EXPERIENCING DEVELOPMENT, CAREERS AND PATIENTS IN SOUTHERN MALAWI

By

Evan F. Guay

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

Anthropology—Doctor of Philosophy

2019

ABSTRACT

EXPERIENCING DEVELOPMENT, CAREERS AND PATIENTS IN SOUTHERN MALAWI

By

Evan F. Guay

International development and global health efforts have come under increased scrutiny in recent decades, as despite a range of interventions spanning seven-decades, improvements in health and wellbeing lag critically behind aspirations in many places throughout the world. Malawi is an icon for challenges in these arenas, as patients, healthcare personnel and planners continue to struggle with high rates of maternal mortality, deaths of children under the age of five, large burdens of infectious and noncommunicable diseases, one of the worst shortages of healthcare personnel in the world, economic stagnation, and disjointed policies. This complex web of hardships implicates processes that stretch from historic geopolitics to institutional human resource policies, to acute breakdowns in communication within clinical encounters, and frequently produces daunting social and personal challenges for healthcare personnel.

Previous research has covered a variety of topics related to development and medicine in Malawi and sub-Saharan Africa, yet studies have left critical voids in understanding the perspectives and practices of Malawian healthcare personnel, themselves—those persons who navigate policies and care for patients on a daily basis. Based upon research from 2011-2017, this dissertation looks closely into healthcare delivery and development efforts in Southern Malawi and delves into Malawi's history, its people, plans and behaviors that make up the quotidian and the extraordinary, the abstract and the intimate, and the successes and the failures of daily experiences. Utilizing 33 in-depth interviews with Malawian clinicians, administrators and medical students, and over 300 hours of participant-observation that involved over 1000 patient

visits across each tier of Malawi’s referral network, I break these challenges into scalar dimensions so as to render them more tractable (e.g. international and national development efforts, clinician shortages at national and institutional levels, and clinicians’ thoughts and practices regarding specific patient populations). I discuss how these pieces fit together, and how and why personnel are seeking greater independence from their national government and international NGOS; how and why Malawi’s particular history contributes to discordances between personnel’s expectations and realities of practice, and how such contrasts exacerbate shortages of personnel; how clinicians rely on heuristics and preferences to manage a variety of patients within tight time constraints, and how these devices can both facilitate and undermine care. Within this discussion, I highlight the fact that there is no ‘universal mechanism’ to explain the details of all of these processes, as each follows a series of highly specific interactions that depends upon the actors and conditions involved. This general argument is not new, but its application to this topic provides novel insight into development efforts and clinical behaviors. By taking this approach, I add to the work of other critical medical anthropologists and development scholars who seek to connect the global to the local, and the sociohistorical to the biocultural, while focusing on areas of great need.

ACKNOWLEDGEMENTS

This project would not have been conceived of, let alone completed, without guidance and contributions from countless mentors, colleagues, friends and family members, not to mention scholars whose work I have attempted to build upon. First and foremost, I wish to express my deep gratitude to all of the Malawian clinicians, nurses, technicians and administrators who made this work possible. I promised anonymity throughout this project, so I will not list your names, but each of you played a critical role in the development of this project. Thank you for welcoming me into your communities, your places of work, your recreational activities and, in some cases, your homes. It has been my immense honor to work with you. Your frank and honest responses to my questions, and your corrections to my misinterpretations and understanding provide the bulk of the value in this project. That said, I do not expect unanimous agreement on all issues discussed in this dissertation, and any mistakes are my own.

Special thanks to the group that I am proud to call my dissertation committee. Dr Karl Seydel, it has been nothing short of an honor and a joy bouncing around ideas and exploring the biking and hiking trails of Malawi with you. You gifted me insights and a hominess that I would not otherwise have found. Thank you to Dr Masako Fujita and Dr Gabriel Wrobel for setting examples through your scholarship, teaching and support; discussions with you expanded my understanding and appreciation of the richness and beauty of human life. Finally, thank you to Dr Linda Hunt; without your mix of kind encouragement and tough love, this project would have crashed on the shores. Thank you for your guidance, patience, personal and professional support throughout these years.

This project would not have been possible had it not been for Dr Andrea Freidus. It is no exaggeration to say that without Andrea, I would not be an anthropologist. Similarly, Dr Don Thomas played an invaluable role in facilitating my work in Malawi. To both of you: I admire your humanity, humility, senses of humor, and your eagerness to constantly expand your experiences and understandings of the world. Thank you for leading by example.

I also owe special thanks for Dr Terrie Taylor, Dr Anne Ferguson and Dr Doug Postels, mentors who invited me into their homes and allowed me to cling to their coat tails. I would be remiss to not thank Dr Claire Wendland, whose scholarship and dinner conversations in Malawi and East Lansing had a profound impact on me both intellectually and personally. Additionally, thank you to Dr Tony Bauer for granting me initial entry into the research arena and opening doors for me to gain medical experience abroad. You changed the trajectory of my life and set me on a path that led to this project. Finally, thank you to Dr Dan Choffnes for showing me what an infinitely curious and exceeding humble scholar and mentor can do; I strive to live up to your example.

Thank you to Dr Justin McCormick, Mrs Bethany Heinlen and the rest of the Michigan State University DO-PhD program. I could not have done this without your support and encouragement. To Dr McCormick, thank you for taking a chance on another anthropologist. Your perspicacious leadership made this project possible. Zikomo kwambiri to the Center for Advanced Studies in International Development for their Foreign Language and Area Studies fellowship, along with Mr Wilson Ndovie for patiently teaching me what I was able to retain of the beautiful Chichewa language. Leaning what I could of Chichewa while going through the first two years of medical school proved to be an immense challenge for me. I appreciate your patience and unwavering sense of humor. Thank you to the Department of Anthropology and the

College of Osteopathic Medicine for your support throughout this process. I am humbled by your support.

Finally, friends and family—I could not have done this without you. Thank you to the Field’s Gym and SCF crews for prodding me to take care of myself throughout these years of reading and writing. To my fellow students and recent graduates of the DO-PhD program, thank you for sharing your tireless commitment to pushing the boundaries of knowledge. Special thanks to Kelly for your friendship and unrelenting laughs as we bounced back and forth between Anthropology and Medicine. I look forward to seeing the wonderful things that you accomplish in this world. To Rob, I cannot articulate how much your friendship has meant to me throughout these years. I am proud to call you my friend and colleague, and I appreciate your waiting around for me to exit the program together. Nebojsa, Ashley and Irena, thank you for your love and support. Thank you to Mike, Sooney, Steve, Kelsey, Liam, Matt and Leah Carroll for the meals, festivities and casual fun that infused normalcy into what could otherwise have been a more isolating time of dissertation writing. I look forward to our family merger in August.

Lastly, thank you to my big sister, Emily, along with Derek, Mason and Avie for being a constant source of support, inspiration and silliness. To my parents, Jim and Terry, words cannot express how grateful I am for all that you have done for me. You showed me that above all else, love matters. Anything that I achieve in life is because of you. And finally, thank you to my brilliant fiancé, Jacqui Carroll, for your ceaseless love and support. You inspire me each day. Thank you for making me a better person.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

"Looking back at the past 10 years, a clear lesson learned is the need to move away from piecemeal approaches and short-term solutions; only long-term action, backed up by political commitment and adequate investments, will lead to the transformative changes required to attain sustainable results in developing the health workforce... It is not all about numbers: the goal of universal health coverage requires a paradigm shift, going beyond a discourse on shortages but rather focusing more explicitly on the accessibility, acceptability, quality and productivity of the health workforce, placing equity at the centre of the agenda. Broader factors also need to be taken into account: an evolving epidemiological profile and population structure are increasing the burden of noncommunicable diseases and long-term care on health systems, and there is increased recognition that health workers can serve as change agents in society, reorienting health systems towards primary care and action on the social determinants of health. A transformative scaling up of health education will reflect such trends in determining health workers' competencies in the 21st century... Ramping up efforts is required to meet the great challenge of ensuring that everyone, whoever they are and wherever they live, has access to a health worker… a simple but universal truth is that there can be no health without a workforce."
--Marie-Paule Kieny, Assistant Director-General of the World Health Organization (WHO 2014)

"Information is a vital resource for all human kind throughout all stages of life. It is therefore important that information should be made available in a form that is applicable and usable, and at the right time"
--Malawi Growth and Development Strategy II (Malawi 2012)

"Bending over is hurting my back," admits Mphatso, as he straightens his body from a hunched position. He had just spent five minutes palpating the abdomen of a child who was admitted to the District Hospital for severe malaria, explained to the child's mother that her baby still has a large liver and will need to continue with treatment, and documented his findings in the patient's health passport (a small notebook that each patient in Malawi must bring to each clinical visit). After extending his back and shaking out his legs, he walks over to check on a child who was just carried into the pediatric high dependency unit (HDU) by his mother. The child is shaking and foaming from his mouth.

