished: (1) assumptions that are made about the world, (2) the communication of these assumptions through symbols, words, actions etcetera, and (3) the social organization or pattern of action for their transmission

(Barth, 2002:3). The second and third faces of knowledge are thus valuable additions to Janzen's dimensions. Barth's framework for analysis can be used to see how knowledges merge, coexist or collide, and it might contribute to reveal the domination of certain assumptions, how and in which media assumptions are communicated, who are included/excluded and how, and who it is that wants to use certain knowledges and why. By way of an actor-oriented focus, this thesis will illuminate individual differences in views and methods of knowledge mediation, despite the identification of some overarching traditions of medical knowledge. In this regard Long (2004) provides a useful supplement to the presentation of knowledge thus far when reminding us of the need to acknowledge

> the existence of 'multiple social realities' (i.e., the coexistence of different understandings and interpretations of experience) [… and that knowledge] is, therefore always essentially provisional, partial and contextual in nature, and people work with a multiplicity of understandings, beliefs and commitments (Long, 2004:15).

Other theory used during the production of this thesis is linked to Kleinman (1980) – and others – who has identified three *contexts of medicine*, which are helpful when looking for different forms of medical knowledge. These are *the popular sector,* consisting of nonprofessionals' own judgment and management regarding health; *the professional sector,* meaning bureaucratically organized medicine; and *the folk-healing sector,* which is constituted by practitioners operating outside of the bureaucracy. Kleinman emphasizes that these must be understood as a complex of sectors, existing in all indigenous healing systems, and often overlapping. Nevertheless, although these are enlightening perspectives, they might lead to static divisions as I see it, overlooking syncretism, creolization and medical pluralism. Stoner (1986) argues in a similar fashion – and can be said to support my argument – when he discusses the problematic trend of studying "medical systems" rather than medical practices chosen by actors based on actual options. He claims that medical systems are mainly analytical constructs, and that healing *techniques* more than healing *systems* surround us. Additionally, he argues that medical pluralism and syncretism have been overshadowed by a false dichotomy and delineation between *modern* and *traditional* medical systems. In his article, he shows that people rarely relate to healing as involving such distinct entities. This categorization also gives the impression that unchanging, identical or

similar practices are found within the two categories, even when there are clear historic and philosophic variations (Stoner, 1986:45). This is not to say, in my opinion, that actors might not benefit from knowledge of how to maneuver within "medical systems," however, following Stoner, the way to approach such knowledge advantages – or power – might be by focusing on *actors that act*, rather than on thinkable resulting overarching structures. We should, one could say, hold two thoughts in our heads simultaneously.

Janzen and Barth both see knowledge as related to power, as do several other scholars. Knowledge is created and recreated in communicative *relations*, and used with purposes and effects. Weber defines power as "the chance of a man or of a number of men to realize their own will in a communal action even against the resistance of others who are participating in the same action" (Weber, 1946:180). However, in chapter six, this definition will prove inadequate in light of some of my empirical data, and a concise definition will prove hard to reach. Nevertheless, Foucault (1976/1999) is among those who see a strong link between power, social control and knowledge. He has focused upon how power produces knowledge, and demonstrated how no power relation exists without knowledge to support it. Knowledge then seems to be a prerequisite for power, and it might stem from power. Further, power as a relational exercise always includes resistance or the possibility of resistance, according to Foucault. His investigations of power and social control within institutions also reveal how health workers can be both intermediators of state – and, I would say, international and more individual – power *and* simultaneously under the influence of power structures themselves (Foucault, 1994:294).

Weber's three forms of *authority from legitimacy* – which he saw as prerequisites for power – are often mentioned in enquiries of different medical practices and knowledges. Weber (1971:88) argues that traditional authority, rational-legal authority, or charismatic authority is attributed to the dominant by the dominated, often in overlapping form. Charismatic authority is, for instance, often identified in relation to medical knowledge when it comes to faith healing preached in church, while traditional authority in medicine is said to be present when knowledge and practice are legitimized with statements such as "this has always been done." In Norway, the rational-legal

authority of biomedicine stands strong as the population largely let science dominate through legislation.

Contrary to Weber, Bourdieu (1996) argues that not all power needs legitimacy: The most effective power is rather the one made natural, or invisible, and which apparently has nothing to do with dominance and social difference. Domination is unconsciously accepted since inclinations have become embodied, or part of our habitus (Bourdieu, 1994). This view agrees with Foucault's argument that modern industrial societies are pervaded by hidden moral control and apparent rationalization through the "natural" invasion of science into everyday life; medical regimes take part in the standardization of people by disciplining the body (Foucault, 1973, 1975/1999). Such perspectives are interesting, when studying transference of knowledges and social values, as one way to include implicit factors to explain events.

In this chapter, I have designated child vaccination as an interesting topic for research. Further, I have argued that an ethnographic study focusing on vaccinators' handling of different forms of knowledge can highlight crucial aspects in the complex chain of processes directed at disease prevention. After accounting for research methods and influencing factors, ranging from practical to personal to theoretical, including strategic research choices made, I continue with context descriptions. The aim is to equip the reader with further background information to enable better judgments of the data production and of the analysis to come.

2 Context descriptions, from national to local to social

The Out Reach clinic was about to finish, and women and children were leaving the gentle shadow of the big tree, under which we had all been gathered. William and I were listening to two women discussing the coming night while they wrapped their babies in blankets and tied them to their backs. "My child will not sleep after vaccination," one of them complained. "Neither will my son. Sometimes he does not sleep until eleven. But for me it's not a problem, I have a torch," the other one replied. The first woman was clearly impressed, and they continued discussing the details of this simple device. I turned to William and asked him what the big deal was about this flashlight. He looked at me, and I realized that I had just posed the most ignorant question of my fieldwork. A sick child is never just a sick child in Mangu, I thought to myself, and a shiver went down my spine as I pictured the darkness that would surround us by five-thirty.

Though this study concerns the work of HSAs in a specific locality at a specific time, wider contexts must be included to unpack observed practices and related processes. I nevertheless choose to begin and end this chapter with the HSAs, since their work is the main enquiry of this thesis. In between I present Malawi – in a world of other nations and international institutions – emphasizing health challenges and official health services specifically. I then introduce the district where the study was conducted, before I encircle Mangu and people living there, including the Health Centre and the HSAs. The contexts interpreted and presented here all influence processes and people's actions locally. Like the researcher presenting the contexts, people have no choice but to operate in some sort of relation to them.

The HSAs

When an outbreak of smallpox hit people in Malawi in the late 1950s, temporary "Smallpox Vaccinators" were appointed. Various health challenges kept arising, however, and this category of health servants evolved via "Cholera Assistants" to "Health Surveillance Assistants" in the 1980s. Nevertheless, it was not until 1995 that the position was officially made permanent (Chilowa & Kadzandira, 2001:11).

The number of duties given HSAs has increased considerably over the years. From being vaccinators and specific outbreak and prevention servants, they have become "the point of contact between the formal health service delivery system and the community" (Chilowa & Kadzandira, 2001:12). With disease prevention and local participation for health improvement becoming trends in the professional health sector their mandate has evolved to include general health and outbreak monitoring, and local advancement of hygiene and sanitation, including water and food in private households, schools and markets. They must also form Village Health Committees and other volunteer forums in their catchment area.[6] A range of health programs imposed by the government or other actors in the health industry need the HSAs to perform a variety of detailed tasks since "they are the ones out there" and "they are there anyway, and know the community well."[7] Advancements in mother- and childcare – instituted by the Millennium Development Goals – are now among the heaviest of these ever increasing burdens. The spreading of health related information and the influencing of people's knowledge on many topics are thus a considerable part of their job, along with extensive reporting. Moreover, HSAs' duties at the health centres also seem to increase. In Mangu HSAs have responsibilities related to patient registers, malaria, AIDS, tuberculosis and nutrition, depending on seniority and additional training.[8] In other words, an HSA in Mangu has a range of responsibilities in addition to vaccination and other U/5 activities. Chilowa and Kadzandira (2001) emphasize how the child vaccination program might suffer from this situation, and many HSAs indeed considered the quantity of imposed tasks to threaten the quality of their performance. Many also had difficulties listing their full range of work tasks. Considering their workload, the frequent introduction of new programs and responsibilities, and individual variations based on varied training and experience, the HSAs' apparent confusion comes as no surprise.

To get a job as an HSA in 2010 applicants needed to have a Malawi School Certificate of Education (MSCE, which implies four years of education after eight years of primary school), or a Malawi Junior Certificate of Education (MJCE, implying two years in

[6] In this context, *catchment area* refers to one or more villages, depending on population size. On average, the distribution in Mangu is approximately one HSA per 2000 people. The official objective is 1:1000.
[7] Stated by a visiting program manager.
[8] See Appendix 2 for a detailed official job description.

secondary school). Theoretically, applicants should also complete the Ministry of Health and Population's HSA training course of eight to ten weeks. As described below, however, the latter is in practice not offered to everyone before they become an HSA. I was told that five of the HSAs in Mangu had an MSCE and fourteen an MJCE. The remaining "senior" had eight years of standard education only, today offered by the government free of charge but of varying quality. She was still around due to long service and experience, I was told.

Of the 20 HSAs working from Mangu health centre, four men and four women were "seniors." They all had thirteen years of HSA experience, and thus more clinical and administrative responsibilities than their HSA colleagues had. Further, there were six female HSAs also permanently employed, in addition to four female and two male "contract workers." In 2006 a donor granted funding in the form of salary payments to increase the number of HSAs in Malawi. These posts were set up with three-year contracts, and the latter group of HSAs had been employed under these terms. In 2010, they were therefore working without a valid contract, and they waited anxiously to hear news about their future and receive their delayed payments, month after month. Their salaries were also lower than the salaries of colleagues on permanent contract with the same time in service. At the Health Centre in Mangu three of these "contract workers," as they were referred to, were also waiting for their official HSA training. The three others had received official training by the Malawian government just before I arrived. Administrators at the District Hospital told me that there were currently 532 HSAs in this southern district, and that of these, 192 had not yet (June 2010) received the official training. The donor (Global Funds) allegedly paid 23 of the HSAs in the area.

The salary level of the HSAs varies, and most gave unclear answers when I asked questions on the topic. This was an area of controversy, as allowances of varying quantity are common for participation in workshops, training sessions, implementation of regular or outbreak-based campaigns or programs, or for individual monthly tasks.[9]

[9] Save the Children, for example, was said to "have a lot of money" and to give the highest allowances: "After training you may get 5000 MKW [about 32 USD] a day from them!" Understandably, a result was varying eagerness to partake in activities depending on allowance levels. I observed several HSAs singing and dancing after

Some of the younger HSAs claimed that the same individuals were constantly granted most of these activities and money. During a vaccination campaign due to a measles outbreak – to which I will return – the HSAs as a group also protested loudly since they found allowance levels preposterous. The "contract workers" made 9900 Malawian Kwacha (MKW, which is about 64 USD) of basic wage a month, though payments were highly erratic. The other "juniors" made about 11000 MKW, while one of the senior men made about 13000 MKW of basic wage. This man also had additional income from animal rearing and farming, as did a number of his colleagues. Some of the female HSAs alternatively sold clothes to supplement their salary. The HSAs spoke openly of how salary, contract and training issues affected their motivation to work.

Paid jobs are not taken for granted in rural Malawi, however, and the HSAs expressed appreciation in this regard. Still, several pointed out the hardships of their work: Moving around to remote villages is a challenge in rains as under the burning sun, and expectations from supervisors are high. I was additionally astonished by the sheer range of responsibilities delegated to the HSAs after limited training, and the risks that came with the job due to this minimal training and the physical conditions. During my stay, one HSA – that I know of – pricked herself on a used needle, and at least two were involved in severe bike accidents. The HSAs often expressed little hope for improved working conditions, due to national budgetary constraints.

The nation

In 1891 Britain established a protectorate in Central Africa, which was named Nyasaland. Their official intention was to end conflicts and human misery arising from Arabic and Portuguese slave trade by introducing Christianity and other measures of refinement. After increased resistance to British rule, the independent nation of Malawi was officially recognised in 1964, and underwent a sudden change to dictatorship under Dr. Hastings Kamuzu Banda. Filling the power vacuum after the colonial power with brutal authority for thirty years, Banda definitely put his mark on Malawi. Since 1994, however, Malawi has been a democracy, though struggling with severe corruption, increased pressure on agricultural lands and human suffering especially related to

receiving 950 MKW at the end of an evaluation meeting; one of them cheering, "Today my family shall eat meat!" while another was happy to afford transport to a sick relative.

poverty and HIV/AIDS. Many people emphasised to me that their country is in great need of international help due to poverty, but also proudly pronounced how President Banda built the country during his regime and how Malawi has never been a place of war. The current government, led by President Bingu wa Mutharika since 2004, is said to have made some but limited improvements (UN-OHRLLS, 2008).

Malawi is a landlocked country of only 118,484 km^2. Twenty percent of this area is covered by the 600km-long Lake Malawi, and the Sub-Saharan country additionally shares borders with Tanzania, Mozambique and Zambia. The scenery is generally quite green and hilly, as Malawi is located at the south end of the Great Rift Valley, but the nature is also varied and changes rapidly from place to place (Eidhammer, 2005:12). The United Nations has estimated the 2010 population to be 15,692,000 (UNPD, 2009). Exact figures are unavailable however, since many citizens are not registered, or reported to the government when deceased, as was notified during the 2004 election (Eidhammer, 2005:105). More than nine different tribes, plus a number of people originating from Asia, Europe, and immigrating or fleeing from other African countries, inhabit Malawi. Estimations indicate that 80,2% of the total population reside in the rural countryside (UNDP, 2009:193). Most rural dwellers make a living as subsistence farmers or workers on large plantations (United Nations Malawi, 2008). The country is therefore vulnerable to deviations from the regular seasonal changes, normally bringing wet and hot weather from November to April. During my stay, alarming statements circulated in the media predicting severe food shortage due to late rains in 2009 – a serious threat as two-thirds of the population *generally* do not have enough food to eat six months of the year (Eidhammer, 2005:16).

The United Nations Development Programme (UNDP) ranked Malawi among the bottom twenty-four countries in its Human Development Index (HDI) published in 2009 (UNDP, 2009:173). This is, however, an improvement compared with 2006 estimates. Life expectancy at birth was 39,8 years in the 2006 report (UNDP, 2006:318) and 52,4 years in the most recent HDI (UNDP, 2009:173). Nevertheless, poverty is widespread, as 73,9% of the population is living on less than 1,25 USD a day, and 65,3% lives under "the national poverty line" (UNDP, 2009:178). When it comes to health, several figures suggest hardships in people's lives. Between 86 and 183 children – on average 120 – out

of 1000 live births never reach the age of five in Malawi, depending on parents' income and education levels (UNDP, 2009:201). The HIV/AIDS prevalence is 11,9% for the adult population aged 15 to 49 (UNAIDS/WHO, 2008:4), and 65,9% of the population is under the age of 25 (UNPD, 2009).

Health challenges and official health services in Malawi

To deal with some of the hardships mentioned above, the Essential Health Package (EHP) was introduced in 2002. Worked out by the Ministry of Health and Population in Malawi, in consultation with its donors, the EHP aims to provide the population with a minimum package of health services free of charge, based on common causes of mortality and morbidity. However, 40% of all health services are provided by the Christian Health Association of Malawi (CHAM) or other private institutions (Ministry of Health [Malawi], 2004:8). Nevertheless, the EHP includes: antiretroviral drugs for HIV/AIDS patients plus voluntary counselling, testing and treatment of other sexually transmitted diseases; safeguarding of reproductive health and family planning plus maternity services; treatment and prevention of malaria and vaccine preventable diseases included in the Expanded Programme on Immunization; tuberculosis and schistosomiasis testing and treatment; treatment of acute respiratory infections; diarrhoeal diseases and injuries; and treatment of malnutrition (Ministry of Health [Malawi], 2004:23). However, I found access, reliability and quality of care to vary. This has dramatic consequences in a country severely affected by the mentioned health threats, with all interrelated complications. Still, the challenges come as no surprise, as the total number of doctors and nurses in 2004 was 266 and 7264, respectively (WHO, 2006). Richardson *et al.* (2009:4) report that nationwide there were 5000 HSAs in 2009. These 5000 are considered to be "the backbone of [the] EHP" according to the Ministry of Health and Population (Ministry of Health [Malawi], 2004:13).

The Malawian Expanded Programme on Immunization (EPI) – which has been developed in collaboration with WHO, UNICEF and other donors since the 1970s – in 2010 included BCG, Polio, DPT-HepB+Hib and measles vaccination for children, and tetanus toxoid vaccination for pregnant women and women of child bearing age. Vitamin A supplements and de-worming tablets are also routinely provided for children under the age of five (Ministry of Health and Population [Malawi], 2003:1). EPI

objectives include vaccination of more than 90% of children before 12 months and more than 80% of targeted women, plus surveillance of vaccine preventable diseases (Ministry of Health and Population [Malawi], 2003:12). To establish the exact vaccination coverage in Malawi is a challenge. A number of births happen outside the health facilities and are therefore not registered, and register books are often in poor condition since they circulate between different vaccination sites without protective cover – to mention some influencing factors. Numbers from two sources indicate the great uncertainty in coverage levels: The Welfare Monitoring Survey from 2007, conducted by the National Statistical Office in Malawi, claims that about 40% of Malawian children are fully vaccinated before their first birthday – as recommended – and it is emphasized that there are great variations between districts, the different vaccines, and that parents' economic capacity influences the child's vaccination status (Nielsen, 2011:54). WHO, on the other hand, operate with coverage levels based on official reporting from the Malawian healthcare system: around 90% in 2007 (WHO, 2011).

The district

Malawi is divided into a northern, central and southern region, and altogether 28 districts with administrative headquarters. There are 22 district hospitals in the country. The public health service model additionally consists of four central hospitals – or tertiary hospitals – and 414 public primary health care facilities or community-level health centres, in addition to 138 run by for-profit or non-profit organizations (Richardson *et al.*, 2009:3). The hospital in the district where I stayed was intended to serve a population of 93,000 people with first line services as a health centre, and 617,195 people scattered over 1715km^2 with second line services. These numbers were obtained at the district hospital and allegedly originate from the National Statistical Office. In addition to the district hospital there are 23 Health Centres in this district, including those run by for-profit and non-profit organizations. Some of these belong to large private tea and macadamia estates, of which there are several in this area. The latter serve workers and their families, who are considered to be among the poorest people living in the district. Most rural Malawians will never utilise central or district hospitals – not to mention private services – but receive only primary health services at health centre level (Richardson *et al.*, 2009:3).

Mangu

According to information from the district hospital, the district is again divided into 10 administrative zones or Traditional Authorities. These are headed by a male or female chief or TA appointed according to local tradition based on inheritance. The TA enthrones at the top of the traditional hierarchy, surpassed only by senior TAs and Paramount Chiefs. The latter might reside in another country – as was the case for the chiefs of several of my household members, who belonged to different tribes – but still possess authority. I was told that TAs and chiefs at some subordinate levels receive a monthly honorarium from the government, and therefore are somewhat pressured to respond to the expectations of the government and especially to those of the ruling party in Malawi. One can wonder if this practice influences, for instance, the vaccination coverage in the country. Signs of cooperation difficulties between some chiefs and some HSAs will be described later. The TA of my area, whom I visited before settling, has five Group Village Headmen under her leadership. The areas headed by three of these constitute Mangu, and comprise 16 villages headed by Village Headmen. The total population of these villages was 27,539 according to a headcount conducted by the HSAs at Mangu Health Centre in 2007–2008. It was emphasised that this number differs from numbers used by, for instance, the national Ministry of Agriculture for various reasons like seasonal labour migration. Also, as services provided via the public health centre are free of charge, many people from neighbouring areas served by private clinics choose to seek help in Mangu. U/5 services are, however, provided for free everywhere since the government decided to fund this service some years ago.

People living in Mangu belong to different tribes, while the absolute majority present themselves as Christians. There is a range of different churches in the area, and in my household all family members were expected to pray together at the end of the day, though three to four different churches were represented. Praying was also part of Health Centre activities to protect from sickness and accidents, as will be illustrated and discussed later. Although the nurse-midwife I lived with has been married to a man belonging to a different church and tribe than her, many Malawians I talked to expressed preference for marrying within their own church and tribe. As in my household, however, extended families of various combinations are not uncommon in the area, and many HSAs were expected to support extended-family members.

Health workers are often involved in seasonal subsistence agriculture with their respective families, as are members of most households in Mangu. The staple crop in Malawi is maize. In Mangu people additionally grow tobacco, sugarcane, groundnuts, sweet potato, Irish potato, banana, avocado, tomato or mango to mention some of the most common crops. The area is lush, characterised by green ridges, which is suitable for agricultural production. Other business activities in the rural area are typically bike repair, selling of groceries and merchandise, tailoring and transportation by bike or car – though the latter means are scarce. Alternatively some try to improve their living condition by working in one of the large plantations, but this was described as a last resort. Due to Mangu's geography it is not a place typically visited by people in transit, and several inhabitants told me the place is much quieter these days than it used to be thirty or forty years ago. Despite alleged emigration, Mangu does host a secondary CHAM boarding school, in addition to the estate plantations, attracting a number of students and agricultural workers.

Delimiting the field of research

For those who can afford it, the four concrete buildings that constitute the Health Centre in Mangu is situated 45 minutes by pickup – over hilly dirt roads – from the main road running past the district's administrative headquarters. Alternatively one can use bicycle taxies when travelling with little luggage. A shortage of ambulances, and the cost of such and other forms of transport, made the distance to the District Hospital a challenge for many people in Mangu. However, compared with other buildings in the area, the Health Centre looks modern and solid, though lacking piped water and electricity. Apart from a few privately owned estate-buildings, the government-owned premises thus stand out. Still, several people emphasized that the first president, Dr. Banda, was the one to give credit for the appearance of the Health Centre.