Mphatso is the lone physician on duty in the pediatric HDU—a small room at one end of the Pediatric Ward that is tasked with caring for the most acutely ill children in the district. It is 11:01am on a Monday, and this is the seventh of twelve patients that he will care for this morning. He began the ward round at 9:30am, when temperatures hovered in the high 60's Fahrenheit (around 20 Celsius) and most guardians were still wrapped in two or three blankets to keep warm. At the beginning of the round, there were 9 patients in 7 beds, along with 11 guardians who shared the beds, sat on stools or stood attentively beside the beds of their children. The morning clouds have since dried up, and warm sun rays penetrate the windows and dance with the vibrant fabrics that cover the heads and bodies of the women, children and mattresses. The temperature is now around 80 degrees Fahrenheit (around 26 Celsius) and the smell of dust and burning plant matter wafts between the horizonal window panes. When the wind changes direction, we are made aware of the hospital's hobbling sewage system.

There's a calm air about Mphatso as he flips through the child's chart and scans each page with his index finger. He has a reputation for being one of the more outgoing members of the hospital staff, with a quick sense of humor, acerbic political insights, and a wiliness to speak up if something seems awry. He wears navy blue chinos with a neon green polo shirt—each now covered in dust from sitting on the hospital beds—a stethoscope around his neck, and the heel of his neon green socks sticks out from the back of his blue clogs. He tells me that he wears these socks to get a rise out of his coworkers. Mphatso grew up with aspirations of becoming an engineer, but he was filtered into medicine by the government. He has served among the highest ranks of district health administration and then set his sights on a career in primary care medicine—a field with a radically different set of responsibilities in Malawi compared to many other places in the world. He moves through the hospital with long strides and a sense of casual confidence that has been earned through years of enduring tough circumstances, yet he retains enough perspective and humor to attempt to "out-cry" a baby when she erupts as he touches her.

Mphatso methodically visits each patient and guardian in descending order of urgency—marching from the "red" beds, of highest priority, to the "yellow" and "green", who can then be discharged—except for when a new, more pressing patient is brought in, as is the case with this child who is having a seizure (the second such child this morning). He bends over the child, who is laying on his side with his head in his mother's lap. With his stethoscope pendulously swinging in front of the child's face, Mphatso pulls down each of the child's eyelids, checking for pallor/anemia, and then lightly touches both of the child's arms, his chest, abdomen, and both shins, to get a sense for the child's movements. With two hands, one on each shin, he double-checks the shaking of the child's legs, and then places his palm on the child's head, to check for fever, before touching both arms, and palpating the child's abdomen with both of his hands. His brow is furrowed, and he asks me to check the child, too. Not wanting to interfere with his exam, but also not wanting to seem like a bad teammate, I oblige and touch the child's forearms—indeed, the child's arms are stiff. Mphatso is told by the nurse that the child has been given a dose of diazepam in an attempt to abort the seizure; however, there is no documentation of the medication in the patients' records. Nobody knows whether the dose was *actually* given, or at what time it was given, so that the child might qualify for some/more—the doses can be given ten minutes apart, but nobody wants to overdose the child and deactivate the respiratory center of his brain. After 26 minutes of fruitless searching, a syringe is prepared and "more" diazepam is given, at which time the child goes limp, stops foaming, and Mphatso moves on to the next bed, where he reclines against the headboard, and scribbles into the patient's health passport that rests on his crossed knee.

At 12:05 Mphatso exclaims to me, with immense relief, "Now we are done. We can go eat!" By the end of the ward round, there are twelve patients in seven beds, twenty-five adult guardians, four siblings and two nurses in the HDU, which is approximately fifteen feet (five meters) by thirty feet (ten meters). People sit on the beds, stools and floor and begin to unpack their lunches, as it is the responsibility of guardians to provide food for patients. Fathers and uncles also start to fill the pediatric ward and join the mothers, aunts and grandmothers for support and a meal. The admitted patients include a one-month-old being treated for malaria and pneumonia—the referring facility did not document that they ever ran a rapid malaria diagnostic test (mRDT), so Mphatso does not know whether the child was correctly diagnosed; he ordered another test—two children who were seizing; a comatose baby who is getting oxygen and treatment for malaria; a one-month-old who is being treated for pneumonia but whose temperature was never recorded; and a seven-month-old child with a cough who was born to an HIV-positive mother (who is not on treatment) and has been repeatedly treated for pneumonia in the health center. Mphatso just identified a heart murmur that is so loud that it can be heard by simply placing one's ear to the baby's chest. As we walk out of the ward, we notice another baby off to the side, on a table. This child was found to be jaundiced and was prescribed phototherapy. Unfortunately, the baby is completely wrapped up in a cloth, so none of the light is reaching her skin. Thankfully, however, when Mphatso unwraps the baby, she is no longer jaundice. She can go home.

On our way out of the HDU, we pass the mother and her child who had been seizing. The child remains still, no more foaming, but he is making a feint moan—a discomforting sound, but it does not seem to be enough to warrant more sedative. Time for lunch.

That afternoon, Mphatso is stationed in the outpatient department along with a clinical officer. They see patients in a rapid-fire style, sharing the same room with one clinician behind the desk and another sitting on a rough-hewn wooden chair and using his palm as a clipboard to scribble in patients' health passports. Patients are oriented at a forty-five-degree angle from each other, presumably for some semblance of privacy. The mother of a woman in the female ward enters, wanting to know why her daughter, who was admitted on Saturday and is in need of abdominal surgery, has not yet been seen. The clinical officer tells her that "elective" surgeries do not take place on Mondays—and they certainly do not take place on the weekend. The clinicians head in-and-out of the exam room, to check on their other responsibilities, and at 3:40pm another physician enters—the ultrasound machine is now available, so Mphatso must go ultrasound the heart of the baby whose murmur could be heard with an unassisted ear.

Thankfully, a small portion of ultrasound gel remains in the tube—I more frequently saw hand sanitizer used as gel medium—so the team can get right to work. Four clinicians hover around the screen of the portable ultrasound machine, each pantomiming Mphatso's movements of the probe, as a visiting physician offers advice. At 4:26pm they are done with the ultrasound. Mphatso explains to the mother what they found. The plan is to wait for the results of the baby's RT-PCR (reverse-transcription polymerase chain reaction, a method for identifying genetic material), and then start on treatment for HIV and tuberculosis, if positive. If PCR is negative, the child will be referred to the central hospital. The exhausted clinicians can go home.

Throughout the ultrasound, I stood toward the outside of the group, able to see the screen and probe, but not wanting to interfere with group communication. Because I was on the outside of the group, I could hear moaning from the child who had been carried in earlier today. After the procedure, and once all of the clinicians had left the ward, I leave the ward and head toward the College of Medicine annex to collect my belongings and head home for the evening. On my way, I cross paths with a visiting physician who was exiting the Female Ward and on her way to the annex, as well. Feeling uneasy about the moaning, I ask her if she has heard anything about the case. She has not—no surprise, as she has been busy in other wards all day. We decided to go talk with the child's mother, a stoic woman with high cheek bones and dark eyes, wearing a black blouse and a turquoise head wrap, as is the custom in the predominately-Muslim town. As she listens to the mother’s report, the physician feels the child, who is burning up with a fever. The mother tells us that the child has seized more than 5 times since the morning round, but she has received no additional clinical attention. After determining that the child is once again—or still—seizing, the physician orders more diazepam, and she takes this as an opportunity to collect the nearby nursing students for an impromptu lecture on managing pediatric seizures, as nurses were the only staff around the ward in the afternoon.

Let us say that this child ends up with scar tissue in her brain because of her high fever and repeated seizures, that the disorganized scar tissue ends up causing epilepsy, and that the girl then goes on to suffer from social ostracization that often accompanies epilepsy in Malawi. What is the “cause” of this girl’s eventual suffering? Is it the rumors of witchcraft and vampirism that can accompany seizures in Malawi? Is it the pathogenicity of *Plasmodium falciparum,* the parasite the causes cerebral malaria in Malawi? Is it the shortage of clinical staff at the district hospital? Is it the insufficient training of the staff who were present? Is it the scheduling of the district hospital, such that two clinicians were placed in the outpatient department, while none were left to monitor the HDU in the afternoon? Is it that Mphatso failed to educate and establish a relationship with the mother so that she would inform him (or another caregiver) when danger signs arose, or maybe she lacked trust in the compassion of the hospital team to go grab someone? Is it that the child did not sleep under a bed net in the nights leading up to this suspected malaria diagnosis? Is it that the family lives in a one room house in which they cook their food, so they leave their door open to let out smoke (and inadvertently let in mosquitos)? Is it that the government is instituting rolling blackouts, so that even if the family did have an electric cooking method, they would not be able to use it? Is it that the wealthy countries of the world refuse to chip in enough to ensure that poor places have enough electricity or healthcare personnel? Is it that global climate change is contributing to local bodies of water drying up, thereby forcing the government to ration electricity? I will not go on any further, but we can easily see how each of these “causes” plays a role in the suffering of this child. How can we make sense of this knot of causes and effects that span from the global geopolitics, to staffing challenges and organizational decisions at the hospital, to poor communication with the clinician and distrust of hospital staff? The strategy that I will employ is to break the problem into smaller pieces, discuss each in turn, and then attempt to explain how they fit together.

This dissertation tells a story about healthcare delivery in Malawi—the history, people, plans and behaviors that make up the quotidian and the extraordinary, the abstract and the intimate, the successes and the failures of biomedicine in a setting with no shortage of challenges. Previous research has covered a variety of topics related to the practice of medicine in Malawi, including memoires from missionary physicians (King and King 1992) and historical accounts that focus on mission settlements (Hokkanen 2007) and colonial practices (Vaughan 1991). Important works have also looked into the thoughts and aspirations of medical students in Malawi (Wendland 2012a; Wendland 2010), and Julie Livingston provides an intimate portrait of the experiences and tough decisions faced by expatriate physicians in an oncology ward in Botswana (Livingston 2012). While each of these makes a valuable contribution to our understanding of biomedicine in Malawi, studies have left critical voids in terms of understanding the daily work of clinicians and administrators across Malawi’s referral network (primary care, district hospitals and central hospitals), and particularly in rural settings, where the majority of patients are served. As Feierman and colleagues argue, "both effective study and effective action require attention to moral experience, social relationships and culture at every level of scale and, most of all, to the capacity for action of those who live and work under difficult conditions at the margins" (Feierman, et al. 2010).

Additionally, a lacuna exists between the specific perspectives and aspirations of Malawian healthcare personnel regarding their career trajectories, and the development of Malawi's national healthcare network, in general. As Claire Wendland recently wrote in a paper drawing from her research into the training of Malawian medical students, "the people who were the targets for capacity building were black boxes, as were the trainers. That is, their experiences, their histories, their inner workings, even their already existing capabilities and weaknesses were set aside as irrelevant to the task at hand. They were interchangeable figures always ready to be upgraded to the next level with a workshop or online training" (Wendland 2016).

This is a dissertation written by a medical anthropologist with medical training, a mixed background that provides me with an acute awareness that healthcare systems function because *people* run them. In that spirit, this work draws us repeatedly to the human elements of health and healing, stressing that healthcare decisions are made by people, rather than abstract 'nations' and 'organizations.' This conclusion was recently supported by a report from the World Health Organization and Global Health Workforce Alliance (WHO-GHWA), which highlights "the centrality of health workforce to improving health services and population health outcomes" and provides insights into the integrated processes that contribute to shortages of providers, while calling for fieldwork to bolster country-specific knowledge (WHO 2014). At the heart of the WHO-GHWA report were countries like Malawi, which was most recently recorded at 3.5 skilled providers per 10,000 population, ranking it among the bottom five countries in the world and suggesting that up to eight times the current number of providers may be needed to meet demands, if all else remains equal (WHO 2017).

Following this brief orientation, we may return to the central issue of how to make sense of the immensely complicated "causes" of healthcare behaviors and outcomes. As mentioned, my strategy is to proceed by analysis, breaking the issue into scalar dimensions, and then, after discussing each, I will provide a more detailed explanation for how the scales interrelate. The central questions of this dissertation are: First, how do Malawian healthcare personnel conceive of the ways in which large-scale trends of national and international organizations shape and influence current healthcare activities in Malawi? To answer this question, I take a "long view" at Malawi's history up to the present, giving special attention to notions of development and current efforts surrounding the Sustainable Development Goals. I also explore personnel's thoughts on these matters, with special attention to more recent national developments, including plans for decentralization.

The second question is how do healthcare personnel—administrators, clinicians and medical students—conceive of their roles and responsibilities within their respective institutions and the broader healthcare network in Malawi, and how is this influenced by their daily work? In addressing this question, I heed Marie-Paule Kieny's guidance at the head of this chapter, to go "beyond a discourse on shortages… [by] focusing more explicitly on the accessibility, acceptability, quality and productivity of the health workforce" (WHO 2014). More precisely, I work *through* notions of shortages to explore personnel's thoughts on their positionality and performance.

My third question is the most proximal to clinical care: how do Malawian personnel internalize the activities of those 'larger' factors, while remaining imbedded within local programs and amenable to the thoughts and affective connections that arise during interpersonal interactions? I examine clinical interactions with an aim of better contextualizing our understanding and providing examples and explanations for variability of clinical encounters.

By taking this course from large scales of time and organization, down to specific clinical behaviors between two people, I add to those projects of other critical medical anthropologists in connecting the global to the local, and the sociohistorical to the biocultural. A central argument of this dissertation is that each scale of analysis relates to those above and below it, yet each requires its own explanation. There are no ‘universal mechanisms’ (e.g. dialectics) to human life, as both history and observations show that events proceed by a series of highly specific interactions that depend on actors and environments. I draw from Merril Singer’s insistence that Medical Anthropology is “the most bioculturally/biosocially oriented of the health social sciences” which is to suggest that Medical Anthropology is also the most social of biological sciences. In making this argument, I neither attempt to disprove or downplay the “social” causes of healthcare and healing, nor do I attempt to disprove or downplay the “biological” causes of these phenomena. Instead, I build from Tim Ingold’s argument for obviating the divide between these understandings, treating them like the scalar demarcations that I impose on healthcare in Malawi, as mere tools for convenience (Ingold 1998). This argument is not new, but its application to clinician-patient relationships provides novel insights into the nature of clinical behaviors and decision-making. By taking this final step, it is my hope to draw attention to many more opportunities for understanding and improving healthcare for both patients and providers.

Chapter Summaries

Chapter two provides necessary background for understanding the context of discussions on national and international development and policies. This discussion explores some of the history of Malawi and notions of development, as well as how those notions interfaced with (or flew past) efforts within healthcare in Malawi, helping us understand why conditions and arrangements were constructed in the way they have been, and—just as importantly—that alternatives and opportunities exist.

Chapter three describes the settings and research methods for this study. The settings described here are not the grand-scale history of Malawi, but rather backgrounds of each of the facilities where I collected this multi-site study. My research methods fall under the umbrella of ethnography and participant observation, the standard tools of Medical Anthropology. This chapter also provides descriptions of my interviews, observations and interpretive methods and strategies.

Chapters four through seven cover research data. Chapter four discusses how current, large-scale development challenges are being addressed by Malawian healthcare personnel. Central to this discussion are the ways in which personnel conceive of and prioritize quality healthcare. Additionally, this chapter explores how Malawian healthcare personnel conceive of interventions by international and national funders and governing bodies, and ways in which coordination (or lack thereof) of local-through-international programs can have specific effects on daily experiences. The discussion then turns to how national trends within Malawi—e.g. decentralization—have been enacted (or not), and what healthcare personnel hope for these policies in their futures. In addition to informing discussions of specific development policies, this chapter makes a larger theoretical argument for expanding our models for what qualifies as development and suggests that excluding the voices of healthcare providers has contributed to the failure of plans and the misrepresentations of intentions.

Chapter five focuses on issues surrounding and contributing to shortages of healthcare personnel in Malawi. Working through an analytic lens, this chapter outlines the history of biomedical training in Malawi and then goes on to discuss personnel’s conceptions and experiences regarding brain drain and burnout. I then zoom out from staffing and practices to discuss the sociality of healthcare personnel, which, I argue, provides important insights into issues surrounding shortages of personnel and allows for the creation of a more robust model for understanding shortages of healthcare personnel.

The last two data chapters focus more specifically on clinicians’ behaviors within clinical settings. Chapter six builds from the work of Vaughan (1994) and Wendland (2012b) to discuss Malawians’ clinical ideals and how practices are modified to cope with high patient volumes, shortages of resources and personnel, and breakdowns in communication. This discussion then delves deeper into clinicians’ decision-making patterns and the effects of these practices on Malawi’s wider healthcare network and development efforts.