Besides the school system and the police force, the Health Centre in Mangu provides some of the very few official permanent jobs available. The services at the Health Centre include outpatient care headed by a Medical Assistant (MA), and family planning and maternity services headed by three nurse-midwifes, besides the additional activities conducted by the HSAs. There is also a small dispensary at this facility, which the employees run by cooperation.

The head of the Health Centre is in theory the Medical Assistant, who must have two years of medical training. The MA substitutes the doctor or clinical officer in rural areas, because Malawi lacks such personnel. Four different young men occupied the position of MA in Mangu during of my stay. The high turnover was related to their dissatisfaction with living in the countryside with no electricity, restaurants or other desired resources. They also complained about not having "real time off duty" as they were living in staff houses next to the Health Centre. Many people from the villages also complained that they were met by a "drunk doctor," "no doctor," or that they were not given the opportunity to fully explain their medical problem to the doctor. The latter came as no surprise to me, since the morning crowds outside the MA's office could be massive.

The next link in the official service line was three nurse-midwives – one of whom was hired by Medecins Sans Frontieres (MSF), with 150% higher income than the two others. They all have three years of vocational education and many years of experience, and thereby functioned as authorities at the Health Centre. Additionally, as the labour ward never closes, the nurse on duty is, theoretically, always present at the Health Centre. At the bottom of the hierarchy – below the HSAs – are Hospital Attendants and guards with no required education. They take care of hygiene and order on the premises, and assist wherever needed. Such assistance might include registering patients, stitching a wound or delivering a baby if no one else is around. There was a high level of cooperation among most staff in the form of delegation of tasks for pragmatic reasons officially or unofficially. People also stood up for each other whenever people from the villages or officials would complain,[10] and reporting a colleague was something many feared to do. Still, I heard of many conflicts typically related to neglected tasks. Such conflicts involved individuals or whole categories of staff disagreeing with each other across "departments." However, strong protests were seldom uttered openly upwards in the organogram, for instance, when people were delegated or imposed unreasonable responsibilities. People's authority seemed, though, somewhat influenced by their age.

[10] The HSAs were supervised by an Environmental Health Officer responsible for HSAs at 3 health centers, in addition to tasks at the District Hospital. This man was thus not around on a daily basis.

The HSAs ranged in age from about 25 to 45, and they all came from rural areas, but few from Mangu. They were all supposed to live in their catchment area, according to the official philosophy regarding HSAs, but few did. This, I was told, was due to lack of proper housing in the villages, or lack of job opportunities for the female HSAs´ husbands. HSAs also expressed the need and wish to stay close to both the Health Centre and the trading centres, where things like basic goods, phone charging and transport are available. When I asked the HSAs if they saw themselves as villagers, several pointed out that they all were villagers coming from the countryside, but that they at the same time had different desires and needs than most people in the area given their knowledge of things like hygiene and nutrition.

The 20 HSAs worked in more or less regular teams of varying size on several tasks, seemingly divided by catchment areas, residential areas, gender and friendship. As William and I took part in all the Out Reach clinics, we regularly cooperated with everyone. However, some individuals were more open to work-related questions and discussions than were others, which may be related to their proficiency in English and their work dedication. Those who seemed most eager to discuss their work were typically, but not exclusively, the male HSAs and seniors. As a result, I chose to spend a lot of time with certain people. However, many of the female HSAs of my age were typically eager to discuss and joke about other topics, such as family life, religion and fashion, and several wanted to introduce me to their family. Overall, I thus ended up spending time with both women and men, "young and old," and got especially close to eight of the HSAs, though on different grounds.

So far, the focus of this chapter has been on contextual factors, ranging from national to local to social – including historical aspects. I now continue with ethical implications relevant for my study – which must be read in light of the context descriptions.

Ethical implications

We were three days into the measles vaccination campaign, and MSF staff had invaded Mangu with their shiny new trucks and huge cooler boxes. It was not even eight o'clock but long queues had already formed outside the reorganized Catholic Church. Inside Team Ten

members were working as fast as they could to prepare the site. I noticed that one of the European supervisors had arrived and was now filling syringes with HSAs from Mangu and a Malawian man I had never seen before. As the supervisor was standing still for the first time, I used the opportunity to ask some questions. The women I thought was a nurse turned out to be a young logistics manager without any training in health care, and the man next to her was her driver. I must have looked surprised because she loudly assured me that "Nobody here are nurses anyway! And these HSA people barely have any training! It's terrible! So anybody can do this job. I just showed my driver. I think you just need to be in the MSF-campaign system." The lips of the senior HSA standing next to her tightened and he looked down.

Anthropological studies of human interaction require high ethical awareness, something William and I discussed the meaning of throughout the fieldwork process. Before settling in Mangu, we talked about the meaning of confidentiality, and how people should feel safe talking to us, knowing that we would not reveal their personal opinions or actions to others. We also discussed how we would always be "at work" when in the rural area, even when relaxing or enjoying ourselves, and that we after this fieldwork period still are obliged to ensure people's anonymity and prevent tracing of statements and actions to individuals as much as possible. The latter has been particularly challenging in the process of writing this thesis, as many potential readers might know where I conducted the study.

During the first weeks in the field, I put particular emphasis on informing people of the purpose of my stay, which was more challenging than expected. Many were not so interested in hearing details about my study and its methodology, and several of the health workers saw it as their obligation to include me in their activities, as they thought I was sent by – their employer – the government. This was, of course, partly true, since approval and location of the study were provided by the Ministry of Health and Population and by the administration at the district hospital. I therefore tried to make it clear that I was not reporting to any officials or acting on their orders, and that cooperation with me was not mandatory. Nevertheless, it took some time before most people saw me as trustworthy and independent, and some never started talking to me in a way that convinced me they really spoke their minds. To act polite and be helpful are

considered very important in Malawi, an issue William and I discussed as we gradually got to know each other and our differences. Statements that to me could seem dishonest could represent proper etiquette as William saw it. Such discussions helped me in my pursuit to understand people's motivations and to understand what their statements meant in the particular context. Nevertheless, towards the end of my stay, many of the HSAs saw me as a potential fighter for their wish for higher salaries and better working conditions, and spoke more critically of certain challenges they face. It was in this regard difficult to explain the limits of my study and authority while also making people aware of the implications of participation. I also found it challenging to decide how open I should be regarding the power differences between 'them' and me. As a researcher and writer, one possesses the power to define and delimit, and one necessarily presents things as one has understood them – from a particular position. It is therefore important to emphasize that I am the responsible party for all content in this thesis, and any possible misunderstandings or misleading descriptions are my responsibility alone.

Another ethical dilemma that needs to be mentioned is illustrated by a question posed by one of the HSAs when I introduced myself to her. She asked me what she would achieve by including me in her work. The fact is, as I told her, that I do not know. My thesis can potentially have long-term positive effects, on its own or as part of the larger research project; but whether this, if it were to happen, would affect her personally is unknown. More concretely however, I believe I eased the work pressure on the HSAs somewhat during my stay, as I typically assisted in weighing the children – often more than 100 per day – carrying equipment and more. Some of the HSAs also told me that they enjoyed discussions with me, and felt that they learned something about a different culture through my presence. Nevertheless, it was hard to leave the area, knowing that our time together take me forward in my career, while the people I met stay behind in the deep poverty and rough country life so widespread in Malawi.

Although my thesis does not investigate whether vaccination is a good thing – it rather investigates how some processes in a vaccination program work – my view on this issue is nevertheless ethically relevant for the data production and subsequent analysis. My training in a biomedically influenced discipline has contributed to my personal conviction that vaccination is generally an important and lifesaving ingredient when

promoting child health. Simultaneously, my years of education have made me aware of different views on and results of vaccination, and aware that it is problematic to see it as only beneficial. Together, these insights give me if not an unbiased, then a nuanced, starting point.

Having accounted for research methods and influencing factors, arenas, actors and ethical implications decisive for this study, I now proceed with illustrations of HSA work in vaccination clinics as I observed and experienced it. These illustrations serve as a starting point for the analyses to come of how the observed HSAs handle different knowledge in their work, and how their knowledge handling might promote vaccination.

3 The U/5 clinic

It had been raining periodically for days. Heavy showers that seemed to penetrate everywhere filling the cold and raw air with loud pounding. I was in my bed listening to the huge racket, wondering if the corrugated iron roof would actually cave in this time and how wet my backpack was on the floor. But most of all I was picturing the road to Lumbo, a village one hour on bicycle from the Health Centre, and the destination for the day. My first Out Reach U/5 clinic had been to a village along the same road in February, and two HSAs, William and I were then surprised by rain, which in minutes turned the dirt roads into mudslides. We were all up to our knees in mud, and had to drag our bikes on the hilly tracks as the wheels were blocked by red clay. It soon felt as if we were walking on stilts, since the mud agglomerated on our shoes. It was late in the afternoon when I came home that day, and I felt grateful that I was not responsible for fetching water, lighting the fire and preparing food for my household, as my traveling companions were. Since then, we had been on this road many times, mostly sweating from the burning sun rather than shivering in rain-soaked clothes.

Darkness was still surrounding me, and I hoped for changing weather as I decided to wait until sunrise before getting up. Once again, this was the luxury of a tenant, only responsible for setting the table and doing the dishes, but not for peeling and boiling cassava on the open fire for breakfast, or for doing other morning house chores. At six-thirty the rain was still pouring down, and I speculated on how bad the hilly road to the Health Centre would be by now. In dry weather, it took 20 minutes by bike at full speed. In this rain, my nurse-midwife hostess told me, "it is no point in you going anyway as none of your HSA colleagues will turn up since they think the other HSAs and the mothers will stay home." For a true "professional" however, it was a different story she said, since the maternity ward could not be abandoned, and she had to release her colleague from night duty, as she would like to be released herself. At seven she took off her nicely polished shoes, put them in a well-used plastic bag which she balanced on her head, wrapped herself in a *chitenje*[11] and marched off. She later told me that she fell on

[11] A multi-purpose piece of cloth with colorful patterns, used by women to protect their clothes, dress up, cover knees and shoulders, carry children on their back, make a political statement etc.

the way, as it was impossible to stay balanced on the slippery road. A bit puzzled by the situation, I kept waiting and wondering what to do. Bicycling was a prerequisite for going as far as scheduled, but would I be able to reach the Health Centre with my bike? If so, would the responsible HSAs also succeed? Would we then be able to transport the equipment all the way to Lumbo, and would mothers bring their children and wait for us even though they would get wet and muddy? I decided to try, since missing out would be worse than getting wet and dirty, and I was interested in seeing how the situation would turn out, with so many uncertain factors for everyone involved. The rainy season had definitely started.

At eight-thirty, I finally reached the Health Centre, after catching up with William on the way. The rain had now lessened to a drizzle and we caught a glimpse of blue sky. The two of us were soon drying in the sun, along with the crowd of sick and injured on the paved corridor floor outside the MA's office. Female relatives of in-patients at the labor ward were cooking in the kitchen area, and the premises were filled with smoke from the fires. After a while, a male HSA on the Lumbo team turned up: Mr. Moni, a junior "contract worker," seemed pleasantly surprised to see us waiting, and smiled as he saw my rain jacket. Many HSAs had commented on its size, since it was a child's jacket, but said it was a good thing, which all HSAs should get as part of their working gear. Several HSAs told me they had indeed asked for raincoats and boots, but the answer from their superiors was always that there was no money for such things at the district hospital.

While the roads were drying, we collected the needed equipment from the small room functioning as the HSAs' office and Public Health Office, in addition to functioning as a storeroom. Here an HSA would be responsible for testing the day's suspected malaria patients. We then strapped the equipment to our bikes with rubber straps made from old tires. This constituted a small cooler box with icepacks, vaccine vials and diluents, large mixing syringes, AD syringes (auto-destructible with a locking mechanism to prevent reuse), a hanging scale, three different registers (vaccination and weight register for the under-ones, weight register for under-fives, and tetanus vaccination register for women) and a cardboard safety box for used syringes. Whenever safety boxes were unavailable or forgotten, some HSAs came up with pragmatic solutions, such as using an avocado as pincushion before discarding the used equipment in a pit latrine.

Like last month, there was no measles vaccine available, allegedly not even at district level. This was a paradox since there was a measles outbreak in the country, and MSF in cooperation with the Malawian government were planning a large-scale vaccination campaign in the near future. The word was that two people from Mangu had already died from measles, and 2000 had died countrywide. I wondered if preparations for the campaign could be the reason for this vaccine shortage, but several HSAs said they were not certain of this, as vaccines were unavailable from time to time anyway. I had observed this myself, and noted that one or more vaccines had been unavailable or had run out – turnout for Out Reach clinics vary and is hard to predict – at 24 of 51 U/5 clinics that I had attended so far.[12] For a long period, unavailability was related to a shortage of gas to run the refrigerator, making it impossible to store the vaccines at +2 to +8 °C at the Health Centre. In such cases, the HSAs at Mangu Health Centre try to cooperate with the nearest CHAM Hospital where they have electricity and freezers, but from time to time one or more vaccines had been unavailable here as well. However, other matters had hindered vaccination too. Once someone, allegedly from the District Hospital, had borrowed the cooler box, and on another occasion, the glass ampoule with diluents for BCG-mixing broke on the bumpy bicycle ride. Another typical hindrance was shortage of syringes. Those affected by lack of vaccine or equipment were often advised to go to another Out Reach or Static U/5 clinic, which I observed people do more or less successfully. Storing vaccines at the CHAM Hospital means someone has to make an additional bike ride before going on an Out Reach. As we knew there were no measles vaccines to collect, we happily noted that this additional ride was not necessary today.

As we were pushing our bikes out of the Health Centre premises, Mr. Moni noticed in the waiting crowd a woman and a child who came from his catchment area. He went to greet them and to ask what was wrong, and the woman told him her sleeping daughter was suffering from fever. He praised her for coming despite the weather and assured her that the MA, living next door, would soon be available. Many HSAs knew most villagers under their responsibility, and were attentive towards them. Some even expressed fear of being held personally responsible for disease outbreaks or other health challenges by villagers and supervisors alike if something were to happen. People also typically stopped HSAs who were on their way to U/5 clinics to ask for advice or news from the

[12] Especially BCG and measles vaccines tended to be unavailable.

Health Centre. These were mostly women with questions about family planning (contraceptive methods) or the present supplies of drugs available at the dispensary. At the Health Centre and in the villages alike, the HSAs were often addressed as "Doctor," a title used amongst the HSAs also. The reason for this varied. Some people did not seem to know the difference between categories of health personnel. Such differentiation might be irrelevant, since they had never met a doctor, and sought help from the best-qualified person available in times of need. It could also be a way of showing respect and recognition, though amongst Health Centre staff "doctor" was often used with a humoristic touch.

At nine-thirty, Mr. Moni, William and I were on our way. The rough landscape in Mangu puts its mark on any vehicle, and Mr. Moni's bike was no exception. Unlike the senior HSAs, he had bought the bike himself, since there was apparently no present arrangement to secure bikes for employees. As everybody else's bike, his bike was old and in constant need of repairs, which he also had to pay for himself since there was no remuneration for maintenances. Many HSAs thus cycled around with no brakes –which must constantly be replaced in a hilly and rocky place – and I witnessed several accidents and near-accidents during my five months on the road with them. Bike trouble is very common on Out Reaches, but luckily, many people make a living by offering repairs by the roadside. If no spare parts are needed, the HSAs usually get help for free, but much needed brake pads made of recycled rubber, new hoses or bike seats are often out of reach – either unavailable or unaffordable. The general seat condition, which I never heard anybody complain about, was something I became painfully aware of as my own seat got more and more worn out. However, this day flat tires stopped us, and as it was difficult to find somewhere to borrow a pump to bring along, we decided that William and I should go ahead with the equipment to the clinic site where we hopefully would meet two HSAs coming directly from their homes.

Continuing on our own through increasingly remote areas, with macadamia orchards surrounding us, I started thinking of one of the female HSAs who wanted her husband to escort her if she had to go for Out Reach alone. Though the other HSAs dismissed the risk of assaults, and said it had been years since the last rape or robbery, I could see why someone would like to have company on this road, also considering the risk of accidents.

In any case, the landscape's beauty always struck me as we climbed heights, and saw the Mulanje Massif and the tall conifer-looking trees I used for orientation on the horizon. Our heavy breathing was the only thing breaking the silence, and the only signs of human life were the tracks, the planted trees and smoke from invisible straw thatched roofs on the distant slopes. As we approached Lumbo, small one- and two-room brick or mud houses appeared in clusters. Hens wandered around while men and women were occupied with different activities. As the sun was out after days of rain, many women were washing clothes, carrying the youngest children on their backs in *chitenjes*. Older women were sitting on straw mats preparing different green leaves and vegetables for cooking. Several put down their work and started walking towards the nursery shed with their children when they saw us pass with the cooler box.

The U/5 sites differ from place to place. Four Out Reach clinics are held in schoolyards, and schoolchildren gather around, pay close attention to everything that goes on and some sing along on health songs. Vaccination is often moved inside an empty classroom, and children hang in the windows and crowd in the doorway to see. One Out Reach is held outside a church, with vaccines given inside if the key is available. One is arranged outside a well-maintained community house, while another is conducted under a tree close to the ruins of a community shed. Two Out Reach U/5 clinics are held under the roof of nursery facilities not regularly in use, one of which is the Clinic in Lumbo, and the last two Out Reach clinics are held at an estate shed in collaboration with an estate HSA and by a water pump, respectively. At the Health Centre, the U/5 clinics are held at an open concrete podium with corrugated iron roof, while vaccines are given in the Public Health Office. At all sites the whole process is conducted as an open group consultation, with crowds of women and children gathering around the HSAs, and the scale is hung – often by gauze – from a tree, beam or separate log construction. Spectators are common, such as accompanying siblings over the age of five, women from the community selling fruits and vegetables, or people passing by. However, the number of children, women and HSAs attending varies greatly from place to place and month to month. Three times I met fathers escorting their children to U/5 as their wives were sick. These men were allowed to go to the front of the queues, and got attention and positive comments from the HSAs.

Approaching the so-called nursery in Lumbo, we could see a small group of women sitting on the veranda floor with their legs stretched out in front of them and children crawling on their laps or suckling at their breasts. Others were lined up in front of a scale hanging from the simple log construction a short distance away. A male volunteer (a "VHC") from the Village Health Committee was trying to calm a screaming child dangling, in a *chitenje,* from the hook of the scale. He was deeply focused on the quivering pointer, trying to establish the weight of the fully dressed child, while making sure the knotted cloth stayed safely on the hook.

In Lumbo two men and one woman from the Village Health Committee always assisted the HSAs during U/5 clinics. Only a few clinics had such volunteers on a regular basis due to lack of initiative by the village chief or responsible HSA, or some sort of collaboration problem, I was told. The VHCs in Lumbo had been taught how to weigh the children and document their weight, and they often supplemented the HSAs during health talks, by suggesting relevant topics for discussion or by giving examples from the village. I noted that the male VHCs today wore light-blue shirts strikingly similar to the blue HSA uniform of which all HSAs had one; a coincidence, I was told. Still, it was evident that most VHCs were proud of their position, and often functioned as spokespeople for their village and advice-givers for their neighbors. One VHC once told me that a challenge of being an appointed Village Health Committee member was that he always had to be a good example for others, and take extra good care of hygiene and sanitation matters in his own household. This was essential, as dedicated VHCs often got inspection tasks and other jobs delegated by the HSAs.

Mothers often dress their children and themselves in nice clothes for the U/5 clinics. Dresses tailored from matching *chitenjes* for mother and daughter, or from shiny, colorful fabrics from China or India are common, though clothing also reveals the economic struggles of many women throughout Mangu, and more generally in some sites. During Static U/5 clinics for those living close to the Health Centre, some women wore wigs, or had long, braided hair extensions, a few even on their daughters, and secondhand well-maintained clothes often substituted the tailored *chitenje* dresses. Some additionally exchanged the *chitenje* on their back with a secondhand baby carrier, though it looked more uncomfortable for both mother and child. Once the shopkeeper's

daughter came to a Static U/5 clinic with her child in a stroller, similar to the one I had as a three-year-old; and though it seemed easier to carry the child on her back on the mud roads, she got a lot of attention and admiring comments. Many children are also very well dressed when brought to U/5 clinics, with several layers of clothing, though the sun is shining, and with big shoes, though they do not walk. Such clothing affects the child's weight, as most mothers take off only the shoes after repeated requests by some of the HSAs. As the attending women often make positive comments about high body weight and fat-looking babies – in addition to nice clothes – several HSAs agreed with me that some mothers might intentionally try to affect the weigh-in process with many layers of clothing. This day I could see that the clothing was especially thick, with big knitted hats and jackets in luminescent colors, justified by the morning's weather.