Chapter seven examines the thoughts and behaviors of Malawian personnel regarding more qualitative and identity-based aspects of patient care. This chapter discusses personnel’s thoughts regarding patients of different ages, genders and socioeconomic statuses, as well as associated differences in behavior that I observed across clinical settings. The discussion then turns to historical trends and features of interpersonal behaviors to explore ways in which patient care is dependent upon long-term cultural trends and immediate experiences.

Chapter eight draws together insights gained from Chapters 2-7 to address the specific aims of this study and elaborate on some of the ways that processes connect across scales of analysis. I then close with a discussion of how insights gained from this dissertation move us further toward obviating divisions between biologic and sociocultural understandings of life.

CHAPTER 2: On History and Development in Malawi

Figure 1: Map of Malawi (ICF 2015)

Malawi is a small, landlocked country in Southeastern Africa, with a varied landscape that includes forest, savannah, mountains, and a large, freshwater lake—Lake Malawi—that stretches along most of its eastern border. The climate is tropical, with rainy and dry seasons that frequently lead to flooding and erosion. Malawi is known for its brilliant diversity of freshwater fish, its picturesque Mulanje Massif, and its friendly, peaceful society[1]. Unfortunately, Malawi is also an icon for challenges of national and international development, as the nation struggles with high rates of maternal mortality, death of children under five-years-old, and a percolating epidemic of noncommunicable diseases (Bank 2016; ICF 2017; Price, et al. 2018; WHO 2015). While progress has been made on many fronts, a 2018 report by the World Bank, entitled *The Changing Wealth of Nations* paints a disturbing picture (Bank 2018). In this report, authors examine countries' combined "wealth"—which they define as "produced capital, natural capital, human capital, and net foreign assets"—and income, to provide a more complete picture than typical analyses that rely upon GDP alone. The authors also report on an "adjusted net savings" (ANS), which is calculated by taking the domestic savings and investments in people (education, ecology and economy), and subtracting natural resources that are extracted (e.g. timber and rare minerals). Malawi is categorized as "not resource-rich" and is found to have "higher dissaving" (a euphemism for wealth extraction) for the period of 1990-2015, with ANS of -9.7 and net foreign assets of USD$ -142/person, meaning that Malawi's

---

[1] Malawi is known as "the warm heart of Africa".

wealth has likely *decreased* over the past 28 years—a trend that generalizes across much of sub-Saharan Africa. Given that Malawi had few natural resources to begin with, we may assume that major losses are predominantly social and environmental.

Over the past 70 years, attempts have been made to counter such trends, as researchers, politicians and activists have sought new ways to conceive of economic and healthcare challenges, relying on approaches that range from health outcome measures, and GDP-dependent analyses, to studies of the mentalities of medical students and the behaviors of patients and community health workers. It is the goal of this chapter to provide enough history, and to plant enough seeds, so that we may build an anthropological understanding of the context in which these issues arose and propagate, so that we may appreciate that numerous, nuanced approaches to social betterment have been attempted—thus, it is unlikely that a 'simple solution' will 'solve' these problems—*and* to appreciate that current efforts at development and biomedicine are no more 'foreign' to Malawi than they are to the United States or Great Britain. Rather, struggles for social betterment can be found throughout Malawi's history.

Before looking back, it is also worth mentioning that many, many individuals and communities were involved in this history—too many to name. In sharing this history, I do not wish to obscure the fact that at each time and in each place, persons acted within their contexts, with the resources and opportunities at hand. Further, it is my goal to convey how Malawi has been constructed by Malawians[2] in a rich interchange with domestic and international actors and organizations. The history of Malawi is simply too rich to fully explore within a single volume,

---

[2] "Malawi" as a territory changed names in its history, but throughout this chapter, to avoid confusion, I refer to the territory as "Malawi" and to its inhabitants as "Malawians," unless they were more transient inhabitants (e.g. missionaries and colonists) or I am speaking of a particular event which changed the territory's name.

let alone a chapter; therefore, I have attempted to highlight some of the most relevant themes for understanding the context in which development and biomedicine are discussed. Additionally, a more dedicated discussion of the history of biomedicine within Malawi is included in Chapter 5.

A History of Africa's Warm Heart

When considering the history of Malawi, we must bear in mind that much of sub-Saharan Africa lacked a written history before European settlement, so "prehistoric Africa" includes times as recent as the 19th century, depending on where we are interested. This *cannot,* however, be taken as evidence in support of Hugh Trevor-Roper's notorious assertion that Africans lack a meaningful cultural history (Fuglestad 1992). In contrast, I am to uphold Joseph Miller's call for Africanist scholars to at least touch on Africa's deep history, as "without early history to give African context to recent experience, Africans' appropriation of current opportunities falls by default into projections of Europe's dreams of "modernization," or lapses into pessimistic resurrections of meta-histories of terminal decline" (Miller 1999). Indeed, without careful attention to the past, one may be tempted to assume that current programs were simply imported into Malawi without active creation, translation or modification by Malawians. Furthermore, looking into Malawi's deep history shows us that interactions with 'outsiders' is *not* a new phenomenon, as human migrations are central to Africa's past.

Thanks to advances in archaeology and nuanced oral histories, Africa is currently known to be the birthplace of humankind, and we have come to appreciate that the Rift Valley—of which Malawi is a part—owns our richest repository of information on early human history, including advances in tools (e.g. Oldowan handaxes, 2.5 million years ago), art (e.g. Blombos caves, roughly 100,000 years ago), and language (Antón, et al. 2014; Berwick and Chomsky 2016; Tattersall 2009; Wrigley 1987). Campbell, et al. (2012) demonstrate how kin structure, diet and disease played a pivotal role in early migrations, and Livingstone (1958) buttresses our understanding by integrating the migration of cultural elements such as iron-workings, pottery and food preferences. Additionally, Livingstone incorporates prevalence of sickle cell gene distribution throughout Africa to illuminate how human culture, environment and disease patterns are intimately related within human expansions. Those persons who settled in Malawi are known as Bantu, as they are part of a single speech group (Bantu languages). Bantu peoples undertook a series of grand expansions that began around 4,000-5,000 years ago, near the Benue Valley of Nigeria-Cameroon, and then extended eastward through savannah "corridors" that opened up in the central African rainforests—possibly due to climate change—or southward along the Atlantic coast, around 1,500-2,000 years ago, having split somewhere around what is currently called Democratic Republic of Congo (Grollemund, et al. 2015; Spear 2005). Grollemund and colleagues suggest that those people who now inhabit the Great Lakes region (i.e. those who settled in what we now call Malawi) overshot the region and then traveled northward to the Great Lakes (ibid). Around 1000 years ago, Bantu peoples arrived in Malawi, where they encountered *Akafula* (i.e. pygmies), who left signs of their artwork on rocks in Malawi, and were either assimilated or eliminated by Bantu peoples (Phiri 2004).

Bearing in mind the apparent sparsity of Africa's population a few thousand years ago (Collins and Burns 2014; Vansina 1990), we may appreciate the enormity of this expansion, as Bantu speakers now inhabit nearly all of sub-Saharan Africa. Along the way, Bantu speakers interacted with a variety of other cultures. David Cohen (1988) suggests that linguistic and cultural borders were porous, and that interactions between groups were extremely local in scale—groups appear to have inhabited territories no larger than 20km in diameter as they exercised trade-based relations and catalyzed a 'Bantuization' of other cultures. Grollemund and colleagues suggest that the expansion “was one of the most influential cultural events of its kind, spreading over a vast geographical area a new, more sedentary way of life that was fundamentally different from that of indigenous forest foragers—ancestral Bantu speakers had mixed-subsistence economies, in which farming gradually gained in importance” (Grollemund, et al. 2015). Expanding these works, Vansina (1990) theorizes that Africa’s past is a story of expanding communities (e.g. districts, villages and kin-households) that led to more complex forms of governance (e.g. households joined to form villages and districts, for farming and protection; and villages and districts joined to give rise to chieftainships and kingdoms), although this path was not unidirectional, nor was the trend always toward centralization, as new challenges were encountered and people invented ways to thrive. Not only did Bantu expansions lead to a peopling of Malawi, but Michalopoulos and Papaioannou (2013) suggest that their precolonial political organizations are linked with current socioeconomic development (as measured by light density from satellite), as they found that that greater centralization of pre-colonial governance correlates with great light density (as measured from satellite view at night), which could not be explained by geography, kinship patterns or pre-colonial economy. In their analysis, Malawi was occupied exclusively by “petty chiefdoms” and “paramount chiefdoms”, with no large states, and Michalopoulos and Papiaoannou suggest that their work supports African historiography and “the importance of ethnic institutions in shaping contemporary economic performance” (ibid).