Among the seated women outside the nursery, a male HSA in civilian clothes and the last two VHCs were plotting children's weight, based on the mothers' reporting. With all the noise and crowding at some occasions, I wondered how anyone could remember the correct body weight for their child, especially those escorting more than one child. Someone ashamed of low body weight could also easily adjust the number that would be documented, but HSAs and mothers told me this system was unproblematic. Pink-colored child health passports were now waved in front of the plotters to catch their attention so that the holders would be handled next. All children born at a health facility receive such a passport, in which growth, vaccination status, medical history, measurements and assessments are recorded. If a child is born under other circumstances, or its passport is lost or destroyed, a new passport can be bought in Mangu for 50 MKW (about 0,3 USD). When a girl reaches puberty, she must purchase a yellow-colored health passport, in which additional recording is made of tetanus toxoid vaccination, family planning measures and maternal services. Alternatively, she receives such a passport, also referred to as "card," when she comes to the Health Centre for her first antenatal checkup. Men and women over 50 years can buy a blue health passport when the other versions of the passports are full. A health passport is a prerequisite for vaccination, and even for medical treatment in general, many said. HSAs thus told people from the villages that they had to keep the family's health passports safe to avoid problems, and loudly scolded women at U/5 clinics for using cut notebooks as an alternative. The word was that the MA would not receive them, or refer anyone seeking

his help who lacked a proper passport, or who lacked proof of all scheduled vaccines, for that matter. Many therefore used empty sugar bags as book covers or containers in an attempt to safeguard the document.

Health passports also function as part of the queue system at the U/5 clinics. When people arrive in the morning, many walking from far away with a child on their back, they put their health passport in a pile or line indicating the order of arrival. They are then free to sit in the shade, on roots or stones or the like, and may use the time to relax and chat with friends. Sometimes the waits are long, or it turns out people have waited in vain. If the HSA calling out names when it is time to form weighing or vaccination queues happens to start at the wrong end of the pile of passports, the attending women protest strongly.

The latecomer: A U/5 attendee places a health passport on the ground to secure her position in the queue. She can then join the others by the scale.

Though many women in the villages are illiterate, and have to color their thumb with pen ink and put a mark whenever a signature is needed, the health passports are a source of information from the Malawian government. In the women's passports, there are drawings and small texts on how a man should take care of his family, and information that regular medication is needed for tuberculosis treatment. In the child passport, one is told how to breastfeed and later feed a child, and in the blue passport, tuberculosis and HIV testing and treatment are recommended.

The senior HSA, Mr. Baga, who is responsible for Lumbo – as catchment area – greeted us with handshakes and big smiles as we approached the site. He was happy to see that we brought vaccines and registers, as he could not have completed the U/5 clinic with only the scale that he had borrowed from a maize seller in the village. Soon more and more women and children came, apparently as the word spread that vaccines had arrived. Several HSAs were frustrated because many people stop bringing the children once vaccination is completed at the age of one, and during health talks they repeatedly spoke of continued growth monitoring as "responsible parenthood." Observing the children attending the clinics confirmed that the large majority were under-ones at all U/5 clinics. Participants were additionally told that responsible parents come early, and do not make the HSAs wait. At these occasions, the listeners were typically addressed as "you villagers," and told, "You always come late," suggesting that this phenomenon is less common in urban areas. Only once did I hear mothers argue that it is the HSAs that usually come late, and not them.

Simultaneously, many HSAs were concerned not to occupy more than necessary of the attendees' time. Proper strategies were thus discussed when vaccines were unavailable. Most HSAs agreed they should not inform people of the shortage before the end of the U/5 clinic, as some might leave to attend to other business, such as working in their field, gathering firewood or preparing food, before weighing and registering their child. But different opinions were put forth on whether they should make a short health talk or no health talk in order to release people quickly, or to the contrary initiate an especially informative, relevant and entertaining health talk "so that people will continue to respect the U/5 despite vaccination problems." Different solutions were

chosen, often coinciding with the individual HSA´s apparent skills and pleasure in doing health talks.

As registers and vaccines had arrived, Mr. Baga soon left plotting the children's weight on the growth charts in the health passports to the VHCs, and started yet another procedure for the passports already handled – and again piled. This task consisted of documenting the weight of the under-ones in the register book, and marking, in both the passport and the under-one register, which vaccines some of these children would receive today. Additionally, he made a mark in the under-five register for every child over one year, indicating whether they were of normal weight or underweight. After this process, he divided the passports into two new piles, distinguishing those up for vaccination today.

As the line in front of the scale was coming to an end, Mr. Moni came cycling up the road. He parked his bike by a tree, slipped between the women seated on the ground and came towards Mr. Baga and me. The two of us were sitting on a bench provided by one of the VHCs, surrounded by piles of health passports. After greetings, the two male HSAs discussed how to proceed with the clinic. The junior HSA, a verbose man in his late twenties, offered to lead the health talk while his colleague finished the registration process. Registrations were often done by the most experienced, and some HSAs openly considered it a challenge to calculate which vaccines were due for the individual child. The air was filled with laughter and women's voices discussing household economy, gifts of clothing from their husbands and the appearances of their children. The two HSAs agreed, and decided to start with some health songs to call people together and silence the crowd. Health songs opened virtually all health talks, and at times substituted them. Especially some of the female HSAs seemed to like this way to 'talk' of health issues, as they often initiated many different songs at each session.

"Mothers," Mr. Moni called out as he clapped his hands, "how are you?" "Fine," replied some of the women sitting close by. "What about your husbands," he continued, "and your children?" More women listened and replied that their husbands were fine, but that some of the children were sick. Mr. Moni told those with sick children to approach him and his colleague later, or to seek help at the health centre. He then asked someone to

initiate a song. After some murmurs, a woman in the back started clapping her hands with changing rhythms. Her lead singing is indicated below with a [1] before the applicable sentence; the replies of the others are unnumbered:

[1]Anakubala tizibala bwino.	*[1]Mothers we should be producing procedurally.*
[1]Chaka Chino mwana cha mawa mwona kulera satichoncho masiku ano zinthu zasintha.	*[1]This year baby; next year baby; family planning is not like that; things have really changed these days.*
Anakubala tizibala bwino.	*Mothers we should be producing procedurally.*
Chaka Chino mwana cha mawa mwona kulera satichoncho masiku ano zinthu zasintha.	*This year baby; next year baby; family planning is not like that; things have really changed these days.*

After the singers had repeated these lines a few times, another woman replaced the lead singer and the loud attuned clapping changed again as a new song began:

[1]Mwana ayamwe bele Dorika.	*[1]The child should be breastfed Dorika.*
Inde, inde Dorika mwakathithi.	*Yes, yes Dorika exclusively.*
[1]Mwana ayamwe bele Dorika.	*[1]The child should be breastfed Dorika.*
Inde, inde Dorika mwakathithi.	*Yes, yes Dorika exclusively.*
[1]Katemele inde aae.	*[1]Vaccines yes aae.*
Ali momo inde eaa.	*It's in there yes eaa.*
[1]Madzi okumwa inde eaa.	*[1]Drinking water yes eaa.*
Ali momo inde.	*It's there yes.*
[1]Chitetezo inde eea.	*[1]Protection yes eaa.*
Chilimomo inde eea.	*It's there yes eaa.*
[1]Nacho chikondinso.	*[1]And also love.*
Inde ea chilimomo inde eea.	*Yes ea it's in there yes eea.*
[1]Katemele inde aae.	*[1]Vaccines yes aae.*
Ali momo inde eaa.	*It's in there yes eaa.*
[1]Madzi okumwa inde eaa.	*[1]Drinking water yes eaa.*
Ali momo inde.	*It's there yes.*
[1]Chitetezo inde eea.	*[1]Protection yes eaa.*
Chilimomo inde eea.	*It's there yes eaa.*
[1]Nacho chikondinso.	*[1]And also love.*
Inde ea chilimomo inde eea.	*Yes ea it's in there yes eea.*

When the song abated, Mr. Baga stood up and started singing:

[1]Timapitakusikero ndi anawa.	*[1]We go to U/5 with the children.*
[1]Timapitandizolinga zinayi:	*[1]We go there with four objectives:*

Timapitakusikero ndi anawa.	*We go to U/5 with the children.*
Timapitandizolinga zinayi:	*We go there with four objectives:*
Choyamba ndiye kumayeza.	*One, weighing.*
Chachiwiri ndiye maphunziro.	*Two, health education.*
Chachitatu ndiye katemera.	*Three, vaccination.*
Adokotala amuone mwanayo.	*Four, the doctor screening the child.*

Mr. Baga's health song was new to me, not surprisingly, as the number of songs and versions of songs seemed to be innumerable. They were composed by the singers, women or health workers alike, and were subject to improvisation and variation. The nurse I lived with told me this tradition originates from the 1970s when a British musician named Jack Adson did volunteer work in Malawi. He allegedly founded The Health Education Band (which is still operating from Lilongwe, with HSA members), and composed a song in Chichewa about how mothers should prepare porridge for their children "with some groundnut flour, and some maize flour…" This song became very popular, and was played a lot on the radio. The nurse said she knew of this origin since she had been a health worker longer than most others. I was told that The Health Education Band still composes some of the songs used during different health-related activities, but "here in the countryside we compose most of the songs we sing ourselves."[13]

"Thank you mothers," Mr. Moni said after the three health songs, "and thank you Doctor! You should be a musician, not an HSA!" he continued triggering laughter from the audience. Then he asked how they should continue this health talk, and some answered they should start with a prayer. Everybody closed their eyes as a woman thanked God for protecting the present children and everybody's journey to and from this U/5 clinic. She asked for further protection against accidents and diseases and for blessing of all activities at this clinic "so that all the sick children get well." Next, Mr. Moni asked the audience what they had discussed last month. Most HSAs used this method to make mothers repeat what they had heard for those not present, correct any misunderstandings and find out which topic to bring up this time as someone else often led the talk the month before. Sometimes someone would be invited to suggest a new theme, or the HSA conducting the health talk would decide on a topic relevant for the

[13] A selection of health songs not included in the main body of this thesis can be found in Appendix 3.

season or the area. Exactly which health information individuals from different villages were presented with was thus influenced by chance. At some U/5 sites, the different vaccines were, for instance, presented several times during my participation, while this subject was never mentioned in other places.

Since Malawi was affected by a measles outbreak during my stay, the outbreak was the most frequent topic discussed during health talks for two months. In Lumbo, two HSAs had informed those present at the previous U/5 clinic about prevention of, symptoms of and measures against measles – after hearing of the outbreak on the radio. Still, several women expressed a wish to hear more about such matters today. Mr. Moni replied that this was a good suggestion since it is a very dangerous, deadly disease, and someone from this area was brought to the Health Centre with measles not long ago. "This means the disease has reached even here," he said. Then he told the crowd that he was not there to teach, but rather to discuss with them so that everybody could learn from each other's experiences and "remind each other of what we know."

While he walked among the women sitting on the floor and the children toddling around them or being breastfed to keep quiet, he asked the audience about signs and symptoms of measles. Red eyes and itchy rash were mentioned, and when nobody continued, he pointed around the crowd, asking questions.[14] The woman sitting next to me said the sick person feels body pain, and Mr. Moni added that another problem with measles is coughing. "This disease spreads when people cough," he said, "so it spreads through air. It is caused by a virus, which means there is no cure for this disease, and at the Hospital[15] they can only treat the different symptoms. In this way it is worse than HIV, which spreads through intercourse, because if someone in your household gets measles, soon everybody might fall sick. I have seen this happen in my own village. This is why prevention is better than cure!" He then asked the listeners if he had forgotten any signs

[14] Many HSAs used questioning as a general method in health talks, or asked women at the conclusion of a clinic to sum up what had been said.
[15] In this context, "Hospital" refers to the Health Centre where there are a few beds available for those waiting for the ambulance (which might take long), or in need of observation an hour or two for the MA to decide if the person should be referred to the District Hospital or sent home. A study by Chilowa and Munthali (1997:7) found that some mothers bring their children to traditional healers when the children are suffering from measles because, as Mr. Moni emphasizes, there is no cure for it at the Hospital.

and symptoms. “Red eyes is a way to recognize this disease, and if you don’t rush to the Hospital and get treatment quickly the sick might go blind,” he continued, before reminding everybody that the best way to avoid measles is to vaccinate the children at 9 months. Someone at the back of the group apparently made some fuss, because the HSA suddenly growled: “You should not make noise! It might be measles in your village, while you may say that you have not been informed of this by the HSA because you have not listened!”

A third male HSA had arrived from his home during Mr. Moni’s speech, and he now stepped forward with something to add. He pointed at an elderly woman escorting two children and asked if she had ever seen anybody suffering from measles. She said no, but the HSA said he knew the elders had experience with it, and that older mothers thus follow the vaccine schedule carefully. “But you young mothers might wait until the child is five years old!” he said; “And that’s why we now have this outbreak. We have not had it in a long time because people have been listening to what has been said here, but now there is no listening. Also, in the past the attacked households used to be put in quarantine and no one was allowed to pass the house. If there are cases around you, then sit down and discuss what you can do, because it is a long way to the Hospital from here... So you should listen to my colleague, so you can avoid this disease.” The female VHC continued: “In the past we did not have the vaccine we have today, but we had *chikule,*[16] which mothers used carefully, and this could treat the disease. It is just as important that you young mothers make sure your children are vaccinated. Additionally, we used to ‘raise the mat’ (*kuyimika mphansa*, my translation). You young mothers of today are not capable of ‘raising the mat’ either, but this is important!” Mr. Moni nodded vigorously and said: “We hospital people recommend ‘raising the mat’ at this time. We recommend this traditional way of doing things.” He then ended the health talk by saying that there was no measles vaccine today, but that the measles vaccination campaign advertised on the radio might be coming next week; so people should be aware.

[16] Explained to me as medical ointment made from herbs and leaves rubbed on the eyes and stomach to stop the rash from spreading. According to one traditional healer, the healers in this area can no longer make this ointment due to lack of knowledge and/or ingredients.

Before we split up at the day's end, I discussed the concept of 'raising the mat' with the VHCs and HSAs. I was told that when one starts talking of the everyday act of rolling together the straw sleeping mat and raising it up against the wall during daytime as 'raising the mat,' it means you abstain from sex in that household. One of the HSAs said, "This is traditionally done by many people in the villages to prevent transmission of spells from parents to child." He explained that people for instance think spells might be transferred when sexually active people, or "hot people," touch a child of less than six months. "Typical reactions are said to be swelling, fever and ill health, or even death of the small child," he continued. I was told that some believe the swelling and fever caused by vaccines are rather a result of contact with a sexually active person. The HSA also said some believe adults can die as well, if they have sex earlier than six months after the women have given birth to a child. "But we HSAs," he emphasized, "we don't use the taboo to prevent spells; we use the taboo from time to time because it can prevent the spread of disease when people stop having sex and therefore don't infect each other. In the past this taboo also worked as a form of family planning," he continued, "but with this HIV epidemic we normally tell the wives they have to have sex with their husbands right away while using contraceptives, so the husbands don't go and have sex with someone else during those six months and bring HIV into the family."

The last activity in the U/5 program was vaccination. Those women with children not up for vaccination were thus called one by one to collect the child's health passport. These women also had to present their own yellow passport so the HSA could control if any of them were candidates for tetanus toxoid vaccination. Some women were escorting the children of neighbors, sisters or daughters, and were strictly told to inform the mothers to come next month for vaccine control. One woman had lost her passport and was thus told to start over with the five 'stabbings' (*kubaya wabayidwa*).[17] This generated giggles from the surrounding women, while the protagonist made strong grimaces. Most HSAs followed this practice when the women's vaccination status was uncertain, since they knew some tried to avoid the injection. Many women told me this was because they feared the pain from the needle, but when I asked if this made them want to protect their children also, they all denied it and said child vaccination to the contrary was an

[17] Chichewa expression meaning to stab and be stabbed with any sharp object such as a knife or syringe; the common way to talk of injection in Mangu.

important protection. When those going home had received their passports, those babies going for vaccines were called, and the women were given their small books.

The newly arrived junior HSA brought the cooler box into the nursery opened by a VHC. It is a one-room concrete building with a corrugated iron roof, lit by two glassless windows with shutters. The only interior is two wooden benches, of which one was now outside for the HSAs to sit on. At most Out Reach sites the HSAs were offered chairs or benches by people living nearby, schoolteachers or VHCs, and it took some time before people would accept that William and I often moved around, sat on the ground with the waiting and listening women, or sat in the back with those selling vegetables, fruits or the local doughnut. "We are visitors and should not be sitting on the ground," some of the HSAs told me. This day William and I sat on the floor while the HSA, Mr. Jinga, reluctantly installed himself on the bench using the cooler box as a table for the vaccines and syringes. Every time he needed a new supply of vaccine vials, he had to lift the lid while trying to prevent equipment falling on the floor. While he was mixing DPT-HepB+Hib by ejecting diluents from one small vial and injecting it into another containing powdered active substance, women were discussing who was the first on the site this morning and thus entitled to go first. As they got louder, Mr. Jinga announced that the one leading the prayer would be first, followed by the two women initiating health songs. These women quickly pushed themselves forward in the crowd while some were protesting quietly. It was not unusual for HSAs to intervene in the queue, and friends such as the pastor's wife, the shopkeeper's daughter or relatives of chiefs were often handled first with few uttered protests.

When vaccination began, the first woman sat down on the bench preparing the baby on her lap. She gave the pink health passport to Mr. Jinga and uncovered the child's thigh. The HSA instructed her to wake the sleeping baby, as he checked the passport where Mr. Baga had entered both polio and DPT-HepB+Hib on this date. He told the women he would start with "the vaccine of the mouth before stabbing with the vaccine of the thigh"[18] to avoid causing the crying child to spit out the three drops. The baby blinked

[18] Vaccines were mostly referred to as "the one of the thigh, arm or mouth," also during health talks on vaccination. Women thus seldom knew the name of the vaccine, but knew *where* the child was supposed to be "stabbed" that particular day. Generally,

his eyes as Mr. Jinga took a firm grip on its cheeks and squeezed its mouth open – like a fish. Three pink cold drops met the tongue and an astounded look spread on the small face. The baby was then placed sideways in the crook of the woman's arm, her one hand holding the baby's loose arm and the other straightening its chubby leg, a technique instructed by the HSAs. As the child was kicking, a mother from the watching crowd was told to give a helping hand. Mr. Jinga reached for one of the six AD syringes[19] he had filled with DPT-HepB+Hib, and as the needle approached the thigh, the seated woman looked away pinching her eyes. Most women do this when their child is injected, whereas the surrounding crowd usually pay close attention.

A startled cry came from the baby before it gasped for air and went on sobbing. The mother smiled sympathetically and tried to push her nipple into the child's mouth while rocking it. The surrounding women giggled and someone commented that judging on the cry "This baby will not sleep tonight!" The next child was soon placed in front of Mr. Jinga, but he determinately called the first woman back, demanding to see her yellow passport. She looked down bashfully and said with a smile that she had forgotten it at home. Mr. Jinga instructed her down on the bench again, filled a syringe with tetanus toxoid from the cooler box and told her to show her shoulder. The other women were now laughing loudly, and shouting out how much this stabbing would hurt. The woman made a dramatic face as she looked away from the needle, and after the injection, she squeezed her shoulder, though she smiled and gave a high five – with an apparently weak arm – to the woman holding her baby.

The vaccinations continued consecutively. Mr. Jinga once called on Mr. Baga to do a BCG, which several of the young HSAs said they did not like to do, because "you need to be very careful," and the two of them discussed the health condition of a particularly skinny baby. The mother was loudly told to take her child to the Health Centre next Monday and to join the nutrition clinic run weekly by two HSAs. On another occasion, I heard an HSA tell a mother in a ragged dress, "But don't think we hand out free maize flour! You can

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mothers also knew the pool of preventable diseases, but many confused which disease was protected by "the vaccine of the arm" etc. I will return to this topic in chapter five and six.

[19] The syringe had fallen from the small cooler-box table without the cannula cap covering the needle, and it was filled with 1/3 of air at the expense of active substance.

leave your buckets at home," making the woman stare at the ground, while the other observers laughed loudly. One woman this day commented before vaccination that her child's thigh had swelled after the last vaccine; it was therefore decided without further discussions to inject the other thigh. Another woman pointed out that Mr. Baga had overlooked that her child should get "the vaccine of the mouth today." Another one was yelled at since her child had not been getting its vaccines regularly and was now lagging behind. The mother said she had been working in the north for some time, but the HSA shook his head, discouraged, and said this was no excuse as she could just have gone to a U/5 clinic there.

The room emptied gradually, and three small puddles appeared where some of the children had urinated through the *chitenje*. There was lots of syringe paper on the floor, and one of the VHCs put it in her pocket and took the yellow safety box, which she would store until next month. Mr. Jinga put the empty vaccine vials in his shirt pocket, and would later sell them to one of the bike repairmen for up to 1MKW (about 0,01 USD) each. Whenever I needed to get a tire patched, I saw these small vials functioning as glue containers.

Valuables: Old vials functioning as glue containers.

It was way past lunch hour when Mr. Moni, William and I waved goodbye to the others and started the bike ride back to the Health Centre with the scale, registers and cooler box. The vials of leftover vaccines were in a small pool of water under the defrosted icepacks, but they would still go back in the fridge when we returned. As always, many people were waving along the road, and we met groups of women headed home with huge bundles of firewood balanced on their heads, and men with slashers returning from the field. Pushing our bikes up the last slopes to the Health Centre while eating bananas we had bought on the way, we saw the woman with a feverish daughter from Mr. Moni's catchment area coming in the other direction. She looked angry and confirmed this while she explained that the MA had never turned up at the Health Centre that day. Mr. Moni sighed deeply and apologized, knowing so well that it would be time consuming and tough for the woman to make the trip again on bare feet carrying her sick child.

Patterns and variations

The story above represents typical aspects of HSA work and will be used, with other empirical examples, to illuminate how HSAs in Mangu handle different knowledge in their work. However, the first part of this thesis also reveals aspects of the harsh reality of HSA work, and thus indicates challenges threatening the Malawian child vaccination program, in addition to the lives of individuals. Making some of the countless effects of poverty visible is important and indispensable when conducting research in this context.