Early Bantus in Malawi were known as the Bandas (named after a Bantu word for lean-to) and the Phiris (named after a Bantu word for mountain)—names that are still common in Malawi, akin to “Jones” and “Smith” in the USA—each of which now follows a matrilineal and matrilocal culture. As foreshadowing for later discussions of gender (in Chapter 7), interpretations of matrilineality are mixed, with DD Phiri suggesting that matrilineality implies that women have had a greater voice in society, whereas Vansina suggests that matrilineality was originally established to oppress women, as woman's brothers often make the decisions, but women are shouldered with the debt, leading to situations whereby females may be treated even worse than if husbands made decisions (Phiri 2004; Vansina 1990).

In addition to kin- and chief-based forms of social organization, spiritual and therapeutic practices played a central role in pre-European Malawi—a role that significantly overlapped with healing (e.g. Malawians had a god of smallpox and a god of divination, practiced incantations/music in religious and healing practices, sick persons were thought to connect with ancestors) (Csordas and Lewton 1998; Cumes 2013; Ngubane 1981). Serving as groups of spiritualist and divining women, Vimbuza emerged as a means for women to influence social and spiritual life in patriarchal Tumbuka society (located mostly in Northern Malawi); whereas Gule wamkulu emerged as groups of married men within matriarchal Chewa society (located mostly in Central and Southern Malawi) who perform duties of social commentary/critique and convey the messages of ancestors (Boucher, et al. 2012; Soko 2014). In this thread of 'traditional healing,' Waite and Vaughan inform us that, contrary to popular belief that public health efforts began elsewhere and were then brought to Africa, substantial public health efforts *did* exist in precolonial times, which included efforts at rainmaking, infectious disease control, sanitation and education (Vaughan 1991; Waite 1992).

Five centuries before Europeans settled in Malawi, firm links had already been constructed between Europe and sub-Saharan Africa, although mostly along Africa's western coast (Lovejoy 1983). Over the centuries between those early interactions and David Livingstone's passage up the Zambezi River, the quake of slavery, conquest and civil wars rippled throughout the continent, destroying livelihoods and, in some cases, eliminating entire speech groups (Vansina 1990). While the precise mechanisms of this history remain unknown, Deaton points out that “it is only in the last two hundred and fifty years that long-term and continuing economic growth in some parts of the world—but not in others—has led to persistent gaps between countries”—thus, large socioeconomic disparities between world regions are a fairly recent phenomenon (Deaton 2013). Nor should we mistake an economic gap for a history of total domination, as evidenced by the Portuguese navy’s repeated defeat at the hands of Africans, Scottish missionaries’ inabilities to coerce locals to join the church, and the British Army’s inability to defeat clans at Nkhotakota (Lovejoy 1983; McCracken 2012; Vaughan 1991).

When Dr David Livingstone arrived on the shores of Malawi in 1859, he was open about his hopes of ‘discovering’ riches, but he also intended to spread the gospel and raise the standard of living in those territories that he encountered (Livingstone 1857). At the time of the establishment of early mission settlements, the Arab-Swahili slave trade was still active—leading to frequent, violent clashes with slave traders—and groups of Ngoni—known for the strength and social necessity of their violent conquests—were migrating from South Africa (McCracken 2012). At this same time, Malawian chiefs (of predominantly Yao culture) were converting to Islam, as McCracken suggests that they were attracted to the religion by the economic incentives of the slave trade (ibid). Early evangelizing activities proved dangerous and futile for Christian missionaries in converting locals— perhaps best illustrated by Dr Robert Laws, an early missionary-physician, who wrote that the accomplishments of his first five years amounted to ‘five graves’ and ‘one convert’ (Eidhammer 2017). When church recruitment strategies proved unproductive, medical services were offered to Africans, in a sort of bait-and-switch strategy, which proved to be much more effective for recruiting parishioners (Farley 1991; Hokkanen 2007). Missionaries' efforts also gained traction following Livingstone's negotiation to end the slave trade in exchange for medical services—a treaty which did little to change the practices of slave traders, who were eventually stopped by force (McCracken 2012).

Following European settlement, social, economic and religious processes were co-produced by Africans, Europeans and Asians (who were involved in the slave trade or brought over from other British colonies). Additionally other Africans, Xhosa missionaries, were brought in from outside of Malawi by Scottish missionaries for the task of evangelizing Ngoni peoples (the Xhosa missionaries proved to be immensely successful in evangelizing) (Thompson 2007).

Colonial Era

Markku Hokkanen informs us that the region that came to be known as Malawi "was in important ways a colonial construct, with largely artificial borders drawn during the Scramble for Africa," and that Britain appears to have entered into the relationship reluctantly, to appease Scottish missionaries and stem the expansion of nearby Portuguese colonists (Hokkanen 2017). Malawi became Britain's poorest and most densely-populated colony in Central Africa, as its landlocked isolation was exacerbated by the fact that it was bordered by colonies that were owned by Portugal and Germany. Some Malawian chiefs and communities resisted European rule, and entire villages were shelled and burned by the British government in an effort to extirpate insubordination (McCracken 2012). The colonial government frequently came into conflict with African traditional healers, religious leaders, and missionaries, as well, as the government strategy of "modified indirect rule" meant that the colonial administration laid the general ground rules, but Malawian leadership (i.e. chiefs) would be kept in place; however, in practice, the colonial administration was unwilling to provide funds to Malawians, nor did they figure out a way to cover their own costs with Malawians' labor. Under colonial rule, traditional healers and Africans drinking beer were thought to have been wiped out, only to resurface decades later—displaying locals' cleverness in hiding their activities from colonists (Soko 2014).

Perhaps more prominently in Malawi than elsewhere, the efforts of early missionaries heavily influenced government plans, and it was not until well into the 1900s that the British government began to assert its will over missionaries. In rhetoric, British colonial administrators maintained the highest standard for missionary practices, and colonial physicians warned of the dangers of ignorant Africans getting their hands on and abusing Western medicine (Hokkanen 2007). In practice, however, lay missionaries were often given minimal training and were counted on to serve regions outside of physicians' catchment areas, thereby creating a rural-urban disparity, since the inception of state-funded biomedicine in Malawi (ibid). The first few decades after European settlement have been called "the unhealthiest period in African history" for local Africans, as Malawians' life expectancies plummeted and government health services were reserved for Europeans until 1929 (Farley 1991; Hokkanen 2007), and contrary to community-level public health efforts of the pre-colonial era, Ruth Prince suggests that "a national context in which public health is promoted *by the government* and extended to citizens on an equal basis has never really existed in Africa, either in the past or in the present" (emphasis mine) (Prince 2014).

Alongside antiparallel trend in illness and institutional authority, Africans soon lost much of their most valuable land, as European settlers acquired vast estates with hopes that they could convince Africans to farm them (Englund 2006; Ferguson 2013b). As it turned out, Africans were not interested in forced labor on British plantations, and they frequently resisted the poor treatment and meager compensation that they received (McCracken 2012). Around the year

1900, an influx of Lomwe from wars in neighboring Mozambique provided Europeans with some labor force, but less than they needed, so in 1908 they levied one of the most unpopular pieces of legislation in local history, the Hut Tax, which required each African household to pay taxes to the colonial government—roughly half of this tax revenue went to paying European salaries, while Europeans were exempt from paying the tax (Eidhammer 2017). Perhaps not surprisingly, Africans resisted, and one of the ultimate results of the hut tax was to establish an employment route between Malawian villages and the mines of South Africa—a conduit that would have devastating effects in future decades, as HIV/AIDS spread like wildfire among mine workers and was then brought home to Malawian families and villages (McCracken 2012).

The grip of colonial rule began to loosen around World War I and II, as British and Malawian personnel were directed to war efforts in Europe, or elsewhere in Africa (King and King 1992). At the dawn of WWI, John Chilembwe—a Malawian priest who initiated numerous community-development programs—sparked an armed rebellion at an estate owned and operated by descendants of David Livingstone who were notoriously ruthless in their treatment of Malawians. The event resulted in the death of three whites and around fifty Malawians, including Chilembwe, himself. The uprising failed in its immediate goal of overtaking the estate, but its symbolic importance reverberates through history, as Chilembwe is remembered as a symbol of Malawian pride and independence (Eidhammer 2017).