Before I proceed with analyses of how HSAs in Mangu handle different knowledge, and how their handling of knowledge might promote vaccination, patterns and variations in their work and working conditions not touched upon in the previous section must be highlighted. First, based on statements from the administration at the District Hospital, experiences of another master student based at a different health centre, and HSAs' own views, I know the situation varies greatly from place to place in the country. This variation is confirmed by Chilowa and Munthali (1998). Settlements are even more scattered on hilly lands in many areas, making Out Reach clinics a big challenge, especially during the rainy season. Problems of cancellation and irregularity are thus said to be more common than my five-month stay in Mangu indicates.

The U/5 scene also varies within Mangu however, from site to site and month to month. As described above, the Static U/5 clinics often stand out regarding attendants' display of material resources, but these U/5 clinics are also bigger than most Out Reach clinics are. Several HSAs and women told me some mothers prefer to come to Mangu because they can ask their husbands for some money, and can on the same trip purchase goods from the nearby trading centre that are unavailable in the remote villages. I also saw women waiting in line for the MA and then the dispensary after attending Static U/5 clinics, apparently combining errands. After observing the high frequency of unavailability or shortage of vaccines, I also realized that people might choose the Static clinics to increase the chances of child vaccination.

However, differences in clinic size were obvious between Out Reach clinics as well. In addition to site localization and the number of villages attached, size differences might be linked to the presence of VHCs. At the site described above there were always three committee volunteers assisting the HSAs, putting emphasis on the importance of the Out Reach U/5 clinic. Many sites, as mentioned, did not have such regular involvement of village representatives, indicating that the Village Headman was not fully cooperating with the responsible HSA for whatever reasons. The number of children attending seemed lower and more irregular at these sites, though this does not mean that the absent children were not vaccinated other places. I will return to other factors that might influence the clinic size in chapter six. Counting the exact number of attendees at every U/5 clinic proved impossible for William and me since people tended to arrive gradually and often after activities had started.

At all sites, the order of activities was arranged according to practicality, though the activities themselves were predetermined. If one HSA arrived alone, facing a large crowd of attendees, he or she typically started with health talk, hoping assistance for weighing and registering would arrive shortly. However, the uncertain and varying startups meant that several attendees often missed the health talk due to late arrivals. Initiating several health songs was a way to handle the challenge of timing, and singing was common while waiting for colleagues or more attendants. The sounds, which can carry far, also indicate that the U/5 clinic has started. Songs on family planning and breastfeeding were most frequent, together with a song typically initiated by HSAs or

attendees when waiting for more children. The latter song illustrates the importance of social control[20] when it comes to U/5 attendance and motherhood in many villages. Sung with clapping and loud howling by a big group of women the message is strong:[21]

[1]There are other mothers that come late; let's laugh them.
There are other mothers that come late; lets laugh them.
[1]iyi let's.
iyi let's.
[1]iyi let's laugh them.
There are other mothers that come late; let's laugh them.
He! He! Ulululu.

[1]There are other mothers that don't know how to prepare porridge; laugh them.
There are other mothers that don't know how to prepare porridge; laugh them.
[1]iyi let's.
iyi let's.
[1]iyi let's laugh them.
Laugh, there are other mothers that don't know how to prepare porridge; let's laugh them.
He! He! Ulululu.

[1]There are other mothers that don't know how to tie the nappies on the baby; let's laugh them.
There are other mothers that don't know how to tie the nappies on the baby; let's laugh them.
[1]iyi let's.
iyi let's.
[1]iyi let's laugh them.
Laugh, there are other mothers that don't know how to tie the nappies on the baby; let's laugh them.
He! He! Ulululu.

[1]There are other mothers that don't know how to wash the nappies; let's laugh them.
There are other mothers that don't know how to wash the nappies; let's laugh them.
[1]iyi let's.
iyi let's.
[1]iyi let's laugh them.
Laugh, there are other mothers that don't know how to wash the nappies; let's laugh them.
He! He! Ulululu.

[20] Social control is defined by Aubert (1987:97) as the process taking place when sanctions are used. These can be positive or negative, official or unofficial, primary or secondary, i.e., direct or through legislation.
[21] The original Chichewa lyrics can be found in Appendix 3, together with songs about how mothers that lose the health passports or do not space births are irresponsible.

As mentioned, especially female HSAs used singing as a method to implement health talk, but the crowds' order and attention were also objectives of the singing. Some female HSAs seemed to struggle more often than others did in achieving this, and sometimes called upon male or senior colleagues to silence the crowd. Several HSAs alternatively used humor such as imitation or vigorous dancing to call for attention. During a health talk on hygiene and cholera, the noise from the crowd turned into roaring laughter and engaged comments when a female HSA attached her big jacket on her belly and walked around like a heavily pregnant woman, instructing her imaginary children to do the dishes in dirty water. Nevertheless, despite the fact that attendees generally seemed to respect the work of HSAs at U/5 clinics, the clinics could be chaotic affairs regardless of who was leading them. I observed vaccines (not syringes!) being interchanged, inaccurately mixed and drawn, or apparently not mixed at all, while women crowded and pushed each other next to the HSA, giving the vaccinator only centimeters to work. Crowding also affected the weighing and registering from time to time, especially at certain sites, with poor success of the responsible party in organizing the situation. Several HSAs said mothers were in a hurry due to other responsibilities, and some HSAs did not want to force people to stand at a distance in the sun or rain while waiting their turn. Vaccination was often conducted under the only roof, tree or bush at the site. During big clinics, several HSAs often cooperated on vaccination. One to three prepared the vaccines and stacked them on an icepack, while one to three injected the children. Further, I experienced varying atmospheres at U/5 clinics, though I am unable to fully explain the variation. Usually the air was filled with laughter; people were smiling and making jokes. But sometimes the attendees´ body language and utterances were generally less positive. Weather conditions perfect for harvesting or unsuitable for moving around, U/5 clinic supply problems, late arrivals, offending statements or funeral arrangements close by seemed relevant at times, though people did not always say they were unhappy.

Finally, a note concerning the content and implementation of health talks: The topics irregularly discussed during forty-eight of the clinics I attended were the following: hygiene, pneumonia, safe motherhood, vaccines, malaria, anemia, nutrition, breast-feeding, family planning, cholera, diarrhea, measles and the vaccination campaign, and *maoka* (explained below). Health talks were not conducted at the other six U/5 clinics I

attended, and this may be related to the personalities of the HSAs present. Six of the HSAs in Mangu did not seem comfortable with speaking in public, nor during U/5 clinics or staff meetings. Their colleagues explained their discomfort to me as resulting from shyness, lack of training or psychological difficulties. There were, in other words, variations in the conduct of the individual HSAs in front of the crowd, though methods and topics were largely shared. The fact that the HSAs regularly listened to each other's presentations is probably one reason for the latter.

Maoka was discussed during health talks separately or in relation to other topics several times from February to June. This was explained to me by women, health workers and traditional healers, as one of two similar health problems believed by many to often affect babies in Mangu. The problem of "hot people" touching children, and thereby inducing fever and swelling, has already been mentioned in relation to the concept of 'raising the mat' – a phenomenon generally denied by HSAs.[22] Their denial seems logical as they otherwise could be labeled disease-carriers themselves. Parents who suffer from general itching, and who have certain problems with their genitals or anus were said to have and possibly transfer *maoka*. Symptoms in children were typically said to be fever and swelling, in addition to diarrhea, a yellowish skin tone or epileptic seizures, but no one claimed to know exactly how *maoka* transfers from adults to babies. In adults it is mainly a sexually transmitted disease. Symptoms of *maoka* in women were more specifically described as itching and rash on vulva, while typical symptoms for men were described similar to symptoms of what I usually call hemorrhoids. The traditional healers I talked to said *maoka* is a common disorder among people seeking their help. Asking the MA I was told that *maoka* is not in the medical books, but that there are other names for things that are similar. The word *maoka* was often used by HSAs, though most emphasized that parents should always take feverish children to the health center, rather than to traditional healers or African doctors, since other diseases could be the current underlying problem. Some HSAs alternatively emphasized that the MA has the best drugs to treat *maoka,* and that these were free of charge unlike treatment offered by traditional healers. Three female HSAs used a health talk to instruct and discuss with

[22] However, some HSAs were concerned when William experienced pain after measles vaccination, and they thought the reason could be that a "hot colleague" who sometimes slept with prostitutes had touched and "stabbed" him.

the women attending that *maoka* is avoided by hygienic measures for women and men. During this health talk, the instructions were direct and detailed, with demonstrations causing a high level of involvement and laughter among the women. However, the HSAs used the Chichewa word for newborn chicken as a metaphor for vagina, and William doubted that any of the male HSAs could discuss the same topic in this open manner. A point to be resumed later in this thesis is that none of the health workers I met openly denied this disease though it is not in the western medical books, as the MA emphasized.

Different traditions of medical knowledge, mediation between views on health, and processed of power, resistance and trust can all be identified in the ethnographic material presented so far. In my analysis I will, for instance, return to how Mr. Moni combined knowledge of sexual taboos and spells with insight concerning how measles spreads according to biomedical views. I will also return to how *maoka* is discussed in combination with biomedical views on treatment and prevention, and I will point to the importance put on prayers in securing good health. Moreover, specific tools for the imparting of knowledge seen in this chapter, such as language adjustments and use of health songs and humor, will also be discussed. Furthermore, I will draw on women's objections to the tetanus toxoid vaccine – while accommodating for the vaccination of their children – and on the strategic use of the vaccines to ensure other practices, when it comes to processes of power, resistance and trust. My analysis of how the HSAs handle knowledge in their work starts, however, with a necessary exploration of relevant and varying medical knowledges.

4 Identifying traditions of medical knowledge

After cycling for one and a half hours, the HSA reached the churchyard that was the U/5 site of the day. He gathered the waiting women and started a health talk: "Today we shall talk about the measles outbreak," he said with a vivid voice. "Maybe some of you have heard on the radio that it has now reached Blantyre!" he continued while walking among the audience sitting on the ground. "There is a proverb: 'Prevention is better than cure' (Kupewa kuposa kuchinza). The sentence is short, but says a lot! Even the Bible emphasizes this. I believe you can look it up in Mafumu verse 18. Has anybody here been attacked by measles? It is a dangerous disease, so we better prevent it." All eyes now followed him, and he continued by emphasizing the importance of the vaccine, hygiene, and handling those with measles symptoms in safe ways.

This chapter presents an overview of different 'traditions of medical knowledge' that I encountered in Mangu and identified as relevant in the work of the HSAs. The aim is *not* to explore each of these traditions in full, but to show how vaccination and other HSA tasks are conducted in culturally complex and ambiguous contexts. The scene of illness and health in Mangu was clearly characterized by medical pluralism. Still, I did not find a general, clear division or unambiguous ranking between different views on causes and cures of illness. On several occasions I rather experienced some sort of medical creolization, syncretism or "hybrid knowledge," to borrow Sillitoe's expression (2007:9). People's views and actions concerning treatment and prevention of ill health seemed to consist of a mix of measures and reasons.[23] There were also great variations in individual views on illness and health, and many people contested the medical knowledge of others. This applies to health workers and people in general, though

[23] Lwanda (2008:26) emphasizes that the Chichewa word "*Mankhwala* (medicine) has a much broader meaning than 'medicine' in western medicine and includes herbs, lotions, potions, charms and all positive healing agents, as well as drugs of witchcraft." He sees a strong link between medical practices and *race* and *class* issues, and illustrates this link with commonly used expressions like *mankhwala achizungu* (Europeans' medicine) and *mtela wachiboyi* (servants' medicine). According to Lwanda (2008:34), there has never been a contest between western science and indigenous science in Malawi – and the African elite now utilize both – but between races during colonialism and between classes in post-colonial times.

caution is needed at this point as some may have had specific agendas when presenting shared or contesting views.

The complexity makes constant changes in practices and views likely, and questions the propriety of the distinctions made between 'traditions of medical knowledge' in this chapter. Stoner (1986:44) concurs, arguing that "the definition and delineation of separate medical systems within societies is perhaps less valuable for the development of an understanding of health-seeking behavior and health care decision making than the clear and focused study of the actual health care alternatives that people utilize in times of illness." *For analytical purposes*, however, I will describe the following traditions of medical knowledge under separate headings – though not as static or totally distinct – mainly by use of classification terminology that I heard in Mangu. Nevertheless, this categorization must not be mistaken to indicate a certain timeframe or stability; nor does a title like "traditional healer" indicate identical practitioners (see Stoner, 1986). The latter term is chosen since this was how people in Mangu translated the Chichewa title *sing'anga*. Additionally, since people often resorted to varying combinations of causes and cures, some causes are described before I present options for cure in this chapter.

Before I proceed, I wish to elaborate on the analytical framework presented in chapter one: When exploring different traditions of knowledge – a necessary part of my analysis – one can preferably draw on Barth's (1990) theoretical framework. According to his Huxley Memorial Lecture of 1989, there is great value in focusing on the different ways that knowledge is *transacted* in different contexts. Barth argues that this focus will help anthropologists highlight and explain variation and similarity in people's lives. He demonstrates a model for studying *functions of different knowledge management* by contrasting inner New Guinea with northern Bali. For the Guru in Bali, knowledge becomes valuable when distributed to others, as Barth sees it, labeling this the practice of sharing. In Melanesia, the opposite is the case, as the initiator relies on a practice of secrecy, veiling his knowledge while creating meaning and significance before his audience through ritual actions and the manipulation of symbols. Sharing and secrecy, respectively, are the practices that give value to knowledge in the two places, thus securing the position of the knowledgeable. "Elegance in performance" is hence most

important for the initiator, while the Guru needs to appear consistent (Barth, 1990:643). An important recognition from this analysis, Barth argues, is that "only through the teaching activities of Gurus [i.e. traditions of knowledge managed by *sharing*] could such bodies of knowledge become capsulated, individualized and transportable" (Barth, 1990:646). It is consequently no coincidence that Christianity, Islam and biomedicine – all based on sharing – hold dominant positions in the world today. However, as will be illustrated below, I found knowledge related to mystical, secret or unknown connections and context-specific reasoning not suitable for generalization to thrive side by side with detailed explanations of biomedical sorts and accounts of faith in a Christian God. I found, in other words, that the various ways of knowledge management were utilized interchangeably in relation to all knowledge, and that health workers and others did not categorically distinguish between knowledges. The possible relevance of socio-economic factors and political history to this mix of knowledges will be discussed later (see footnotes 25 and 35).

Nevertheless, an important lesson that I draw from Barth is that traditions of knowledge are reproduced and cause different effects through the varying ways in which they are transacted. Hence, a study of HSAs' handling of knowledges – operating in contexts of complex mixes, as is soon to be seen – would probably be supported by Barth. Seen through his theoretical framework, the HSAs' work appears interesting, important and impressive – though I find his conclusion, that knowledge managed by sharing holds a dominant position, problematic in this context. Harrison (1995) also finds Barth's theoretical framework to be unsatisfactory. He supplements Barth's model by emphasizing how a combination of secrecy and open distribution is always needed to make any kind of knowledge, and thereby the position as knowledgeable, valuable: "In other words, the 'management' of knowledge is the complicated, precarious and difficult task of trying to operate with both of these two theories at the same time" (Harrison, 1995:13). Harrison's point will be elaborated shortly. With theory on how knowledge is *managed* and the importance of this in mind, I now turn to the presentation of different traditions of medical knowledge relevant in HSA work.

Biomedicine

At Mangu Health Centre biomedical views on illness and health dominated. Biomedicine or western medicine has been defined as "[…] medicine that originated in Europe after the development of modern science and technology" (WHO, 1978), or as "a branch of medicine that is combined with research in biology" (UNEP, 2003). Anthropologists, however, here represented by Sillitoe (2007:5), remind us that "[f]olk knowledge from Europe and elsewhere has informed the development of science," making biomedicine nothing more than culturally constituted views of reality. Nevertheless, the MA in Mangu was supposed to use biomedical charts from the World Health Organization to diagnose patients, various test equipment was used to prove people's malaria and HIV status, and sputum samples were taken to the CHAM hospital for tuberculosis analysis. Additionally, basic pharmaceutical drugs were most of the time available free of charge from the Health Centre Dispensary. Still, Lwanda (2005:113) notes that many hospital practitioners in Malawi have to use phenomenological – or what I call clinical – observations extensively, much like traditional practitioners often do, due to lack of sophisticated equipment. Lwanda's observation coincides with my observations of the situation in Mangu.

The Health Centre buildings were, as described in chapter two, often associated with "the first President," Dr. Kamuzu Banda. The Ministry of Health and Population arranged the present-day activities through the district administration in cooperation with MSF. MSF's presence was visible to everyone in the form of logos on most of the few cars and posters in the area. Many health workers and villagers additionally considered weekly services, such as injection of contraceptives, modern. To follow family planning preached by Health Center staff on many occasions was talked of by women as "taking part in development." Drawing on Barth's (2002:3) model for studying traditions of knowledge – or more specifically on his second and third "faces of knowledge," presented in the analytical framework – one may say that the biomedical views postulated at the Health Centre seemed, in words and symbols, linked to 'modernity' and 'development.' Recall also, how the Health Centre buildings in themselves stood out. Furthermore, this link seemed to bring some 'solidity' to the biomedical views.

However, although copies of written material were distributed from time to time, and a lot of time was spent discussing the different report requirements, most of the HSAs' biomedical knowledge was passed on orally. The constant repetitions and the presence of colleagues during health talks, as exemplified in chapter three, were useful in this regard. The radio was also an important means for transmitting knowledge of different kinds, and those who could afford one spread the information to others, for instance on the measles outbreak and the coming vaccination campaign.

One can easily identify ways of knowledge management typical within biomedical practices that resemble the teaching-based strategies of the Guru, as described by Barth (1990): Biomedical research results are generally seen as valuable when they are based on open sharing, mainly because the knowledge is then considered verifiable for others. Additionally, public display of biomedical practices, like during the U/5 clinics, has been linked to African colonial history and a European desire to spread information and thereby enhance the superiority of biomedicine (Hunt, 1999) – again coinciding with Barth (1990). However, in the next chapter I will point to how HSAs utilize varying ways of knowledge management in their work. As mentioned, Harrison (1995) also nuances the relation between different traditions of knowledge and specific ways of knowledge management. He emphasizes how biomedical scientists have a need to secure their knowledge in more ways than through spreading it, and that *patenting* therefore has been introduced. In Mangu, the color on one's uniform indicates and secures one's position in the health personnel hierarchy – as a form of patenting – and people clearly acted according to these codes. For many HSAs, it was unthinkable to openly question the ways of a nurse (dressed in white) or of a district nurse (dressed in dark green).

Biomedicine in the village: The older children keep an eye on the U/5 activities – from a safe distance.

Witchcraft

Besides individual predisposition, behavior and the spread of pathogens – foci stemming from the professional sector (see Kleinman, 1980) – most people I met in Mangu considered witchcraft to be a cause of disease. Eriksen defines witchcraft as "an individual ability to harm others in spiritual ways" (1998:316, my translation), and Lwanda describes it as

> A functional reality, in the sense of ability to utilize human agency to poison, used for malign purposes by its practitioners and feared by victims and would be victims, and [...] A social [... discursive] and mental construct that enables some sense to be made of the miserable colonial and postcolonial socio-economic reality of life in Malawi [...] (Lwanda, 2005:242).

Considering Barth's (2002:3) three faces of knowledge, witchcraft was not discussed in public at the Health Centre while I was present – contrary, of course, to biomedical views. Nevertheless, witchcraft was a frequent topic during conversations that were more private, often in the form of retellings of someone's frightening and mystical encounter with it. Some mothers told me they did not want to talk about witchcraft in front of their children since witches training young Malawians, who then kill their

parents with disease or the like, was "a widespread problem these days." This particular problem was nevertheless debated publicly in the media during my stay. Hence, witchcraft was both a private and a public matter. Still, it was generally said to be inflicted by people close to the victim, and envy was a common motivation to use witchcraft, I was told. Furthermore, witchcraft differed from the use of magic, in that the former's objective was to harm. Thieves were thus believed to sometimes use magic to escape from the police, by making themselves invisible or turn into soil.

The relationship between witchcraft and disease was one day exemplified to me after a routine home visit for inspection of hygiene and sanitation. Present in the house we had inspected were two women, an HSA, a VHC, William and me. One of the women quickly replied to one of my questions that "witchcraft causing disease is not so common anymore." However, her neighbor strongly disagreed. She identified witchcraft by the many people dying from AIDS. Addressing me, the woman explained that there are two types of AIDS: one caused by the spread of HIV and one caused by witchcraft. Allegedly, you could identify the different types when people went to the Health Center for medicines: those getting better and surviving had HIV-related AIDS, but when the medicines did not work you could be sure that what looked like AIDS was caused by witchcraft. None of the others denied her explanation, not during the conversation or during my long trip home with the HSA. Such classification of diseases was recognizable among women bringing children to U/5 clinics also, and many expressed confidence in vaccination as protection against certain diseases since they had nothing to do with witchcraft.

The AIDS and witchcraft discussion above arose out of my curiosity regarding three posters hanging on the wall in the house we inspected. They were all big, colorful drawings distributed by a Christian NGO. Two of the posters encouraged turning to God in prayer while taking care of each other when facing disease, while the third postulated abandonment of traditional and herbal medicine to safeguard children's health. Both the role of traditional healers and faith in God were prominent in many people's views on health, illness and disease prevention, and knowledge on related ways of curing will be discussed shortly.