Entering the Era of Development

In the context of the stock market crash of 1929, which set the world economy on its heels, and an enormous toll that WWII took on the British Empire—forcing it to borrow heavily from the United States—Britain's' grip continued to loosen on Malawi. This period also brought British investment in hospitals, schools, transportation, and cash crops such as tobacco, nuts and trees. Randall Packard points to the Cape Town Conference of 1932 as a change in theories of governance, as representatives laid out principles by which colonial health services should be reorganized (Packard 2016). These principles included: 1) incorporate preventive health services; 2) foster cooperation between health and other sectors; 3) improve the economic status of locals; 4) increase education on basic hygiene; and 5) include locals and women in the work. Three years later, these aims were affirmed at the League of Nations conference in Johannesburg. Despite such theoretical pronouncements, Packard suggests, global health efforts displayed little interest in understanding local cultures or variability, and any interest that they had seemed to evaporate in the post-WWII era. At this time, world leaders gathered to mark a 'new era' in development, as they gathered at Bretton Woods, New Hampshire to draft plans for the global economy—a meeting that eventually gave birth to the International Monetary Fund (IMF) and World Bank (WB). Francis Omaswa suggests that Africans went to these institutions:

> "begging for advice and for money and we got both, in exchange for certain core values. Africans lost self-respect, self-confidence, self-determination… African technocrats and politicians accepted being humiliated by their donor counterparts and were forced to accept and implement solutions that they knew would not work. The new order dictated that Africans were told what to do and how by foreign technocrats and politicians who did not have the same depth of understanding of the African situation as the locals" (cite Omsawa 2014).

Concurrently, social scientists played a significant role in attempts to draft interventions in "developing" settings, and British officials adopted the goal of transforming Malawi into a prosperous asset (Eidhammer 2017). At the time, Martinussen tells us, international efforts assumed "that the developing countries' own traditions and inherent economic, social and political structures and institutions [were] of little importance as determining factors for their social development," as nations could presumably be guided to industrialization by wealthier, Western governments (Martinussen 1997). The height of these understandings were perhaps best illustrated by the inaugural speech of American President Truman, who promised to "embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas." He continued:

> "More than half the people of the world are living in conditions approaching misery. Their food is inadequate. They are victims of disease. Their economic life is primitive and stagnant. Their poverty is a handicap and a threat both to them and to more prosperous areas. For the first time in history, humanity possesses the knowledge and skill to relieve the suffering of these people. The United States is pre-eminent among nations in the development of industrial and scientific techniques. The material resources which we can afford to use for assistance of other peoples are limited. But our imponderable resources in technical knowledge are constantly growing and are inexhaustible. I believe that we should make available to peace-loving peoples the benefits of our store of technical knowledge in order to help them realize their aspirations for a better life. And, in cooperation with other nations, we should foster capital investment in areas needing development."

Thanks to the USA's dominant global position following WWII, this school of thought reigned supreme in international development circles for roughly three decades, as Packard (2016) suggests that this era was characterized by narrow interventions aimed at nutritional and anti-disease projects, under the hope of capitalizing on the newest biomedical understandings, with such projects likely leading to more harm than good, as programs were both technically ineffective and disempowering to local peoples.

While this notion of development predominated in 'official' circles, it would be a mistake to assume that 'development' has ever been fully represented by a single theory or school of thought. Indeed, Martinussen provides us with an analysis of differing views on development—notions which are worth reviewing here, so that we may make better sense of current efforts. The first notion, ***economic growth***, which has been popular in some circles since the 1950s, can be understood as "a process whereby the real per capita income of a country increases over a long period of time while simultaneously poverty is reduced and the inequality in society is generally diminished" (Martinussen 1997). This school of thought is related to ***modernization*** theory, which was popular in the 1940s and 1950s and suggests that "Third World" countries can improve by groping their way toward similarities with North-Western nations, as in Truman's goals, expressed above (ibid). Running counter to these theories, and growing in popularity in the 1960s, ***dependency*** theorists suggested that developing countries must *break free* from colonial powers—and many authors suggested that countries should form socialized systems. More recently, development as ***capacity building*** suggests that people and institutions must be supported or "empowered" (Martinussen 1997). Related to this school, and perhaps described most famously by Amartya Sen, development as ***human welfare*** and ***capabilities*** suggests that individual freedoms and capabilities should be the principle ends *and means* of development, and these freedoms are thought to act synergistically (Sen 1999). Sen argues:

> "the adult who lacks the means of having medical treatment for an ailment for which she suffers is not only prey to preventable morbidity and possibly escapable mortality, but may also be denied the freedom to do various things—for herself and others—that she may wish to do as a responsible human being… The argument for social support in expanding people's freedom can, therefore, be seen as an argument *for* individual responsibility, not against it" (Sen 1999).

One of the most recent theories of development, Martinussen tells us, is ***sustainable development***—a set of theories that arose around the late 1980s and can be thought of as "a process that fulfills present human needs without endangering the opportunities of future generations to fulfil their needs" (Martinussen 1997). These efforts tend to focus on creating systems that dissuade extravagant lifestyles, while also meeting basic human needs of the poor. Notions of sustainable development will be discussed at greater length in Chapter 4.

The most recent conception of development, Martinussen (1997) suggests, is development as ***history***, which arose among anthropologists and denies any hierarchical ranking of cultures and argues that each culture must be understood within its own history. Proponents of this perspective suggest that any changes should be determined by those persons who live in the society. In this vein, Ferguson persuasively argues that ahistorical notions of development are likely to have serious shortcomings based of their lack of context, and he critiques the ahistorical nature of capabilities arguments, which, he argues, inappropriately posit dependency as the antithesis of development—thus, "to wish for [dependency]… seems to be a wish for one's own devaluation, and even dehumanization" (Ferguson 2013a). Ferguson points to the history of southeastern Africa to show that dependency relationships can guarantee protection and resources (ibid)—indeed, ramifications of these kinship relations will be discussed in Chapter 7. Similarly, Englund critiques individualistic models that render "empowerment through relationships… unthinkable," thereby handicapping locally-based, historically-rooted efforts from serving as viable models for development agencies (Englund 2006). Rather than stick to a single one of these theories, I will use them like tools, applying whichever one seems most useful for the discussion at hand. That said, I will admit my bias toward the historical- and capability-based understanding, so as to not surprise any readers when I attempt to braid together history and experience (particularly in chapters 5 and 7).

Liberation

Despite changes in post-war 'development' aims, Malawi continued to struggle financially, so colonial administrators tried to cut their losses by consolidating their rule of Malawi—for its 'surplus labor'—with Northern Rhodesia (i.e. Zambia) for its mineral wealth, and Southern Rhodesia (i.e. Zimbabwe) for its agricultural and manufacturing capacities (Eidhammer 2017). Malawians vehemently opposed this move, as they wanted a transition from British rule to self-rule and did *not* want to be ruled by white Rhodesians, who had a reputation for callously enforcing harsh working conditions upon Africans. However, following the election of Winston Churchill, Malawi was forced to enter the Rhodesian Federation. Following that move, Malawians did not simply roll over. The combined efforts of organized labor and young radicals (the 'Young Turks') leveraged popular sentiments and, after 10 years of resistance, Malawi left the federation for national independence, which was eventually granted in 1964, and then "Malawi" formally became a republic in 1966, under the leadership of Dr Kamuzu Banda (King and King 1992). Reflecting upon the period of European rule, Asbjorn Eidhammer suggests:

> "The slave trade was crushed, and the violence and raids for women and cattle between some of the ethnic groups were brought to an end. Few resources were taken out of the protectorate, although not much was invested either. What adds to this impression is the undeniable admiration people of Nyasaland had for the British and everything that was British. Even the struggle for independence was not anti-British" (Eidhammer 2017).

Not all authors see such a 'balanced' situation, however, as Mamdani (1996) suggests that the British colonial administration fragmented the population along racial, ethnic and rural-urban lines, in order to form units that could be manipulated for colonial aims, and that independence governments maintained or strengthened these divides by continuing colonial policies or enacting policies that buttressed divides/increased tribalism. Francis Omaswa suggests that following independence, "the net result was a mismanaged Africa with bankrupt and collapsed economies, on her knees as a beggar for aid in order to provide basic services to her populations and to make a new beginning economically, socially and politically" (Omaswa 2014). Importantly, President K Banda remained in good relations with the British, even retaining colonial officials in his independence government, and he soon cracked down on the Young Turks and other domestic intellectuals, forcing them into exile or prison—or worse. Indeed, Vail and White (1991) describe how K Banda amplified tribalism and regionalism within Malawi in a process that crystallized when African intellectuals—the most influential of whom had received a missionary education—gave cultural definitions to these tribes.