Spells or "crossings"

A third way to incur illness, described by many people I met, was by way of spells (*ku tsempho mwana*) or what William translated and described as "crossings" by unknown mechanisms. Nevertheless, sexual intercourse – especially within six months after childbirth – frequently seemed to be considered as an underlying cause of many spells. Fever, swelling and pain caused by physical contact with "hot people," and transference of *maoka* from parent to child are previously mentioned examples of "crossings." I was also told that many people in Mangu believe "mature women"[24] should not touch salt while cooking, as people eating the salted food might get sick. Some therefore instructed their children to salt the food; other households did not use salt. Some women avoided cooking altogether when menstruating, to prevent similar unfortunate occurrences. Disagreements over the latter "crossings" resulted in irreconcilable conflicts between my host and her first housekeeper. The nurse-midwife considered these types of spells to be nonsense, and instructed her reluctant employee to use salt and to cook despite her menstruation. To avoid a similar situation in the future, the nurse eventually hired a man to replace the female housekeeper.

Another practice said to cause sickness was that of breastfeeding while pregnant. When the consistency and color of women's breast milk changes and "becomes thin and yellowish" during new pregnancies, children drinking this milk allegedly risked becoming weak and thin from lack of nourishment, or from poisoning. Such undernourished-looking children were referred to as *ntumbidwa*, and were seen by some HSAs as a sign of the mother's ignorance regarding family planning. Alternatively, the condition of such children was related to violation of the sexual taboo concerning sexual intercourse earlier than six months after childbirth. Use of this taboo-related spell in HSA work will be investigated further in chapter six. My host told me, while we were discussing *ntumbidwas*, that she herself had stopped breastfeeding quickly some forty years ago, and that her four children – who were close in age – were all healthy. One can thus see how she utilizes different traditions of medical knowledge in two different settings: in relation to women's cooking and to breastfeeding.

[24] A woman is considered mature when she starts menstruating.

This brief account of witchcraft and spells as causes of illness in Mangu partly coincides with Evans-Pritchard's (1937) argument, based on his studies among the Azande of Central Africa. Evans-Pritchard claimed that witchcraft and sorcery explains events that are otherwise inexplicable. Admittedly, one may wonder why some respond to anti-retroviral treatment while others do not, and why breast milk often changes during new pregnancy. Asking a traditional healer to explain how *maoka* transfers to children, I was told she did not know, but that it may happen in the same mysterious way that HIV sometimes transfers when breastfeeding, and sometimes does not. However, many Malawians would not agree that witchcraft and spells are only found to explain illness that is otherwise inexplicable. First, witchcraft and spells are valid explanations in themselves. Second, as my host one day commented, partly joking: "Nobody dies in Malawi without *some* inference of witches." Witchcraft is, in other words, often combined with other causes. In his practice as a biomedical doctor, Lwanda (2005) concurringly observed that many Malawians with Western education made use of traditional medicine while being in-patients at Central Hospitals. According to Lwanda's book, references to *ufiti* (witchcraft) are made by politicians, city dwellers and among the rural population.[25] This has made Lwanda wonder if the strong hold of different medical knowledges in Malawi exists out of want, need or necessity.

From Malawian newspapers, I got the impression that mostly women and especially elderly widows were accused of being witches and practicing witchcraft. Male and female health workers were also vulnerable to such accusations, however, when people found their practices unsatisfactory or suspicious. One of the HSAs one day found an anonymous note pronouncing that he was a witch, and I heard stories of nurses being accused after delivering several stillborns within a short period. Spells, on the other hand, could be transferred by anyone unintentionally and unconsciously, as indicated by one of the HSAs in chapter three. However, like the HSA, Lwanda (2005:58-59) notes that such phenomena are often related to transgression of sexual taboos. Lwanda thereby sees spells and witchcraft as originating from once useful ways to handle health-related challenges.

[25] Lwanda (2005:107-108) emphasizes, however, that the "state use of *ufiti* discourse" can be linked to a repudiation of liability in the health sector.

Traditional healers, herbalists and traditional birth attendants

To cure ill health and prevent health problems, people in Mangu turned to various traditions of medical knowledge. Asking the owner of a small shop close to the Health Centre, I was quickly provided with a list of twelve traditional healers in the area. The shopkeeper also pointed out which healers were the most popular. These *sing'angas* were all male, but after visiting two of them, William and I were also referred to – and later visited – a female healer who worked more specifically with children.

All three healers told me they could cure *specific* problems, and only two of them treated illnesses caused by witchcraft. All three allegedly recognized those suffering from ill health beyond their specialty, and referred such patients to the Health Centre. I was also told that patients were referred to the healers from the Health Centre, and that even Health Centre staff utilized their services. For example, adults with bloody stools were often sent to them for treatment against *maoka*. As a Norwegian nurse, I have been taught that fresh blood in patients' stools could be a symptom of hemorrhoids. Other symptoms indicating *maoka* also match symptoms of hemorrhoids. Since the Ministry of Health and Population in Malawi has defined specific areas of priority for public health services in their EHP (see chapter two), the need for additional treatment for such things as bloody stools – with whatever cause – from a folk healing sector comes as no surprise.

The two male healers were mostly concerned with witchcraft-induced suffering, and used razorblade cutting, herbs, roots and ash to cure their patients. They both participated in official monthly meetings for the traditional healers in the district, and proudly showed me piles of certificates issued by the government on a yearly basis. These documents stated that the healers had committed to always use the best new medical treatment available. The latter exemplify Stoner's (1986:44) argument – introduced in the analytical framework – that changes and mixes within medical practices are the norm rather than the exception. One of the traditional healers also repeatedly emphasized that there were certain problems in his sector, claiming that some colleagues were just after money and that they did not really have healing skills. He also said that he never treated children himself, but referred them to the Health Centre. Both his mother and his father had been traditional healers, but this *sing'anga*

had not learned the craft from them. Rather he had felt a need to help people as he got older, and he had started dreaming about healing after his parents were dead.

The female healer – who had been taught by her father – did not list witchcraft-induced suffering as her area of expertise. As such, she fits into a category I choose to call herbalists, who have competence in using herbs to heal and prevent health problems, but who do not have an official title, and who are not approached specifically with problems caused by witches. On the preventive side, she and one of the male healers provided certain necklaces to newborns. These objects had a ring of herbs, said to strengthen the head and prevent it from growing unnaturally. Many children at U/5 clinics bore such a necklace, and some women told me it cured headaches. Another method frequently used to prevent ill health in babies was to tying strings around their waists.[26] The same two healers also offered such strings, but just like mothers I talked to, they gave somewhat different explanations for it. One claimed that they strengthen the back and stomach, while the other said they protect from spells transferred by "hot" fathers. I will return to the latter practice when exploring the concept of trust in chapter six. Parents could also promote strength and good health by using herbs from the healers in the children's bath water. Lwanda (2005:198) argues that the different causes of illness handled by traditional practitioners give these healers cultural, medical and religious powers as guardians of moral trespassing, and he states that "the use of scarification for vaccination, fortification and treatment is still common [in Malawi]" (Lwanda, 2005:210).

The female herbalist might also have been a traditional birth attendant, though she did not make this explicit.[27] All the same, I find it likely since she – as the only one – talked of how the government had attempted to stop some of her practices regarding children's health. However, all but one practice had continued on demand from local women: She

[26] Observing one of the nurses conducting postnatal checkups, offered at one week, I noticed that all ten newborns I saw had such a string tied around their waist. The nurse did not comment upon their gear, and said, when I asked, that children get this from traditional healers, as it is believed to make them healthy and strong.
[27] Practicing as a traditional birth attendant, in the sense of delivering babies without official state-regulated education, is illegal in Malawi. However, as illuminated in the next section, the government recognizes their existence and influence, resulting in some pragmatic or paradoxical approaches.

had abandoned the smearing of a herbal mix on the cut umbilical cord, which would make the rind fall off, this woman told me. Some health workers had believed that this caused infections, and consequently stopped the practice. Apart from this ban, all three healers denied facing any problems with staff from the Health Centre or other health officials.

During visits from District Hospital personnel, however, I heard representatives of different HSA-based health programs remind the HSAs in Mangu that "the government does not support traditional birth attendants." They stressed that the Ministry wants all births to take place at the health centers or hospitals, and that HSAs are responsible for making this happen. Some HSAs replied that the government's periodic training of traditional birth attendants made it difficult for the HSAs to persuade villagers to abandon these services and rather to walk for hours during labor to the Health Centre. The general response to this concern was that the government was "aware of this," and "was working to find solutions."

The government seemed to implement similar paradoxical practices towards traditional healers. HSAs complained that the healers' official meetings and government-issued certificates increased their authority in the villages, and they feared that people would rather go to healers during disease outbreaks. This worry seems reasonable given the HSAs responsibility for monitoring and reporting disease outbreaks to the district administration and the Ministry. HSAs thus often referred to traditional healers – some used the term "African doctors" – and traditional birth attendants during health talk. Mostly, people were warned and told they would lose money by using traditional services instead of the free health centre services. Many HSAs also emphasized that sick children should always be brought straight and quickly to the Health Centre, and not first to the traditional healer. Still, most HSAs seemed to approve of my visits to such healers, and agreed that the healers were an important part of the picture when studying local health, curing and prevention. Some HSAs also agreed that as long as the sick came to the Health Centre first, going to the traditional healer as well might not be such a bad idea. Still, I never observed patients being referred to traditional healers, maybe since the MA would be the one to do this from his office.

One of the traditional healers I visited was also a church elder. In other words, he was an active part of the congregation, performing ceremonial and other tasks, supervising and giving advice. This unusual combination demonstrates the relationship between the church and witchcraft, further indicating the complexity of the medical landscape. Many people, including health workers, saw witchcraft as "the devil's work," and praying was consequently an important cure or counterforce. I was told that traditional healers in a way practice witchcraft themselves, and that the path to evil is short from this position. Some thus claimed that the use of traditional healers is sinful, like the posters from the Christian NGO illustrated earlier. The healer mentioned above had therefore denied the congregation's first request that he become a church elder. He had later changed his mind, however, when it was emphasized that people thought he was after all fighting the devil and not hurting, but rather helping people. The healer said he was now considered to work for the benefit of the congregation through his healing. This *sing'anga*'s combined position can be related to his popularity, as his church relations might increase people's perception of him as morally acceptable and trustworthy. For as Marwick (1965) has emphasized, based on his studies of witchcraft and sorcery in Malawi and Zambia: Witchcraft-related activities are always bound to local morals and values, since witchcraft represents the opposite of the 'good' and socially acceptable. Several elderly people concurred with this observation, stating that witchcraft seemed to be an increasing problem these days since there was so much immorality everywhere.

Faith healing

While in Mangu I was often told of God's will and ultimate power, and of the answers to be found in the Bible. Asking for protection against ill health and for cure of disease were very common elements in prayers both in private and U/5 settings. The latter is exemplified in chapter three. As seen in this chapter's introductory vignette, some HSAs also referred to Christian religion beyond prayers. Several people I talked to considered praying the most important measure to fight ill health, and some considered the Bible the most important source of health information: "The Bible tells you not to have sex with anyone but your husband or wife, and it tells you about healthy food," I was told when asking for examples. Still, to some extent, praying was considered most effective when conducted in secrecy. In my household, I was told that our praying was very effective since outsiders did not know exactly how, and how much, we prayed. I also

heard of several secret prayer groups, consisting of women – including health workers – from the same congregation. The time and place of such group gatherings were not to be revealed to anyone, and sometimes even the existence of prayer groups was considered confidential. I was told that this was necessary to prevent witches or church members involved with the devil in other ways from interfering with the prayers and their effects.

The various churches were also officially involved with health issues, and with medical knowledge as presented at the Health Centre. For example, in the Seventh Day Adventist Church – the second largest church in Mangu – they had a committee working with HIV/AIDS issues, mainly spreading information. Similarly, the HSAs were instructed to make sure information was spread through the different churches before the measles vaccination campaign. In the rural setting, this is an effective way to spread information.

When asking questions on vaccination coverage in Mangu, I was early on told of small religious groups that do not believe in biomedicine or any medical treatment other than God's help through prayer. People often talked of such Christians as stupid, and I was told stories about how someone had died, or how chiefs told people to move from their villages if they refused to go to the Health Centre. Still, most of these stories were second-hand stories, and few seemed to know Seventh Day Apostolic Church members or Jehovah's Witnesses themselves. Before the measles vaccination campaign, several HSAs told me that such repudiation was not a big problem in Mangu. Moreover, some HSAs were allegedly often able to persuade skeptical mothers to let their children be vaccinated all the same. Pragmatically, these women were encouraged to utilize Out Reach clinics out of sight of their church elders. "But if people continue to refuse, we leave them alone," I was told. After the measles vaccination campaign started, however, Malawian media were full of stories of conflicts between religious groups and health workers.[28] In Mangu, no such episodes were reported, and everyone I met was eager to get their children and teenage relatives vaccinated.

Faith healing – in different versions – is thus a central tradition of medical knowledge, together with other knowledges, for many people in Mangu. In this regard Foucault's

[28] For example, the heading in *Malawi News* 19 June 2010, page 2: "Vaccination at gunpoint for Apostolic faithful."

(1976/1999) observation from modern industrial societies, that health professionals have taken over the role of the priests as guardians of reality, does not fully apply in this setting. Nobody I met seemed to have absolute faith in 'a scientific truth,' as anybody could be a witch, and God was the final judge. There was thus a decisive reality beyond the observable, and many causes and cures of illness operating beyond the body. Some causes and cures were characterized by secrecy and individuals' mystical abilities; others were not. Different coexisting truths seemed to derive from different social practices. As Eriksen has emphasized, sticking to conflicting ideas might be rational as it can feel safe, and differing knowledges become important when they are of use (Eriksen, 1998:298).

The purpose of this chapter has been to highlight the culturally complex and ambiguous contexts in which the HSAs operate, including the variety of health experts that parents in Mangu seek out to safeguard their children's health. The complex context of medical knowledges described, characterized by interlacing, parallels, mixes and opposites, substantiates variation and change. Still, factors like the focus on continuation of ancestors' ways and their traditions of medical knowledge, as seen in chapter three and discussed in the following, seemed simultaneously to have a stabilizing effect. Ways in which the traditions of medical knowledge presented above were handled by HSAs will be highlighted in the remaining chapters, along with effects of this handling.

5 HSAs as mediators between individual, local, national and international views on health

"We ask the Audience before starting the health messages, in order to know how they know about the topic you need to tell them about. If you hear what they know it is easy for you to know where to start in order to convince the people in the villages [sic]" (Response to a question in the HSA questionnaire, Appendix 1).

In this chapter, I will discuss how the HSAs handle different forms of knowledge in their work, and highlight some effects of their knowledge management. The U/5 clinics will for this purpose be seen as arenas where different interfaces occur. The aim of this approach is to shed light on how HSA work is conducted from, or through, positions of multi-relations, often influenced by different traditions of medical knowledge and different ways of knowledge management. Ortner (1996) defines a borderland as a terrain of cultural encounters – or *interfaces*, which is a descriptive term used by the SUM MEDIC project – where the meeting actors might be more or less dominant depending on their backgrounds and experiences. Interfaces are hence always encounters of unequal power, never level and never neutral; and they are always about culture, in relation to grounds *and* objects of negotiations (Ortner, 1996:181-182). However, the cultural and political terms that develop in the relation do not necessarily accord with any of the actors' own worlds, according to Roalkvam *et al.* (2008:19). Actors can also enter into a more vertical interface on the basis of differing *viewpoints* as I see it, despite similar backgrounds. However, to qualify as an interface the contact point must be one where translations – of, for example, knowledge – occur. This means that outcomes or decisions are likely to be different than if performances are made outside an interface.[29]

In his discussion of the interface concept as a methodological device and theoretical framework, Long (1989) highlights its value for studying the "potentially conflicting

[29] Emphasized by participants in a SUM MEDIC 'Core Group meeting', held in 2011 at the Centre for Development and the Environment, Oslo.

nature" of intersections between social systems. He defines "social interfaces as 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 interests, are most likely to be found" (Long, 1989:1-2). Although this definition highlights the importance of "linkage structures and processes" and the need to take one's investigations to "broader institutional frameworks and power fields" – for instance when studying traditions of knowledge – this is a *system-centered* definition that does not coincide on its own with the actor-oriented focus of this thesis.[30] On a par with Stoner (1986), Ortner (2005) argues that such focus on acting subjects has been partially neglected by anthropologists due to the heritage from structuralist ideas, plus the assumed complexity of the matter. Ortner sees, however, no contradiction between a focus on actors, with conflicting interests, agencies and struggles over power, and the broader study of shared – or contested – culture. In fact, studying actors is the best way to unpack and understand social effects. Muraskin concurs, arguing in one of his studies exploring global vaccination that "[h]umans are not simply passive players subjected to outside forces – institutional or otherwise – since such forces don't exist outside of the people who embody them" (Muraskin, 2005:118).[31] On the other hand, Long's definition might open up to interfaces – for instance between traditions of medical knowledge – possibly occurring *within* actors as well. In this chapter, I will describe situations where such *inter*-actor interfaces between knowledges are identifiable in relation to HSAs working in Mangu. This will be explored along with the HSAs' pragmatic mediation of knowledge in other interfaces. The interface concept is, then, useful to analytically highlight knowledge encounters, friction and junctures (Ortner, 1996:181).

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[30] This is not to say that Long is a supporter of structuralist views – he would argue that he is quite the opposite (see Long, 2004), which other references to his work in this thesis also confirm – but I interpret *this definition* as such. Interestingly, he avoids defining social interface in a direct way in the 2004 publication.

[31] To promote perspectives of *acting subjects* and thereby avoid misleading generalizations and exotifications, Barth (1995) urges us to talk of *knowledge* rather than *culture*, as this leads to a greater focus on flows and processes, and thus gives a more nuanced presentation. However, Barth (1995:66) does emphasize that "the same or similar knowledge is obviously used and reproduced in different local populations to provide grounds for their thoughts and actions. But there are also very divergent bodies of knowledge and different ways of knowing within populations as well as between them." We should thus focus on "how different kinds of knowledge are constituted, produced and used" (Barth, 1995:67).

Several actors can be identified at the U/5 clinics, with direct or indirect presence. First, there are the *individuals:* the women, HSAs, and occasional VHCs – holding combinations of more or less rare titles. As individuals, they have unique experiences of illness and health. Further, there is the *local community,* represented by the individual Village Health Committee members, the participating women, foodstuff sellers and the occasional passerby, as a collective group. This group often shares experiences based on the area's history of disease, leadership, healthcare encounters and the like. Other actors involved in interfaces during the U/5 clinics might be the health professionals representing a *specific occupation*, as well as the resources and directives of the *national* Ministry of Health, with its donors. *International* views on health are also represented by use of equipment and techniques – practical and theoretical – learned during training and workshops, stemming from international organizations such as WHO.[32]

The HSAs are hence mediators in different interfaces in varying ways in this setting. They are the first-line representatives interacting – or interfacing – as individuals with the child, caretaker and other community members, and they represent positions and possibly differing views as professionals, government representatives and international policy promoters. Many HSAs seemed somewhat aware of their position of multi-relations, and emphasized their duty to link the rural dwellers with the directives of "the Ministry" channeled through the District Hospital. "Since most people cannot afford a radio, this is a very important task," one HSA told me. Many HSAs also expressed that they are originally rural villagers themselves and thereby able to connect with people in Mangu through knowledge of village life.[33] Nevertheless, HSAs also emphasized how they differ from other community members due to their accumulated new knowledge on hygiene, nutrition and the like. "We HSAs pretend to [still] be villagers, and use the language they use and what they know, but we polish the knowledge they have," one

[32] A weak point in this study is related to the fact that I never got a chance to participate in the official training offered to HSAs, to analyze its content firsthand. However, I have interviewed Environmental Health Officers involved with the training at the district hospital, and was shown material for the coming (somewhat revised) course.
[33] This argument was also used by officials when giving instructions to the HSAs – as mentioned previously – and by the HSAs when they in turn instructed volunteers. During the yearly elephantiasis campaign, volunteers from several villages were told their participation was crucial as "people trust that you, whom they know, are not poisoning them [with the Albendazole tablets], and they will therefore not misinterpret side effects as something else [witchcraft], as has happened before."

female junior HSA told me. Her statement illustrates how HSAs actively use their different positions and knowledges when facing villagers.

Similarly, a senior HSA told me that he adjusts his language during health talks to "focus on what's important." When it came to information on vaccination, he felt it was most pressing for mothers to know *where* the child should be injected, *when*, and in *what sequence*. "In this way, the women can make sure the children go through the vaccination program correctly," he said. As most of his colleagues, he therefore did not focus on the biomedical names of vaccines and related diseases when talking to people in the villages. They rather talked repeatedly of "the vaccines of the thigh," "the vaccine of the arm" and "the vaccine of the mouth;" they referred to relevant symptoms such as "the big cough," and also focused on the *number* and *timing* of injections and drops connected to different body parts.[34] These language adjustments illustrate how HSAs strategically or pragmatically handle knowledge at interfaces, according to their interpretation of the context. However, the practice stands in contrast to Chilowa and Munthali's (1998:57-58) recommendation of "mass education campaigns […] to sensitize the mothers." This policy advice – to the Malawian government – was based on a survey showing that many women could not 'correctly' list diseases and vaccines or make clear distinctions between them. Several HSAs I met would probably argue that such a priority is flawed, since the most pressing information needed in Mangu is on *when* and *for what* to take your child to the remote Health Centre and U/5 clinic: mothers need to be symptom and practice experts, not experts on biomedical terminology. Moreover, increasing the level of knowledge on mainly abstract biomedical terms and distinctions before people can afford a radio, and before newspapers and books are available, and a considerable percentage can read them, will without doubt require considerable time and resources. In other words, efforts in several arenas are required to fully achieve Chilowa and Munthali's recommended objective.