President K Banda was fiercely pro-Capitalist, opposed the independence of Mozambique and Angola, and made Malawi the only regional country to support the Apartheid government in South Africa. His ideology is described as an opportunistic mix of 'traditional' values and

European ideals that served to keep him in power and repress his opponents until, in 1971, he extinguished domestic opposition and declared himself ‘president for life’ (Eidhammer 2017).

For the international community, post-war benevolence dissipated as the Cold War took shape, and resource extraction accelerated throughout Africa, making “development” an industry (Packard 2016). President K Banda allied himself with the US during the Cold War, in a relationship predicated on free markets and military support, which some suggest stretched the brutal dictator’s rule for decades longer than it otherwise would have lasted (Kalipeni 1995; King and King 2000).

Neoliberalism

On the heels of the 1973 oil embargo and droughts in Malawi, as countries around the world were realizing that they could not repay their international loans from the IMF and WB, a new, financialized approach to international development rose to the fore (Ganti 2014; Reubi 2016). This approach to economics was accompanied by calls to shrink public/state-funded activities and encourage ‘individual responsibility’—a cluster of aims that is termed “neoliberal” by scholars, as such moves take laissez-faire economic theories to an extreme (Pfeiffer and Chapman 2010). In 1981, the WB published the “Berg Report” (actually titled *Accelerated Development in Sub-Saharan Africa: a Plan for Action”)*, which Keshavjee (2014) suggests blamed governments for poor economic performances and spelled the end of Keynesian economics (whereby states were expected to intervene to regulate ‘market’ inconsistencies) for the WB. With countries in need of money, and international lending agencies effectively abandoning Keynesian ideals, the terrain was fertile for Structural Adjustment Policies (SAPs), which have been called “the practical tools” of neoliberalism, as they make the receipt of international moneys contingent upon reducing government spending/public services, a move which led to a smaller state sector and precipitated the formation of non-government organizations (NGOs) and community-based organization (CBOs) to cover for vacancies (Chirwa 1998; Englund 2006; Mburu 1989; Pfeiffer and Chapman 2010). SAPs were purported to "control inflation, repay international debt, and stimulate economic growth" via "free markets, privatization, small government, and economic deregulation" (Pfeiffer and Chapman 2010). Qualifying for funds from international bodies such as the IMF and WB became contingent upon compliance with the conditions of SAPs, so countries like Malawi were left with a "choice" between no public health care, or a larger budget that accords with neoliberal priorities—most opted for the latter. In the two decades leading up to SAPs, Malawi's annual growth rate was 6%; however, once SAPs were implemented, real per capita income in sub-Saharan Africa actually *declined*, and debt grew from 27.4% of GNP in 1980 to 98.3% in 1989 (National Economic Council 1998). With this hindsight, Malawi's government concluded that after 34 years of independence, "there has not been significant social and human development" (ibid). In following these policies, public healthcare services shrunk and care was pushed onto families (despite no evidence that self-care programs save money or improve outcomes), with paternalistic land rights combining with off-the-grid homes to place women-headed households at increased vulnerability (Aantjes, et al. 2014; Kenworthy 2014; Mkandawire, et al. 2015). Devalued currency, eliminated fertilizer subsidies, and erased floor prices for crops (elements of SAPs) led to the creation of parastatals that syphoned-off profits and pulled the rug out from under Malawi's subsistence farmers (Ellis 2006). Perhaps not surprisingly, shortcomings of "market ideology" in healthcare were recognized long ago, as noted in the WB's 1980 *Health Sector Policy Report*, which noted how consumers lack adequate information to make rational choices, they are often too sick to think 'rationally', families often make choices for individuals, externalities abound (making discrete outcomes unrealistic), competition is limited because of tremendous costs of healthcare, healthcare catastrophes are fairly unpredictable (making them hard to plan for) and inequalities of wealth and income preclude any semblance of widespread ‘free market’ behavior (Packard 2016).

Consequently to SAPs, NGOs and CBOs have exploded in number throughout Malawi. Chirwa (1998) and Englund (2006) are critical of how such organizations frequently cater to political, rather than social or economic matters, whereas Sachs (2008) applauds NGOs for tackling non- or supra-market problems, which he suggests governments and private enterprise are not in a position to address, and Mburu (1989) adds that NGOs have an advantage of flexibility—a debate that is worth bearing in mind when considering discussions of Mobile Clinics in subsequent chapters.

Keshavjee (2014) argues that, as part of this neoliberal movement, in 1987 the Bamako Initiative was implemented by sub-Saharan Ministries of Health, which spearheaded initiatives for rolling drug budgets, whereby donors provide an initial investment, and then “consumers” pay for medications at a markup to re-coup 50-60% of costs, with the effect of abandoning the poorest citizens. It is important to note that Malawi has been an exception to this rule. As Luke Messac points, "Malawi’s penchant for ignoring the advice of its more market-oriented technical assistants is nowhere clearer than in its refusal to institute point-of-care user fees at government hospitals and health centres,” making Malawi one of only six countries (of the 50 countries with the highest mortality rates) to not implement user fees at public health facilities (Messac 2014). Such debates linger to this day, as will be discussed in Chapter 4. Given the amount of literature on this topic, it is important to recognize that such issues are more complicated than ‘market-versus-public’, as Bridget O’Laughlin recently reviewed this dichotomy and concluded that despite abundant case studies showing how privatization shrinks health care coverage, the epidemiology of *quality of care* between private and public provisions remains unclear, reaffirming the necessity of studying context- and content-contingencies (O'Laughlin 2016). Controversy surrounding neoliberalism also extends into medical anthropology, as Reubi suggests that there is currently “an epidemic” of citing neoliberalism, leaving us “with the impression that everything, from biomedical research to patienthood, has become ‘neoliberal’,” and that “the field of global health and development is no exception” (Reubi 2016). Bell and Green (2016) suggest that neoliberalism has come to represent four clusters of concepts: 1) ideologic hegemony; 2) policy and programs/austerity; 3) state form/minimization; and 4) governmentality/citizens’ internalization of rules and acceptance of the presence or absence of rules for a given domain of life. Given such a plurality of uses and understandings of “neoliberalism,” we may ask why anthropologists continue to use the concept. Ganti draws parallels between “neoliberalism”, “culture” and “political economy” to suggest that “neoliberalism” “provides a common vocabulary that enables scholars to draw connections across vastly different cultural contexts and geographical regions, thus allowing them to transcend the provincialities and legacies of an area-studies paradigm and anthropology’s own history of discrete culture areas" (Ganti 2014). Implications of these debates will be revisited in chapter 4.

In the midst of this ‘neoliberalization’ of the economy, HIV/AIDS struck Malawi, with the first case occurring around 1985, and HIV prevalence rose to around 17% of the adult population of Malawi in the 1990s. From there, HIV and associated opportunistic infections, along with political denial and neglect of the infected patients, ravaged the population, leading to high rates of orphanhood, suffering and premature death. In this context of a weak economy and insufficient healthcare, President K Banda's grip on the country began to loosen, and in 1992 a letter from seven Catholic bishops was distributed secretly throughout the country and read aloud in 130 churches and a thousand prayer groups. In the letter, the bishops expressed that they must speak up against injustices of the growing disparity between rich and poor, falling standards of education, lack of political freedoms, and inequities in healthcare (Eidhammer 2017). That letter happened to be followed-up by drought, famine, a strike at the largest textile factory in the country, and then resistance from other religious organizations and professionals throughout the country—a combination which sealed K Banda's fate (ibid). Unfortunately, while K Banda lost his grip on the country, his legacy of internal divisions persisted, as Kaspin (1995) points out that the largest 'tribe' in each region supported its own presidential candidate for the 1994 election.

In this context, Malawi elected Bakili Muluzi as President in 1994. Muluzi is a business man from the Southern Region who was known for his generosity and frequent gift-giving—and, among some Malawians whom I interviewed, for opening the door to wide-spread corruption across government and civil society. Thankfully, however, Muluzi is also known for discontinuing K Banda's brutal crackdowns on intellectuals and dissidents, and ultimately Muluzi abided by the constitutional limits on his terms. In his statement in the *Vision 2020,* Muluzi criticized Malawi's dependence upon short- and medium-term plans, which he said only resulted in poverty, scant social services, food insecurity and growing government debt (National Economic Council 1998). The *Vision* also offered a list of topics to be addressed for national development: "good governance, sustainable economic growth and development, vibrant culture…food security and nutrition, science and technology-led development, social sector development, fair and equitable distribution of income and wealth, and sustainable environmental management"—all of which continue to guide policies today (ibid).