The above paragraph also indicates that Barth's (1990) distinction between open and secret knowledge management is problematic. HSAs withhold *some* biomedical information in *some* settings, for different reasons. Further, the position of the HSA is

[34] This is demonstrated in chapter 3, and by the song "About the vaccines" which opens my thesis and is recorded in Chichewa in Appendix 3.

strongly, but not solely, influenced by the individual's ability to teach in a consistent way during health talks. I would say that "elegance in performance," identified by Barth (1990:643) as central to knowledge management characterized by secrecy, was just as important as consistency in HSA work. Such elegance was, for instance, displayed through humor, dance and imitation. One concrete example is the previously mentioned newborn chicken metaphor that was employed for presenting detailed hygiene measures – to prevent *maoka* in female genitals – causing a high level of laughter and engagement. The earlier description of the HSA who imitated a heavily pregnant woman to inform about cholera measures, totally capturing the audience, is another example. The HSAs' immediate goal in these situations was, however, not to veil knowledge while creating meaning and significance before the audience – as Barth interprets the elegant performances of the Melanesian initiators to be aimed at. The objective of *this* elegance was rather, similar to the language adjustments (withholding knowledge), to spread information and get certain messages through. The success of the HSAs' management is, of course, highly related to their familiarity with the context and the audience.

Although HSAs often argued in favor of the state during health talks ("We do actually have *laws* in this country!"), on some occasions several felt *directly* squeezed by conflicting interests and expectations related to their various positions and knowledges. For example, during the measles vaccination campaign mentioned earlier, the instructions from the government were to offer injections to those between 6 months and 15 years, restrictions allegedly resulting from a limited campaign budget. When informed of the restriction, villagers responded with questions like "Do they want us to die?" and "So, who will take care of the children, then, if they are vaccinated and we die?" The HSAs seemed to understand and identify with people's frustrations. The vulnerable position of rural citizens when it comes to reaching the healthcare facilities in times of need – as when they are infected with measles – were, for instance, discussed among HSAs, indicating their sympathy.[35] Then, when vaccinations started, some HSAs did not

[35] Lwanda (2008:26) stresses how biomedical services in Malawi historically have been characterized by elitism and marginalization of the majority, while "[…] one could argue that [non-bio]medical provision was more equitable […] In 1964, Dr Banda wanted to charge 'three pence' to the poor to attend government hospitals at a time when he was able to maintain two 'Europeans only' hospitals." These were, according to Lwanda (2008:37), free of charge.

ask people in the queues for their age. Other HSAs actively decided to use surplus vaccine to inject those above the age limit who were still around at the end of the day.[36] These choices illustrate that pragmatic practices influence vaccination coverage, and they illustrate the importance of empirical studies, since one cannot predict how people act based on identifications of who or what they represent. I will return to these acts in the next chapter, and will analyze the events further – from a power and resistance perspective.

As exemplified in chapter three and elaborated in chapter four, multiple traditions of medical knowledge are relevant in the work of the HSAs. The HSAs' handlings of these knowledges need to be related to the several positions they hold. One needs, in other words, to include more than their acquaintance with the challenges of rural life in Malawi. Though HSAs are trained according to biomedical views on health and illness, their handling – or *mediation* – of knowledge in the interfaces they form part of, is additionally influenced by their other relations. HSAs are church members with faith healing experiences, and they are rural residents surrounded by sexual taboos, witchcraft speculations and traditional healers. In the face of U/5 participants, the HSAs thus seldom denied people's various views on causes of illness and health, although different forms of negotiation of knowledge – especially in relation to cures – took place. These negotiations appeared as syncretism, hybridization or creolization of knowledges, and empirical examples of such events leading to reproduction and configuration of knowledge will be highlighted and discussed below. The point to be made here is that one in this setting can identify interfaces between biomedical advice and local 'realities' unfolding between the HSAs and other U/5 participants, *and* within the health workers themselves.

[36] The campaign's "target number" was much higher than the numbers actually met by the teams I was part of during the campaign. According to local inhabitants, this discrepancy was due to miscalculations by the government on the actual population number in Mangu. There was thus a significant surplus of measles vaccine at the end of all five campaign days, even though all parents I met seemed very eager to get their children vaccinated. An MSF representative told me she had seen several queue fights in other districts as people were desperate to get the injection, and some people residing in districts not covered by the campaign walked to the district where I conducted fieldwork to be vaccinated.

In his analysis of politics, culture and medicine in Malawi, Lwanda (2005) stresses how different traditions of medical knowledge, such as witchcraft- and taboo-related knowledge, have often been mistaken for ignorance by biomedical practitioners. However, as Lwanda sees it, these approaches rather represent pragmatic solutions to the many health challenges faced by a poor population. He therefore warns against pressures for change of practices and norms without first ensuring widespread socio-economic changes. Without an alternative medical system in place, the results of abandoning – or banning – present views will be dramatic (Lwanda, 2005:294). But Lwanda (2008:23) also emphasizes that "[…] culture should not be [used as] a reason for providing reduced modern medical services."

In this regard, many of the approaches implemented by the HSAs are of high value. In their use of non-biomedical concepts like *maoka* – which is identified by many people as one of the main health threats in Mangu – HSAs show an essential understanding of the context in which they work, and an ability to truly see people, their perceived health challenges and their limited resources. By focusing on how one can deal with *maoka,* as illustrated empirically in chapter three, the HSAs are able to enter into a partnership, or non-conflictive interface, with people from the villages. I will later argue that such a practice probably affects their overall work in positive ways. Moreover, focusing discussions on how to handle threats like *maoka*, rather than dismissing the problem as not a part of biomedical knowledge, leads to a pragmatic syncretism of knowledges. Such syncretism makes the added knowledge somewhat familiar to the target audience of HSA services. This practice can give people a feeling of ownership of the knowledge, which in turn might make the knowledge trustworthy. The advice given is, in other words, matched with contextual life experiences. Like Lwanda (2005:312) points out, the situation is adjusted to reality rather than – or I would say *and* – to 'book knowledge.' Interestingly, Stoner (1986) focuses on the importance of seeing the complexity in which people act, when trying to *study* human relations to illness and health. His argument, which is part of his critique of scholars' excessive focus on abstract systems rather than on actors that act, is however also relevant for the HSAs as health mediators:

> Medical decisions are life decisions and bear upon all aspects of human existence. Thus, to focus solely on perceived medical systems and not on other areas of people's lives that directly affect health care decisions ignores the essential nature of the human experience and the interconnectedness, at many levels, of belief and action (Stoner, 1986:46-47).

Furthermore, in chapter three, the HSAs' handling and use of taboos are explicitly exemplified. The HSA Mr. Moni uses his knowledge on virus infection, in combination with local knowledge and traditions on sexual abstinence, in an attempt to convey the seriousness of the measles disease and to reduce, by familiar measures, its spread. Mr. Moni also catches the audience's attention by relating to familiar and controversial issues. Moreover, one might say that he additionally gives the local women a sense of ownership, and empowers them to handle the situation, through this mediation between biomedical knowledge and local resources. People's use of taboos and spells, as means to achieve control of individual actions, will be investigated further in the next chapter on power, resistance and trust. In this chapter, my objective is rather to illuminate how the HSAs' practices can be seen to represent pragmatic solutions to the health challenges faced by a poor population, on a par with Lwanda (2005:294).

A central means to spread information, and thus to produce, reproduce or configure knowledge in the U/5 setting, is the use of health songs. Lwanda argues that the importance of proverbs and music lyrics in Malawi is related to the fact that many communities in the country are still mainly "orally driven." Therefore, "[music lyrics are] after oral discourse, the most effective and far-reaching medium in Malawi for disseminating health promotion messages among the general and student populations" (Lwanda, 2005:235). Singing is, in other words, a historically founded way to handle and pass on knowledge. At the same time, the concept of health songs was explained in chapter three as having been introduced by a British musician during Britain's colonial rule, and such songs are frequently used by NGOs and others involved in health related aid. HIV/AIDS songs have, for instance, proliferated under the circumstances of the last three decades in Africa. The songs are thus both old and new, and this might affect the information spread through the songs. In this situation, it is the means of knowledge dissemination that are familiar, and new information might thereby appear trustworthy. The (possibly new) messages in the songs additionally come in a catchy form; they are

easy to remember, and they are open to creativity and thus to ownership by those performing them.

The long history of oral poetry in Southern Africa, with and without music, is analyzed by Vail and White (1991). They argue that poetry and songs represent an "arena where competing 'histories' clash, subjected not only to political reevaluation but to moral and spiritual reassessment" (Vail & White, 1991:xiii). This statement supports the viewpoint that the songs are both old and new, and part of ongoing processes where involved actors have agendas. Health songs, in other words, represent interfaces. Different traditions of knowledge merge in them, and different actors are involved as composers, singers, the topic of songs, or as the audience. Further, Vail and White (1991:56, 285-286) emphasize that one cannot assume song performances to represent "the popular voice," and that singing has been an important tool for expressing opposition as well as for political suppression and propaganda in Malawi.

The following song – one of those most frequently sung during U/5 clinics in Mangu – can exemplify some above points. It definitely deals with a recently introduced topic – that of "family planning" – and it represents a mix of knowledges. The theme, as it is phrased, stems from the professional health sector, and it is interspersed with words associated with modernity and economy. The lyrics is presented, however, by rhythmic clapping, repetitions, exchanges between a soloist and a choir, and howling of "Eeee," all found in old songs (see Vail & White, 1991):

[1]Njira kulera mayi ndiyabwino imazetsa chitukuko cha pa banja amayi ena.	*[1]Familyplanning methods are good; they bring development in the family; other mothers.*
Eeee.	*Eeee.*
[1]Ana wabala ngati amalonda.	*[1]They produce children as if for sale.*
[1]Anawabala ngati ogulitsa, amayi ena.	*[1]They produce as if for sale; other mothers.*
Eeee.	*Eeee.*
[1]Anawabala ngati amalonda.	*[1]They produce as if for sale.*
[1]Anawabala ngati amalonda, abambo ena.	*[1]They produce as if for sale; other fathers.*
Eeee.	*Eeee.*
[1]Anawabala ngati amalonda.	*[1]They produce as if for sale.*

Another tool utilized by many HSAs during health talks was the classification of knowledge or practices by drawing historical lines, or by making distinctions. As seen in chapter three, comparisons with the ways of "your parents" or "our forefathers" were common. The points made were often that "vaccines are not new; it is just the way we do it that has changed," as one HSA put it, and "we must continue the good ways of our parents." Like Mr. Jinga exemplifies, the "young mothers of today" were often told to follow the good example of the elders, though today's methods might be described as more modern. It was thus alluded to the importance of continuation – or ongoing inclusion, as no tradition is ever completely static – of practices, while divisions were introduced between "young" and "elderly," or between "ancestors" and "mothers of today." Other contrasts were also emphasized, such as between "*this* Out Reach U/5, where you always come late" and other "catchment areas where everybody comes early." Sometimes the rural population was also differentiated from people in the cities, or from the health workers themselves. The HSAs' goal was allegedly to make U/5 participants follow the good examples of others. Furthermore, one can interpret this focus on continuation as a stabilizing measure. However, distinctions between 'them and you,' or 'then and now,' might also strengthen internal group solidarity, or lead to other more or less unintended effects. Elaborations on how individuals or groups of people – health workers and others – acted to advance their own position, influence others, or resist impositions from others, are found in the following chapter.

In this chapter, I have illuminated and discussed how HSAs slide between different views on health and illness in their work during U/5 clinics. HSAs mediate different knowledges under the influence of different interfaces, and by different means: They discuss local views on health, such as *maoka* complications, in combination with biomedical views, and they use language and methods acquired from the government, NGOs and other contacts, together with local ways of conveying information. By such mediation, HSAs make room for familiarization and possibly individual feelings of ownership towards the mediated knowledge. That HSAs give the audience opportunities to participate and contribute is also influential. Hence, consequences of their pragmatic and synchronizing knowledge handling have been suggested: As I see it, the audience's appropriation of new ideas, and their feelings towards the U/5 clinics and the clinics' activities are promoted because of the HSAs' efforts. The HSAs utilize considerable

practical knowledge versus theoretical book knowledge, in Lwanda's terminology (2005:167).

After interviewing and observing HSAs working with HIV counseling, Angotti (2010:986) draws similar conclusions: "[the HSAs] are intermediaries between the rule-making of international and national policymakers, and the norms of the communities in which they live and work." Angotti describes how HSAs adapt their practices, messages and views to the local context during their "task of translation," as has been highlighted here. This adaption, she emphasizes, leaves the HSAs with ethical dilemmas related to conflicting expectations, while their training does not focus on contingencies and variations in people's active interpretation and local framing. In the next chapter, I will highlight an ethical dilemma similar to those described by Angotti when I investigate further the HSAs' language adjustments discussed in this chapter. Angotti (2010:990-992) relates the HSAs' dilemmas to the fact that plans often originate far from where they are to be implemented, and as overall plans they cannot satisfy all contexts – while the HSAs hold unique positions both living *and* working in *specific* rural areas. Angotti's points open up to a dilemma that I often reflected upon during fieldwork. While it should be undisputed that the HSAs I met are not cared for or awarded fairly and proportionally considering the responsibilities and risks of their work, their positions as poor rural dwellers might be a central factor to their success as knowledge translators and vaccinators in this context. Increased training and salary might change this unique position, unless measures are taken to sensitize the vaccinators to the interfaces they are part of, and to how proximity to and positive use of local traditions of medical knowledge are central to their successful knowledge mediation and thereby to the vaccination coverage. Of course, development of such training programs – sensitive to complexities and issues of power – might be a utopian goal, considering the history of intervention policies.

Pragmatic solutions: An HSA has prevented accidents by inserting the used syringes into an avocado.

After analyzing how HSAs mediate between individual, local, national and international views on health, and how they use locally adjusted, varied and pragmatic methods of knowledge management, I will now explore how processes of power, resistance and trust are involved in HSA work. As indicated in this chapter, the way knowledges are handled in the U/5 setting influences how attendees relate to the promoted information, and influences moreover, the way they act with this information in mind. When discussing processes of power, resistance and trust, it becomes clear, however, that one cannot isolate what goes on in this arena from wider relations and processes.

6 Power, resistance and trust

On our way home from the Out Reach clinic, Bertha, William and I were invited by one of the mothers to sit outside her tiny house while she served us mangos. With the intense heat and our long bike ride home, the sweet fruit was a pleasant source of liquid. Two small girls in torn dresses were staring at me from the doorway, while I made a mess with the sticky delight. I wondered if it was because of my foreign appearance, or the fact that the others neatly ate what we were served while I had mango juice all over my face and yellow fibers hanging from my teeth. The HSA called one of the girls forward and inspected some wounds around her mouth. I felt a lump form in my throat while memories of some of the AIDS patients I got to know in Tanzania some years ago came to mind. Bertha and the mother exchanged a few words before we all sat in silence for a while. When we had to get going the woman came from the back of her house with a huge bag of mangos that she offered the HSA. I felt discouraged when Bertha accepted and happily commented in English that this is one of the reasons she enjoys going for Out Reach to the villages. The woman was obviously much poorer than the HSA, and I saw her offer as a form of payment to someone possessing needed resources already paid for through the government. I later learned to view these situations in a more positive and complex light when I realized that perishable agricultural products make certain investments reasonable: When food cannot be preserved, it makes sense to offer some to people who might later provide direct or indirect services. Villagers sometimes possess too much of something that several of the HSAs desire, especially those female HSAs whose husbands have jobs, since these families are unable to cultivate very much themselves.

In this penultimate chapter, I explore how processes of power, resistance and trust unfold in the U/5 setting, especially, but not exclusively, in relation to the HSAs' handling of knowledge. This exploration is essential in light of the previous chapter, which disclosed that these factors are influential to HSA work. Moreover, power, resistance and trust influence – as more or less underlying factors – the effects of HSA work, like the HSAs' varied methods of knowledge management in themselves do. Importantly, these effects include the way parents act in relation to vaccination in the local area. In other words, I believe it is vital to include a perspective on the concepts of power,

resistance and trust to understand the HSAs' work, why they handle knowledge as they do, and the effects of their practices.

Long (2004:30) argues that power is particularly significant in intervention situations – such as the U/5 clinics – since an interplay or confrontation between 'expert' and 'lay' forms of knowledge, beliefs and values takes place. As demonstrated throughout this thesis, I see the situation in Mangu as highly complex when it comes to actors' views and practices regarding illness and health. The flows of power, resistance and trust then also appear multidirectional, multilayered and ever changing. Furthermore, this flow means that one cannot isolate the HSAs' use of knowledges, or the U/5 setting as such, when analyzing the ways of power-related processes. Practices and relations in other arenas and contexts affect what goes on at the U/5 and influence the effects of clinic practices. The interface concept from chapter five is a helpful tool to identify multidirectional flows of power, resistance and trust, and it is therefore utilized below. Initially, I also resume and elaborate on theory from my analytical framework. I choose to recall and reflect carefully on the introduced tools for thought since they help me to illuminate the complexity I need to impart, and hence shape my views and discussion to a considerable extent. Thereafter, I direct the reader's attention towards power, and the related processes of resistance and trust in the HSAs' knowledge management.

Power and empirical complexity

As cited in chapter one, Weber (1946) postulates that a person has power when he is able to force his will on others, even if they resist. His definition entails that when reluctant women are vaccinated with tetanus toxoid, as described in chapter three, some form of power is displayed. However, in this situation, it is not entirely clear who holds the power. It might be the HSA as a particular individual or church member, or as a representative of the Malawian professional health sector or of the government. It might be the chief, receiving honorarium from the government and possessing authority to expel people from his or her area,[37] or it might be the community as a group of actors

[37] Chiefs (alternatively VHCs) and HSAs, and through them the government, seem to some extent to be mutually dependent. A Village Headwoman I met was frustrated since the responsible HSA did not perform according to her expectations, allegedly putting her

conducting social control. Alternatively, it can be a combination of different factors and actors that make these women follow orders. The history of governance in Malawi is, for example, also part of the context in which people act.[38] In other words, Weber's basic definition does not seem to capture the web of actors and agendas on the ground, nor is it adequate to identify what or where the ability to exercise power comes from if one could isolate a clear power relation.

Weber (1971) distinguishes three forms of legitimizing authority as essential prerequisites for power: traditional authority, charismatic authority or rational-legal authority. These forms of legitimizing authority are often mentioned when different traditions of medical knowledge are discussed. However, I draw on Foucault (1973, 1975/1999) and Bourdieu (1996) to nuance this view in the analytical framework. These two scholars have both claimed that forces seen as "natural" – and thus part of the habitual, not in need of legitimacy – might be the most powerful. In Mangu, many people told me of their country's dependence on donors, or of their personal need of help from outsiders like me. At times, their argument seemed to involve more than money or economic capital (see Bourdieu, 1985). I uncomfortably heard my host lecture the other family members on how "whites are always honest and hardworking." On another occasion, two HSAs wanted me to decide what to do when we found out that the scale one of them had borrowed from a maize seller did not indicate the children's exact body weight. When I asked why they turned to me, they told me they thought I knew best. I was puzzled by these and similar events since I so often asked questions that people found strange, naïve and even stupid, and because my clumsy handling of village life made it pretty clear that I was totally dependent on help. Still, people did not seem to question my abilities. It is important to emphasize, though, that people's habitus – if that is what I observed – do change. Child vaccination has, for instance, become an automatic and integrated part of child care in many countries (Streefland *et al.*, 1999:1713).

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village in danger. I also noticed how HSAs who cooperated with dedicated chiefs or VHCs seemed to get crucial assistance in the rural setting, e.g. to spread messages.

[38] I, for instance, allude to the fact that Malawi is a former colony and dictatorship where people like my host vividly remember how citizens were forced to participate in celebrations and follow other orders. Furthermore, there was only one radio station available in Malawi until 1999, and there still is only one Malawian TV station.

Further, given the abrupt historic changes in many African countries, one can wonder if people's habitus have been or are changing particularly rapid here.

The importance of including un-legitimated, un-questioned, and habitual forms when analyzing power accords with Wolf's (1994:218-219) view on power as being manifested in four different modes. Wolf argues that it can be embodied by (1) a person's attributes, (2) a person's ability to maneuver socially, (3) the design of organizational processes by actors or operational units, or (4) by structural tendencies making people think and act in certain ways thus steering their flows of energy. In other words, Wolf sees different kinds of power manifested in different kinds of relationships, not limited to interpersonal relations. This theory indicates that one all-embracing definition of power might be unattainable. Simultaneously, it enables me to question observations that I made in Mangu, and to point to signs and effects of different forms of power in a complex context. For instance, Wolf's third and fourth modes of power inspired the following question while I participated in HSA work: Why do people tend to seek advise from others when they feel sick, instead of withdrawing like many sick animals do? One could argue that humans do so because they are strategic beings, but to protect the crowd from infection and to avoid imposing a burden on the community might be just as rational. However, there seem to be no limits to the number of 'experts' that many are willing to consult, and the diversity of methods that many patients, in Mangu and elsewhere, wish to take on. The amounts of effort, time and capital that people are willing to invest in health assistance from various 'experts' offering their services are considerable. Further, it seems like invented practices – such as vaccination with its tendency to become part of parent's habitus in many countries (cf. Streefland *et al.*, 1999:1713) – create widespread dependence and markets which are hard to question. In this regard, the HSAs can be said to build on and contribute to an expert-seeking practice based on complex agendas and effects. Furthermore, empirical material from this thesis indicates that there are several direct and indirect stakeholders involved with the U/5 clinics. Chiefs are among the influential actors – more or less depending on their honorarium from the government. This recognition necessitates a wide approach to unpack HSA work in the U/5 setting. HSAs must operate in relation to a traditional hierarchy that often influences people's practices. As a thought experiment, one can wonder what would be the outcome if chiefs suddenly instructed parents in

their villages to stop having their children vaccinated. I believe the result of such a situation in the 21st century is hard to predict.

Wolf (1994:219) argues that the actor-oriented view of Ortner fails to capture all power relations since there is always more going on than "real people doing real things." As I see it, anthropologists should nevertheless *start with what people do,* including the effects of people's practices, as the basis for analysis and theory building, and proceed from this basis to reflections on the abstract. However, the concrete and the abstract are interdependent parts in anthropology, and a discussion of only one part might fall short.

Signs of resistance

Foucault (e.g., 1982) in fact also gives reason to emphasize what people do, despite the fact that his theories often form the basis for quite abstract discourse analyses. Foucault has shown how power is always relational, making scholars open their eyes to the ever-present possibility of resistance. Reed-Danahay (1996:36-41) brings this perspective further in her investigation of rural parents' encounters with the French school system. She identifies "everyday domination" and "everyday resistance" – power and resistance of a concealed and un-confrontational sort. These are valuable points when studying U/5 clinics in Malawi (cf. Chilowa & Kadzandira 2001). As described in chapter three, U/5 attendees rarely protested when yelled at by HSAs. Still, it can be interpreted as a sign of "everyday resistance" when only a few mothers turned up at Out Reach clinics where yelling was common. The U/5 system allows people to choose between different sites and days, although HSAs sometimes dismissed women who did not reside in the site area if there were too many attendees. Simultaneously, HSAs used the threat of dismissal by the MA, or the public health services in general, in an attempt to ensure that people got their children vaccinated at one clinic or the other. Observed practices might therefore be even more complex: According to Long (2004:30), patients often comply for strategic reasons. Some women might, in other words, accept the yelling, stand in line to weigh their children, or sing and pray like the HSAs command, not because they wish to, but to get the desired vaccines.[39] Further, the HSAs can use the vaccines to fulfill

[39] It is interesting to recall at this point how especially young, female HSAs sometimes struggled to get the crowd's attention and to establish order, while people on other occasions referred to the same HSAs as "Doctor," clearly with respect.

several desires. One basic goal is, of course, to keep their jobs by fulfilling government targets on a variety of childcare measures. I will return to, and nuance, their motives later, when looking more specifically at the HSAs' handling of knowledges in light of power-related processes.

However, whether organizers and participants – through absence, late arrivals and the like – demonstrate resistance *or* power is difficult to establish. When arriving late, some HSAs emphasized to the impatient crowd that they had many important *work* tasks that needed their attention from time to time; so, jobless people in the villages just had to wait for the U/5 clinic to start. It is in this situation difficult to differentiate clearly between resistance and power, much like the challenge of establishing which act starts a chain of events. The important point here, though, is not to decide whether actors are exercising power *or* resistance, but to remember that modes of power are not one-sided, they are relational and dynamic, and that such modes might be un-confrontational or more or less invisible – presented as a natural inevitable phenomenon. Nevertheless, agendas and dynamics can still be tricky to reveal – recall, for instance, my reflections on the mango gift in the above empirical vignette. Similarly, I would have difficulty giving a full account of how accusations of witchcraft affect accusers and accused health workers. Further, while I occasionally observed HSAs yell at U/5 participants, it was clear that they also respected the lives of mothers in this rural setting and wanted to add as little as possible to their burdens. Respect is illustrated in chapter three, when HSAs do not want to make women stand in line in the burning sun – leading to crowding and tough working conditions. Another sign of respect can be identified when HSAs discuss how to proceed with the U/5 clinic, considering the mothers' pending tasks. Moreover, though yelling is often considered a demonstration of power, it is not totally clear what effects the HSAs' yelling had. Typical phrases were "you villagers" or "you young mothers of today" combined with some negative statement regarding people's practices, often comparing them with some better performing group. The aim of the HSAs was to make people emulate the good behavior of others, as mentioned in the previous chapter. In the U/5 setting, this includes seeking immunization and other healthcare measures to secure the children's lives. From this perspective, the HSAs' use of power can be seen as positive (see Norvoll, 2009:69). However, when the health workers were faced with similarly phrased accusations themselves, group solidarity seemed to be invoked, which

enabled collective resistance, though not always openly. This reaction illustrates how intention is not the same as consequence (see Norvoll, 2009:72). I will return to the above points later.

Trust or hope?

The power-resistance thematic also brings me to another factor that seems relevant when exploring HSA work in the U/5 setting: When one cannot identify resistance within a power situation, the concept of trust might be brought into the analysis. Let me exemplify this empirically: As illustrated in chapter three, all mothers I met in Mangu seemed eager to vaccinate their children, yet at the same time resisted tetanus toxoid injections for themselves by letting other people escort their children on vaccination day. However, when I asked them what vaccines really are, or in other words, what the HSAs inject in their children, they all said they did not know. A majority emphasized that vaccination is what the government or their parents recommends, and they had no reason to doubt that it protects against certain diseases or strengthens the child.[40] One woman told me she trusts the HSAs since they at least have some education and training in child health, while she has none.

Trust, then, seems to transmit power, creating space where one actor risks something of value – such as her child's health – while another is allowed to administer this valuable on her behalf. This coincides with Grimen's (2001) view on trust. Through doctor-patient examples, Grimen argues that trust – or power transmission – and thus creation of a space in which the doctor can act, involves rational, calculated or inevitable risk for the patient. Patients might trust a doctor and risk their health based on the doctor's legal authorization, because the particular doctor seems to be the most effective alternative, or because there is no other alternative. According to Grimen (2001:3617) this means that trust might be a result of power. Furthermore, we are more likely to trust an actor with power – especially when we are vulnerable and lack alternatives for action. Grimen also emphasizes the variation in whether people are aware of the power relations that arises from their trust. Grimen's point on how trust is related to power and vulnerability

[40] It is here appropriate to recall that governmental and international strategies on vaccination "are guided by powerful cultural assumptions and political interests" (Hardon, 2004:263). The mobilization of ideas might originate from political agendas.

is thought provoking when studying health practices among some of the poorest people in the world.

Grimen argues in one of his books (2009) that one can identify degrees of trust and mistrust based on how many precautions people *act* with, while trust does not mean certain expectations, contrary to many definitions. Grimen argues that it is common to expect some sort of good intention and positive result; but what trust is, as in *why we trust,* is impossible to define because people's reasoning varies with space, time and other factors. However, we can study trust, including the vulnerability trust causes, through studying people's practices. In other words, we can investigate how people show trust or mistrust and the effects of this, without theoretical generalization of their reasoning or what lies behind their expectations. Still, some observations from Mangu make me question if 'trust' is necessarily the right way to label situations in which people allow others to administer their valuable while acting with few precautions. At one Out Reach site,[41] mothers waited for hours, but no HSA turned up. The next month the same thing seemed to be happening, and William and I were told this was common. I doubt that it was *trust* that made these women risk their precious time and repeatedly come back and wait for the health workers. They all made it clear that they were not surprised when the responsible HSA did not turn up. They were, nevertheless, willing to come, and it appeared to me as if *hope* was involved rather than *trust*. In this rural context, people seemed to accept, or at least cope with, irregularities that strained the patience, hopes and convictions of a European urban woman like me. As I see it, the concept of trust might not be viable without outlining its relation to the concept of hope, at least in the context of extreme poverty.

Grimen's introduction of mistrust has also made me reflect on whether *mistrust* coincides with *resistance*. Through empirical examples from Mangu, I conclude that the two, at least sometimes, involve different processes: We can *resist* someone's power when we control something the other party has an interest in. Villagers' physical presence is, for instance, a prerequisite for HSAs to do their job. A person might show signs of *mistrust* – act with many precautions – however, through practices that do not

[41] After some months in Mangu, William and I sometimes left for U/5 on our own to talk to attendees before the clinic started.

necessarily affect one's relations, such as when women choose to have traditional healers tie strings around the newborns' waists. Many do this to avoid spells transferring to the babies from their fathers, in case the latter are sexually active. This reasoning seemed to be based on knowledge withheld from most men, as only females told me of this. Finally, our precautions might become threats in themselves (Grimen, 2009:136). One example is people's fruit-picking practice in Mangu: In order to avoid theft, most fruits are harvested and eaten before they are ripe and at their peak in nourishment.

Power in knowledge management

After demonstrating that processes of power, resistance and trust are complex and unfold in myriad ways in the U/5 setting and beyond, I now turn to how HSAs handle different traditions of knowledge in this setting, influencing and being influenced by such processes. Varying effects and aspects of their practices are indicated, though I am unable to fully unpack all aspects, links and consequences – considering the level of complexity – related to modes of power, resistance and trust in observations made.

In the previous chapter, I discuss how Mr. Moni and other HSAs draw on different traditions of medical knowledge in their work. I also point to some effects of their knowledge management such as captivation of the audience, and persuasion through familiarization of the information. Moreover, the HSAs I met included and excluded information, more or less knowingly and strategically, with the aim of convincing U/5 attendees of new ideas through catchy and, or, old familiar measures – such as singing. When influencing the audience by combining or alternating between different local knowledge and biomedical views on health and illness, and by adjusting their information to the context in which they work, the HSAs take part in power processes. However, their objectives are complex, and Wolf's four modes of power are all in play with varying clarity. Mr. Moni enjoyed being the centre of attention, and as a young man with certain attributes, he maneuvered in a way that secured him an influential position in his catchment area, where he also lived. By combining "elegance in performance" with comprehensive knowledge presentations in consistent ways (cf. Barth, 1990) he emerged as someone worth listening to and seeking advice from.

However, through the implementation of health talks and other activities, HSAs do not only influence their personal position in the local community. By leading the situation and handling knowledges in different ways, they also try to influence participants so they together fulfill the goals of the government and district administration. Hardon (2004:264) argues that use of different traditions of knowledge in the area of vaccination might legitimate intervention by "the immunizing state." Following this perspective one might see the U/5 setting in itself as a ritualization of the state and its power by modern and traditionalizing means (see Lwanda, 2005:214) bringing the state and the individual together. The focus and volume of this thesis do not allow such an analysis here, but concentration on HSAs' pragmatic handling of knowledges makes it clear that their knowledge management – mixing different traditions or not – does more than influence their personal position, *and*, as I see it, the state's position.

I have earlier pointed to how HSAs talked about the vaccines during U/5 clinics, and how their language adjustments made information available – or convincing – and useful to rural mothers. The language adjustments were said to enable mothers to support correct vaccination of their children, while parts of the biomedical knowledge was left out. Based on these data it is appropriate to question if parents in Mangu are really allowed to make informed decisions on whether to follow government recommendations on child vaccination. I believe that the language adjustments exemplify that Wolf's (1994) third and fourth modes of power are both in play: HSAs contribute to organizational processes and structural tendencies that influence people's practices by adjusting the flows and the faces of the knowledge they present. This is not to say, however, that the HSAs deliberately try to promote state recommendations by depriving people of their chances to make informed decisions. Rather, from my experience, the HSAs utilize power-laden methods, more or less knowingly and strategically, to sensitize parents to the value of immunization and other measures, more than to secure government targets as such. Along with expressing general concerns related to their duty of fulfilling government-imposed tasks, all HSAs I met expressed a strong belief in the lifesaving potential of vaccines. Interestingly, some were also somewhat skeptical towards other program's priorities, based on their opinions concerning the feasibility of the priorities and the urgency of other issues. As I see it, the HSAs' practices thereby involve a form of power that is positive and productive – an

aspect of the concept of power that Foucault is known to have highlighted. The HSAs maneuver with the aim of getting messages through – and in practice some tasks seemed to be prioritized before others – based on familiarity with the local context. Seen against this context one could say that they both facilitate state power and adjust state power, with positive and productive goals. Furthermore, abandonment of power-laden knowledge management could have unpredictable consequences regarding, for instance, vaccination coverage. I will point to other examples of positively laden power in the HSAs' knowledge management shortly.

However, the practices of knowledge dissemination involved power aspects that were clearly negative as well. Though U/5 attendees were often invited to take part in "knowledge discussions" during health talks, the randomness of health-talk topics illustrates how many people in the rural area, to some extent, are at the mercy of the HSAs regarding information. Recall that vaccination was never discussed at all in some U/5 sites during my stay. The consequences and the importance of such unstable health-talk practices must, though, be linked to the fact that a considerable number of families in Mangu are not in a position to gain information through technological channels. The above data make it clear that the HSAs operate in relation to ethical dilemmas – as Angotti (2010) has highlighted in her study of other HSA activities. Still, to make the HSAs accountable for these dilemmas – beyond instructing them to secure proper health-talk schedules – is problematic and to a considerable extent unreasonable. To do so would mean making the HSAs accountable for the many effects of poverty – poverty must, for instance, be said to contribute to the limited channels of information distribution in the area. I also suspect that given the HSAs' short training, the unavailability of refresher courses, and their work environment, it is unreasonable to expect HSAs both to considerably broaden and nuance their presentation concerning vaccines – meaning sensibly discussing pros and cons and such – and to nuance their presentation concerning other topics.

This thesis has also highlighted that some HSAs promote local moral values by supporting sexual taboos or the risk of spells.[42] Mr. Moni emphasized, as explained in

[42] Additionally, I observed HSAs command participants to lead the crowd in prayer; most HSAs were unwilling to start the U/5 clinic until the crowd prayed. This practice

chapter three, how HSAs now and then strategically do this when the taboos are somehow concurrent with biomedical knowledge and government targets. When HSAs draw on taboos and their consequences – in other words combine moral responsibility and anxiety – they promote individual practices of a certain kind. In this way, community perspectives influence individual decisions, and social control is intensified. The risk of your child becoming *ntumbidwa* – ill from a breast milk-spell that arises when mothers defy a sexual taboo – is a previously mentioned example of local moral discourses that was used by some HSAs. Signs of *ntumbidwa* indicate that you do not "space your births" by abstaining from sexual intercourse or, alternatively, by "taking part in development through following family planning methods." However, when some HSAs talk of children as *ntumbidwa,* they risk shaming the exposed mothers such that they might not bring all their children to the U/5 clinic. In this setting, the number of children you have under the age of five is revealed to many people. The HSAs' intentions – which in relation to the *ntumbidwa* example include promoting family planning – might, in other words, differ from the consequences of their power-laden knowledge handling.

Nevertheless, I have also discussed how HSAs' handling of local views on health can be an effective way of adjusting 'book knowledge' to the local reality (see Lwanda, 2005). An example is their inclusion of *maoka* in the health-talk repertoire, focusing on how one can deal with it, rather than dismissing it. I have argued that this practice represents a non-conflictive interface that upholds respect for the health issues that people experience, and thereby is likely to increase people's support of the U/5 activities. By including familiar views and methods in their work, the HSAs also appeal to people's trust and promote people's acquisition of new knowledge. Again, the HSAs' methods can be seen as power-laden, but the objectives and results of their knowledge management are not therefore only negative.

The above points additionally indicate that the power of the government – or international regulations on child health – can be seen as somewhat restricted in Mangu.

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also aids a certain morality. "If we don't pray, how can we then be protected from accidents and ensure that the children get the vaccines correctly?" one HSA asked her audience.

As mentioned in chapter four, I did not experience hegemony in the form of one tradition of medical knowledge being dominant or generally favored over others among people I met. Rather, many seemed to prefer a combination of views and practices. The remoteness of the area and the few government services available might be two reasons for the extensive coexistence of varied medical knowledge in Mangu. Moreover, the Malawian social security system is to a considerable extent based on family and community relations, and control over medicine does not reside exclusively with a professional elite. One can see this situation from two perspectives: It can, on the one hand, be argued that people in Mangu are free from certain forms of domination, enabled to uphold reasoning of varied forms due to their distance to the state. However, Eriksen (2007:66) emphasizes in relation to linguistic pluralism that such situations may arise from groups of people being "neglected by the globalizing forces" rather than from their own desire to uphold traditions of language or, in this context, medical knowledge. In other words, instead of indicating a low level of power, the situation could be interpreted as the opposite.

HSAs thus mediate state power and international views on health to a certain extent through their methods of knowledge management, while they also contribute to other processes. It should be emphasized, however, that several of the HSAs felt they were subject to considerable village and state power themselves. Their experiences support Foucault's (1994) argument that health workers are power mediators and are simultaneously subjected to power themselves. Such feelings became evident when some HSAs resolved conflicting expectations of the government and villagers by utilizing surplus measles vaccine to vaccinate people above the official age limit during the measles vaccination campaign. Moreover, as mentioned in chapter two, many HSAs feared that villagers would not give satisfactory answers if questioned by HSA supervisors conducting quality checks. Nevertheless, I was told that it is easy to lose one's motivation as HSA, since one is constantly required to make extensive reports, without ever seeing any responses to them. Furthermore, one senior HSA wrote in his questionnaire that

> [m]ost of the activities we [HSAs] do for Malawi, making our country a good performer, are exposed as if it's Nurses who are doing it. For instance, on posters you see Nurses in white uniforms administering vaccines, yet on the ground it is done by HSAs. They [the

> government/district administration] are keeping on shifting many tasks to us, without shifting benefits. When we try to complain of something which we need, they always interfere by saying that we can easily be dismissed, because our rank is not recognized internationally. At the same time each and every program coordinator is waiting for HSAs to work for their program to work.

The government and the district administration control salaries, working conditions, and training content and opportunities – though equipped with limited means, and highly dependant on donors. Additionally, the HSAs I met seemed to have no political power, while a supervisor pointed to their lack of legal protection. As a result, protesting was feared by the HSAs, since few other jobs are available. However, after studying the work they conduct – how they maneuver to achieve goals based on familiarity with the local context and respect for village life – it seems clear that the government, and international donors, depend on the HSAs as well – as officials also commented (see footnote seven). Still, for HSAs to throw their weight about, if at all feasible, would require coordinated opposition. Such opposition might be a particular challenge in a poverty-affected context.

At the needlepoint: U/5 attendees pay close attention while the HSA "stabs with the vaccine of the thigh."

In this chapter, I have explored how power, resistance and trust unfold in the U/5 setting. I have also looked at how HSAs influence and are influenced by such complex processes in their knowledge management, and I have looked at some of the positive and negative effects of their work for U/5 activities and participants. In so doing, I have highlighted the relational nature and concealed aspects of power, resistance and trust. I have demonstrated that strict definitions might be problematic to utilize when grappling with a multifaceted empirical context. Furthermore, I have argued that practices interpreted in other contexts as signs of *trust* should not always be labeled in this way in the context of extreme poverty. I rather identify *hope* as an influential factor in some occasions.

From the last two chapters, it has become clear that HSAs secure their position by both sharing and concealing knowledge, and by both consistency and elegance in

performance (cf. Barth, 1990; Harrison, 1995). Furthermore, when they draw on different traditions of medical knowledge and use varied methods of knowledge dissemination, the effects are both personal and collective, and can be seen as both positive and negative. Processes of influence, unfolding in and beyond the U/5 setting, have certainly proven to be complex and ambiguous. Nevertheless, it seems reasonable to conclude that without the HSAs' context-specific knowledge management there might not be such a generally positive attitude towards vaccination in Mangu, which in turn saves lives. The chain of processes directed at disease prevention, or more specifically the coverage levels achieved through the Malawian child vaccination program, would not look the same without the HSAs and their knowledge handling.

7 Conclusion: HSAs "the backbone of EHP"

With this thesis, I hope to have achieved two things. Firstly, I hope to have highlighted how some vaccinators in Malawi handle different forms of knowledge in their work, and how their specific efforts might influence the vaccination coverage in the local area. I believe my observations on this part point to some of the strengths of the Malawian child vaccination program. By managing knowledges in pragmatic and synchronizing ways, the HSAs influence how rural parents relate to the U/5 clinics, including vaccination and other activities. As I see it, the HSAs' efforts are a central reason for the positive attitude toward vaccination. They are thereby essential to the claimed success of the Malawian child vaccination program, at least in Mangu.[43] The study of how HSAs handle individual, local, national and international views on health is a valuable contribution to the understanding of how the complex chain of processes directed at disease prevention can unfold.

By illuminating how the Malawian vaccinators manage knowledges in complex ways, I have also contributed to the anthropological literature on knowledge management. One of my arguments is that HSAs utilize various methods of knowledge dissemination interchangeably in relation to knowledges that are not categorically distinguished. The HSAs' objectives have also proven dynamic and complex. One should therefore be cautious when designating how "the knowledgeable" make their knowledge valuable and which effects this has (see Barth, 1990; Harrison, 1995). My enquiry has also led me to a discussion of how processes of power, resistance and trust unfold in relation to HSA work. My empirical examples have made it clear that these factors need a nuanced approach. One might not be able to clearly establish who the dominant party in this setting is, and signs interpreted as trust in other contexts might rather be signs of hope from individuals subjected to poverty. I have highlighted that power is not necessarily negative, and that the knowledge management of the HSAs involves both positive and

[43] Of course, a range of other factors is influential as well. Economy and politics, the Out Reach system and neighboring women's attitudes can all be identified as relevant for vaccination coverage through this enquiry. One of the HSAs put it this way: "They [the parents] must vaccinate since we are right there in their village. They have no excuse!"

negative aspects of power. However, the consequences of the HSAs' practices do not always match the intentions, and I have also found the HSAs to operate in relation to ethical dilemmas. Still, to make them solely accountable for the dilemmas and for how to deal with them is unreasonable in this context. The latter point brings me to the second thing I hope to have achieved with this thesis.

By way of studying how HSAs handle knowledge, I have also learned under which challenging circumstances the HSAs I met in Malawi conduct their crucial work. This is central to any investigation of their practices, and I hope to have exposed some of the harsh effects of severe poverty through this thesis. To include observations on the many faces of poverty is ethically essential, it is relevant to my research questions, and it is important since it conveys weaknesses of the Malawian child vaccination program. I understand the challenging and – as I see it – unsustainable working conditions to threaten the HSAs' performances, and as such to threaten one of the strengths of the vaccination program. Lack of theoretical and practical training, refresher courses and equipment such as brake pads for the bikes endangers both the HSAs and the children. The task load and the insufficient salaries also make the program unstable, not to mention the effects that such challenges have on the life of the individuals. Moreover, as Chilowa and Kadzandira (2001:17-18,60) see it, the HSAs' success with child vaccination has turned into a threatening curse. The two researchers argue that success in one task has led to so many other tasks that the HSAs are now overloaded. Their workload is presented as one of several factors that threaten the immunization coverage in Malawi. My observations from 2010 coincide with these statements. This is not to say, however, that one should not make use of the HSAs and their strengths beyond vaccination. Moreover, I strongly believe that the skills they demonstrate in the U/5 setting can and do influence the HSAs' other tasks in positive ways. When the HSAs enter into non-conflictive interfaces through pragmatic knowledge management, and offer vaccination services in ways that make sense to the mothers, the attendees of U/5 clinics are less likely to feel intimidated when the same health workers come to conduct hygiene and sanitation inspections or to recommend maternity services. However, without proper resources, in the form of enough personnel, properly adapted training and proper physical and financial considerations, one risks losing more than one achieves. Exhausted health workers could easily lead to service collapse.

If I have succeeded in my two goals it should now be evident that the HSAs I met work as mediators and translators, facilitating communication between actors that often relies on different medical knowledge, that is, between villagers, on the one hand, and plan-makers in the district administration, the national ministry or international institutions, on the other. The HSAs' efforts can be said to compensate both for knowledge-related misfits *and* for (poverty-induced) deficiencies in the nationally and internationally planned program. Their essential role is to some extent recognized by actors in the Ministry of Health and Population. HSAs are, after all, described as "the backbone of [the] EHP" (Ministry of Health [Malawi], 2004:13). Still, this recognition needs to be better reflected in their working conditions, training and salaries. By revealing some of the Malawian vaccination program's vulnerabilities and strengths this thesis has also showed that this program is "an ongoing, socially-constructed and negotiated process, not simply the execution of an already-specified plan or framework for action with expected outcomes" (Long, 2004:27). Moreover, the observation that many actors are more or less directly involved – such as chiefs and VHCs, or priests and traditional healers that influence people's views on health and illness – illustrates that vaccination programs involve more than "targets." The programs are, in other words, highly dynamic and thereby changing.

I will round off this thesis by providing two alternative perspectives to Anita Hardon's (2004) review article on anthropological immunization studies, in the "*Encyclopedia of Medical Anthropology*." My points arise from this thesis' accounting for the complexity and relevance of some vaccinators handling of knowledges in relation to how a child vaccination program works. After summing up the history of vaccination, Hardon highlights anthropologists' focus in the past, present and near future regarding immunization as object of investigation. According to Hardon, research resources have largely been channeled to the identification of structural and cultural barriers to increased vaccination coverage. More specifically, investigations have been made of local acceptability of vaccination, in relation to people's disease etiology and explanatory models. Local reactions to monitoring arrangements have been studied, as have been the workings of the "immunizing state" and phrases like "universal coverage." And enquiries have also been made into how individuals weigh costs and benefits when considering vaccination, and who it is that resist vaccination in European countries. That

distrust of the state, media scares and rumors have a negative effect on vaccination coverage are among the findings that anthropologists have asserted over the years. When it comes to findings on "service-level factors," several problem areas have been pointed to by anthropologists and others (Hardon, 2004:265): Inconvenience for the caretakers regarding space, time and costs, and irregularities, delays and cancelations in the organization of vaccination days have all proven to hinder child vaccination. Moreover, inattentiveness, shirking and rudeness from staff have been found to have decisive negative influence on vaccination practices, amongst other places in Malawi.

With my study, I hope to have demonstrated that there is more to vaccination workers than negatives such as yelling and carelessness. I hope it has become clear that the introduced HSAs' insight into village life and their familiarity with the local context enable them to mediate knowledges in non-conflictive interfaces, by a variety of context-adjusted methods. I believe that vaccinators' successful translation, or knowledge mediation, is a prerequisite for vaccination most places. The knowledge management of vaccinators should therefore be an important entry point to vaccine related studies for other anthropologists as well. In other words, the exploration of vaccinators' handling of knowledges should have been included in Hardon's (2004) suggestions for important anthropological approaches to vaccination as an object of investigation in the future.

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Appendix 1: Questionnaire

(Nine out of sixteen questionnaires were answered by HSAs in Mangu.)
Dear HSA.

As part of my study on the vaccination system in Malawi, and the working conditions and methods of the HSA's that carries this system into effect, I have 7 questions that I hope you will find the time to answer. Your valuable information and opinions will help me to understand, and ensure that you have given me your insight into what it means to work as an HSA in Malawi. The information will be integrated into the larger research project "Explaining Differential Immunization Coverage" based at the University of Oslo –Norway, in cooperation with REACH TRUST Malawi, in a confidential manner. The research project has ethical clearance from the Ministry of Health in Malawi [the questionnaire was also approved by the administration at the district hospital]. I am very grateful for your time, and for always welcoming me and [William] in your busy routines.

You can answer the questions anonymously, in English or Chichewa, and as you wish according to length. If you have no comment, you can leave the relevant question unanswered. If you wish you can answer the questions orally by talking to [William] and me.

Once more, thank you very much!
Kristin Alfsen

1. What is your opinion on the relationship between monthly assigned work tasks from your superiors, and the amount of work tasks possible for you to perform in practice? Please indicate why some work tasks might be challenging or impossible to perform well.

   Kodi mungatifotokozele maganizo anu pa gwilizano wa pakati pa ntchito zomwe akuluakulu/mabwana anu amafuna kuti mugwile mwenzi uliwonse ndi ntchito zomwe inu mungathe kukwanitsa kugwila? Chonde tifotokozeleni zifukwa zomwe ntchito zina ndi zovuta kapena zosantheka kukwanitsa kuzigwila?

2. What is the positive and negative sides of working as an HSA?

Kodi ndi zabwino zotani komanso ndi zoyipa zotani zomwe mumakumana nanzo pa ntchito yanu ngati mulangizi wa za umoyo?

3. What kind of challenges do you meet as an HSA? (With superiors, colleagues, villagers, practical performance etc).

   Kodi mumakumana ndi zovuta/zopinga zotani, inu ngati mulangizi wa za umoyo? (Ndi mabwana/akuluakulu, anzanu ku ntchito, anthu aku mudzi, kayendetsedwe ka ntchito etc.)

4. What is your opinion of the vaccination system in Malawi (positive and negative sides)? Would you recommend it to other countries?

   Kodi maganizo anu ndi otani a njira/ndondomeko yogwilitsidwa ntchito ya kapelekedwe ka katemeta M'malawi muno (ubwino ndi kuyipa)? Kodi mungamvomeleze kuti izitsatilidwa mayiko enanso?

5. How do people in the villages receive the knowledge that you try to share with them during health talks and other activities? Which methods do you use to make people understand? What might be the reasons for their understanding or misunderstanding?

   Kodi anthu a ku midzi amalandila bwanji mzeru zomwe inu mumafuna mutawagawila, pa nthawi yomwe mukumphunzitsa za umoyo wabwino ndi ntchito zina ndi zina? Mumagwilitsa ntchito njira zanji kuti anthu akuvetsetseni? Kodi ndi zifukwa ziti zomwe zimawavetsetsa kapena kusamva.

6. From where do you get your knowledge on health issues?

   Kodi nzeru za ntchito yanu ya za umoyo mumazitenga kuti?

7. How could one improve child health and health in general in (rural) Malawi?

   Kodi munthu angapititse bwanji patsogolo umoyo wa mwana ndi nkhani ya umoyo ku midzi M'malawi muno?

Appendix 2: Official job description for Health Surveillance Assistants

(Source: teaching material intended for HSAs, displayed by the District Environmental Officer at the District Hospital, 13.05.2010)

1. Job Title: Health Surveillance Assistant
2. Qualification: Malawi School Certificate of Education (MSCE) or Malawi Junior Certificate of Education (MJCE) plus successful completion of MoH [Ministry of Health] HSA training.
3. Grade: M (in Malawi civil services this is a starting grade for those with MSCE an certificates).
4. Description: HSA's are engaged to provide primary health care services at community level. S/he is the link between the health facility and the community s/he serves.
5. Place of Deployment: In the community in an assigned 'catchment area'.
6. Responsible to: Assistant Environmental Health Officer [AEHO].
7. Duties:
    a. Conducts community Assessment within an assigned catchment area and facilities in solving health problems in that catchment area.
    b. Facilitates formation of Village Health Committees [VHC] in the catchment area.
    c. Promotion of hygiene and sanitation through regular inspections, health education and giving feedback to communities.
    d. Supervises VHCs and other health committees.
    e. Conducts information, Education and communication for the maintenance and improvement of the health status of the community.
    f. Provides immunizations, Vitamin A, de worming drugs, and growth monitoring in children under the age of five, and TTV in women of child bearing age.
    g. Conducts disease surveillance and response on disease outbreaks.
    h. Facilitates provision of safe water supply, chlorination of water at household level, and monitors water quality.
    i. Conducts village clinics on specified days and referral of severe cases to the nearest health facility.
    j. Maintains equipment for the job.
    k. Collects and records data in relevant registers such as VHCs, MHIS (e.g. under five) registers, quarterly report forms.
    l. Conducts patient / client tracing, follow up, and monitoring.
    m. Inspects public facilities such as schools, markets, public toilets, water sources, restaurants for maintenance of good hygiene.

n. Motivates communities to utilize health services such as reproductive health services.
o. Promotes and participates in the delivery of accelerated Child Survival and Development as follows:
    i. Environmental hygiene practices.
    ii. Safe water supply.
    iii. Food Hygiene practices.
    iv. Good nutrition practices.
    v. Antenatal care including PMTCT [Prevent Mother-to-Child Transmission].
    vi. Infant and young child feeding.
    vii. Vector and vermin control.
    viii. Family health
p. Any other duties deemed reasonable by his/her supervisors assigned from time to time.

POINTS TO NOTE

- In the ideal the HSA reports to the SHSA [Senior Health Surveillance Assistant] who reports to the AEHO.
- Where AEHO is not available HSA reports to community nurse. Where both AEHO and CN are not available HSA reports to health facility in-charge. In [this district] HSAs report to 'community supervisor'. This is a local administrative arrangement.
- Currently HSAs and SHSAs are at grades O and N which are un-established grades.

It is proposed that those with the required qualifications should be moved to established grades M and L respectively.

Appendix 3: Health songs performed during U/5 clinics in Mangu

Most songs in this Appendix have been documented by HSAs in Chichewa on my request. William and I have then translated them into English, and compared the lyrics with our own records of songs performed during U/5 clinics. The health songs were all frequently heard during U/5 clinics attended in 2010, often with small variations, however. As in the above chapters lead singing is indicated with [1] before the applicable sentence, while remaining sentences were replied by the other attendants. Clapping of hands with changing rhythms is a central part of all songs.

How to hold the baby when breastfeeding:

[1]Inu amai.	*[1]You mother.*
Mwana m'nyamuleni bwino pakuyamwa bele.	*Carry the baby well when breastfeeding.*
[1]Mutu.	*[1]Head.*
Mutu pa chigong'ontho.	*Head on the upper arm.*
[1]Mkono.	*[1]Arm.*
Kono pa thako la mwana.	*Arm on the child's buttocks.*
[1]Mimba.	*[1]Belly.*
Mimba pa mimba ya mayi.	*Belly on the mothers belly.*
[1]Mwana.	*[1]Child.*
Mwana ayang'ane belelo ayamwe.	*Child should face the breast to breastfeed.*
[1]Kuti.	*[1]So that.*
Kuti ayamwe bwino.	*So that to breastfeed well.*

Importance of U/5 card and nutrition:

[1]Khadi tengu mawa tayu. Susamala.	*[1]You collected the card, tomorrow lost it. You are careless.*
Susamala sikelo koma kunyoza eeaeh zako izo.	*You don't care about the U/5 clinic, but insulting eeaeh it's you problem.*
[1]Khadi tengu mawa tayu. Susamala.	*[1]You collected the card, tomorrow lost it. You are careless.*
Susamala sikelo koma kunyoza eeaeh zako izo.	*You don't care about the U/5 clinic, but insulting eeaeh it's you problem.*
[1]Mwana akadwala. [X2]	*[1]When the child falls sick. [X2]*
Kaya wekha kaya mwana akatupa. [X2]	*It's your problem when the child swells. [X2]*
[1]Susamala.	*[1]You don't take good care.*

Susamala sikelo koma kunyoza eeaeh yako izo.	*You don't care about the U/5 clinic, but insulting eeaeh it's your problem.*
[1]Phala phiku bamboo pasu. Susamala.	*[1]You prepare porridge, give it to the husband. You are careless.*
Susamala sikelo koma kunyoza eeaeh zako izo.	*You don't care about the U/5 clinic, but insulting eeaeh it's your problem.*
[1]Phala phiku bamboo pasu. Susamala.	*[1]You prepare porridge, give it to the husband. You are careless.*
Susamala sikelo koma kunyoza eeaeh zako izo.	*You don't care about the U/5 clinic, but insulting eeaeh it's your problem.*

<u>I will still go to the U/5:</u>

[1]Khadi langa lataika. [X2]	*[1]I lost my card. [X2]*
[1]Lataikira nyumba mommu. [X2]	*[1]I lost it inside the house. [X2]*
[1]Ndafunafuna sindinapeze. Ndipitabe ine. [X2]	*[1]I have tried to look for it but I didn't find it. I will still go. [X2]*
Eeeh.	*Eeeh.*
[1]Ndipitabe inne.	*[1]I will still go.*
Kusikelo.	*To the U/5 clinic.*
[1]Ndipitabe inne.	*[1]I will still go.*
Kusikelo.	*To the U/5 clinic.*
[1]Mwana wanga akudwala. Kutsegula ndi kusanza.	*[1]My child is sick, diarrhea and vomiting.*
[1]Ndipitabe inne.	*[1]I will still go.*
Eeeh.	*Eeeh.*
[1]Ndipitabe inne.	*[1]I will still go.*
Kusikelo.	*To the U/5 clinic.*

<u>About the vaccines:</u>

[1]Katemera alipo munayi, eeh aeeh katemera. [X2]	*[1]There are four vaccines, eeh aeeh vaccines. [X2]*
Katemera alipo munayi, eeh aeeh	*There are four vaccines, eeh aeeh vaccines.*

katemera.

[1]Oyamba. [X2]	*[1]The first one. [X2]*
Ndiwa chifuwa, chachikulu, eeh aeeh katemera.	*Is for the big cough [tuberculosis], eeh aeeh vaccine.*
[1]Wachiwiri. [X2]	*[1]The second one. [X2]*
Ndi wa chifuwa, chokoka mtima, eeh aeeh katemera.	*Is for the cough that pulls the heart [whooping cough], eeh aeeh vaccine.*
[1]Wachitatu. [X2]	*[1]The third one. [X2]*
Ndi wapolio, eeh aeeh katemera.	*Is for polio, eeh aeeh vaccine.*
[1]Wachinayi. [X2]	*[1]The fourth one. [X2]*
Ndi wachikuku, eeh aeeh katemera.	*Is for measles, eeh aeeh vaccine.*

About the HSA's:

[1]Azaumoyo, azaumoyo. [X2]	*[1]HSAs, HSAs. [X2]*
[1]Alimbana ndi matenda owononga. [X2]	*[1]They fight destructive diseases. [X2]*
Azaumoyo, azaumoyo. [X2]	*HSAs, HSAs. [X2]*
Alimbana ndi matenda owononga.	*They fight destructive diseases.*
[1]Azaumoyo, azaumoyo. [X2]	*[1]HSAs, HSAs. [X2]*
[1]Alimbana ndi mankhwala oteteza ana. [X2]	*[1]They fight with preventive medicine for children. [X2]*
Azaumoyo, azaumoya. [X2]	*HSAs, HSAs. [X2]*
Alimbana ndi makhwala oteteza ana.	*They fight with preventive medicines for children.*
[1]Azaumoyo, azaumoyo. [X2]	*[1]HSAs, HSAs. [X2]*
[1]Alimbana ndi katemera amene amateteza ana kumatenda. [X2]	*[1]They fight with vaccines that prevent diseases in children. [X2]*
Azaumoyo, azaumoyo. [X2]	*HSAs, HSAs. [X2]*
Alimbana ndi katemera amene amateteza kumatenda.	*They fight with vaccines that prevent diseases in children.*

Breastfeeding:

[1]Bele bele lamayi. [X2]	*[1]Breast breast from the mother. [X2]*
Bele labwino.	*Breast is good.*
[1]Bele ilo muli chakudya chabwino.	*[1]In that breast there is good food.*
Bele la mayi.	*Breast from the mother.*
[1]Bele ilo mavitamin.	*[1]In that breast there are multi-vitamins.*
Bele la mayi.	*Brest from the mother.*
[1]Bele ilo muli madzi akumwa.	*[1]In that breast there is drinking water.*
Bele la mayi.	*Breast from the mother.*
[1]Bele muli chikondi.	*[1]In that breast you will find love.*
Bele la mayi.	*Breast from the mother.*

Go to the U/5:

[1]Nane mzapita mawa.	*[1]Me too will go tomorrow.*
Nane mzapita mawa bambo akalola kusikelo.	*Me too will go tomorrow if my husband allows me to go to the U/5 clinic.*
[1]Anaphiri akulilira kusikelo.	*[1]Anaphiri is crying for the U/5 clinic.*
Aeeaeeh.	*Aeeaeeh.*
[1]Anaphiri akulilira kusikelo.	*[1]Anaphiri is crying for the U/5 clinic.*
Aeeaeeh.	*Aeeaeeh.*
[1]Nane.	*[1]Me too.*
Nane mzapita mawa bambo akalola kusikelo.	*Me too will go tomorrow if my husband allows me to go to the U/5 clinic.*

Let's laugh at them:

[1]Alipo amayi ena amabwera mochedwa tiwaseke.	*[1]There are other mothers that come late; let's laugh them.*
Alipo amayi ena amabwera mochedwa tiwaseke.	*There are other mothers that come late; lets laugh them.*
[1]iyi tiwa.	*[1]iyi let's.*
iyi tiwa.	*iyi let's.*
[1]iyi tiwaseke.	*[1]iyi let's laugh them.*
Seka alipo amayi ena amabwera mochedwa tiwaseke.	*There are other mothers that come late; let's laugh them.*
He! He! Ulululu.	*He! He! Ulululu.*
[1]Alipo amayi ena sakudziwa	*[1]There are other mothers that don't know how to*

kuphika kwa phala tiwaseke.	*prepare porridge; laugh them.*
Alipo amayi ena sakudziwa kuphika kwa phala tiwaseke.	*There are other mothers that don't know how to prepare porridge; laugh them.*
[1]iyi tiwa.	*[1]iyi let's.*
iyi tiwa.	*iyi let's.*
[1]iyi tiwaseke.	*[1]iyi let's laugh them.*
Seke alipo amayi ena sakiziwa kuphika tiwa seke.	*Laugh, there are other mothers that don't know how to prepare porridge; let's laugh them.*
He! He! Ulululu.	*He! He! Ulululu.*
[1]Alipo amayi ena sakudziwa kuchapa tiwaseke.	*[1]There are other mothers that don't know how to do laundry; let's laugh them.*
Alipo amayi ena sakudziwa kuchapa tiwaseke.	*There are other mothers that don't know how to do laundry; let's laugh them.*
[1]iyi tiwa.	*[1]iyi let's.*
iyi tiwa.	*iyi let's.*
[1]iyi tiwaseke.	*[1]iyi let's laugh them.*
Seka alipo amayi ena sakudziwa kuchapa tiwaseke.	*Laugh, there are other mothers that don't know how to do laundry; let's laugh them.*
He! He! Ulululu.	*He! He! Ulululu.*
[1]Alipo amayi ena sakudziwa kuveka matewela tiwaseke.	*[1]There are other mothers that don't know how to tie the nappies on the baby; let's laugh them.*
Alipo amayi ena sakudziwa kuveka matewela tiwaseke.	*There are other mothers that don't know how to tie the nappies on the baby; let's laugh them.*
[1]iyi tiwa.	*[1]iyi let's.*
iyi tiwa.	*iyi let's.*
[1]iyi tiwaseke.	*[1]iyi let's laugh them.*
Seke alipo amayi ena sakudziwa kuveka tiwaseke.	*Laugh, there are other mothers that don't know how to tie the nappies on the baby; let's laugh them.*
He! He! Ulululu.	*He! He! Ulululu.*
[1]Alipo amayi ena sakudziwa knchapa matewela tiwaseke.	*[1]There are other mothers that don't know how to wash the nappies; let's laugh them.*
Alipo amayi ena sakudziwa	*There are other mothers that don't know how to*

kuchapa matewela tiwaseke.	*wash the nappies; let's laugh them.*
[1]iyi tiwa.	*[1]iyi let's.*
iyi tiwa.	*iyi let's.*
[1]iyi tiwaseke.	*[1]iyi let's laugh them.*
Seke alipo amayi ena sakudziwa kuchapa matewela tiwaseke.	*Laugh, there are other mothers that don't know how to wash the nappies; let's laugh them.*
He! He! Ulululu.	*He! He! Ulululu.*