A New Millennium

During the second term of Bakili Muluzi, the United Nations drafted the Millennium Development Goals (MDGs), which have been called “the most widely supported and comprehensive development goals the world has ever established” (Lomazzi, et al. 2014). This agenda contains eight goals with 18 targets, was supported by all 191 countries, over 1000 NGOs, and placed special emphasis on developments in Africa (Cheney 2010). The MDGs were lauded for their specificity and measurability, although they catalyzed mixed results. Editors of the *Economist* write:

> “Overall, the MDGs have a decent record. Some (such as reducing maternal and child mortality) will be missed by miles. But others, such as cutting by half the share of people who live in abject poverty, have been reached. The MDGs themselves do not always deserve the credit: the plunge in the global poverty rate has far more to do with growth in China than anything agreed on at the UN. But in other cases, such as boosting access to clean water, the prospect of missing an international target shamed countries into acting better than they might have otherwise” (Economist 2015)

The first Malawian president elected in the MDG-era was Bingu Mutharika, who was elected in 2004. At this time, food scarcity was a major issue, as were finances and healthcare. B Mutharika’s national strategy was outlined in Malawi’s first Growth and Development Strategy (MGDS I), which focused on six priority areas: 1) Agriculture and Food Security; 2) Irrigation and Water Development; 3) Transport Infrastructure Development; 4) Energy Generation and Supply; 5) Integrated Rural Development; and 6) Prevention and Management of Nutrition Disorders, HIV and AIDS (Malawi 2006). Like each of his predecessors, B Mutharika’s legacy is mixed, although no one whom I talked to doubts his grand aspirations or desire for change. Among his accomplishments were his decision to act in direct contrast to IMF orders by subsidizing fertilizer for farmers, which transformed Malawi from a food importer with periodic famines to a country with a food surplus; his moves toward gender equity, for which some progress was made; and his plans to create an inland port to facilitate trade between Zimbabwe, Zambia, Malawi, Mozambique and into the Indian Ocean—unfortunately, Mozambique did not agree, and the project has yet to be realized (Eidhammer 2017). However, a review by the World Bank, IMF and International Development Association notes that poverty reduction and employment creation underperformed, and wealth disparities actually worsened during the 2004-2011 period, especially in rural areas (as indicated by the Gini coefficient) (Bank 2012). The WB and IMF suggest that this underperformance occurred because the entire MGDS I was “a disjointed picture” concerning “priorities and the actual amount of resources that were brought to operationalize the priorities” (ibid)—this will be discussed in Chapters 4 and 5.

Mutharika is also remembered as trying to push ‘too fast’ for Malawi to gain independence from donors, as he implemented a zero-deficit budget, which happened to follow the "Great Recession" of 2008—which changed funding from recipient-need-driven to provider-allocation-driven—and coincided with a dramatic drop in tobacco prices (Malawi’s main cash crop) (Eidhammer 2017). In the following years, the IMF declared that Malawi’s central bank was artificially buttressing its currency and recommended that donors cease to lend Malawi money. As he came under increasing heat, B Mutharika expelled the British High Commissioner, who had commented on B Mutharika’s growing autocratic tendencies (ibid). In response, the British government froze and redirected their aid, which further exacerbated Malawi’s shortages in foreign exchange currency, causing parts of society to come to a literal standstill—motorists had to queue for days to get petrol. Facebook groups were created to let people know which fuel stations would be receiving petrol each day, with speculations as to the time of arrival. At this time, I made my first trip to Malawi and, along with dozens of others, waited for hours in my vehicle to get petrol. Just across the border in Mozambique, entrepreneurs could be seen with 5-gallon jugs of gasoline stacked up in pyramids, enticing Malawians to engage in illegal trade.

That summer coincided with the “Arab [or African] Spring”, and protests erupted in the streets. Some protestors marched through the streets waving branches and carrying signs that included “NO VAT [value added tax] ON MILK!” while others burned tires in the street. The next day, Malawian newspapers showed images of a protestor’s arm that had been fileted-open by a panga-wielding thug from the president’s youth support organization.

B Mutharika’s response was inconsistent, encouraging peace while stoking flames with fiery rhetoric. Domestic conflicts smoldered until March 2012, when a group led by a clergyman issued B Mutharika an ultimatum that he must leave office within 90 days. Less than a month later, B Mutharika had a heart attack in office and was brought to Kamuzu Central Hospital, already deceased (the facility lacked an intensive care unit). As Eidhammer remarks, “In a sad way, the head of state fell victim to the resource constraints in the public health service” (Eidhammer 2017). In a bizarre turn of events, B Mutharika’s body was flown to South Africa and the administration denied his death for days. Rumors circulated that his brother, current president Peter Mutharika, would fly in from the United States and try to take the presidential seat from Vice President Joyce Banda, who was legally the successor but had recently been ousted from the party and gone on to form her own party.

Despite attempts from the Mutharika’s party to secure the office, Joyce Banda, a woman with a background in business, ended up as president. President J Banda was celebrated as one of the star female politicians in the world, particularly in sub-Saharan Africa. She quickly moved to normalize international relations, which included devaluing the kwacha, cutting executive spending, and creating special programs that focus on maternal wellbeing. Soon after entering office, J Banda released Malawi Growth and Development Strategy II (MGDS II), which placed greater emphasis on coordination and integration of programs. Within this report, J Banda points to government limitations and suggests that “the scope of the private sector participation will be widened to involve them in the provision of other public goods and services" (Malawi 2012). Additionally, the role of donors and development partners “shall be to assist across the board with financial and technical resources to implement the activities outlined in the MGDS II,” that is, *not* to provide wide public services, but to play a supplemental role (ibid). The WB, IMF and International Development Association applauded J Banda’s currency devaluation as “a clear signal of [Malawi’s] commitment to regain control over the management of the economy and improve external competitiveness,” and the cross-cutting, thematic reporting of some of MDGS II, which, they say, “raises the possibility of improved implementation when compared to the MGDS I” (Bank 2012). However, as with MGDS I, the IMF and WB tagged MGDS II as ‘unrealistic’ because of its assumptions about generous donor-provided budgets (ibid). Eidhammer (2017) remarks that Malawi may have been its most transparent during J Banda’s term; unfortunately, such positive sentiments came crashing down in 2014, when the “Cashgate” scandal was uncovered, in which tens of millions of US dollars were stolen from government accounts by government officials. The incident shook Malawian politics to the core and severely undermined public faith in the government.

J Banda’s term ended in 2014, when Peter Mutharika—the younger brother of Bingu Mutharika and the man who tried to sweep in to fill the presidency back in 2012—won the election. President P Mutharika has remained relatively quiet as compared to his brother’s grand plans. Following Cashgate, P Mutharika’s administration has been clouded by concerns of national corruption, as will be discussed in Chapter 4. News of the Anti-Corruption Bureau dominated the airwaves during my trip to Malawi in 2017. In the summer of 2018, P Mutharika was implicated in a multi-million-US-dollar graft scandal involving monies allocated to police lunches—money which reportedly ended up in Mutharika's bank account. We will see how this plays out.

In 2015, as the MDGs expired, and the UN carried out a retrospective analysis of the successes of the MDGs, finding six common factors that contributed to success: 1) national consensus was developed for local change; 2) the voices of poor communities were incorporated into plans; 3) projects had international support and partnerships; 4) attention was given to the inequalities that restrain progress; 5) initiatives were adaptive; and 6) adequate financing and a supportive environment were necessary to catalyze novel initiatives (UNDP 2016)—findings which provide support for development theories based upon capabilities and local histories, as participation and deliberation appear to be keys to success.

The Current Era: Aims at "Sustainability"

As the MDGs came to a close, an international group of political delegates, activists and scholars met to draft a new direction for the future of development that would harness the gains and lessons learned from the MDGs, while pushing them a step further in terms of breadth and inclusivity. Buse and Hawkes tell us that the official working group sought to take the MDGs "out of isolation… with more focus on illness prevention and promotion of wellbeing, and more collaboration with other sectors that influence health and illness outcomes—including, importantly new approaches to curb the "profit-driven" determinants of illness" (Buse and Hawkes 2015). The meeting showed greater participation from national governments of developing countries than had the drafting of the MDGs. One of the first proposals traced the Human Rights Council's Universal Periodic Review, whereby civil society organizations would periodically review and report on government policy; however, that proposal was shelved because of fears of "mud-slinging" and "naming and shaming" (Donald and Way 2016).

Developing countries also proposed more robust “monitoring and accountability” measures pertaining to donors and international actors; however, co-chairs of the document replaced “monitoring and accountability” with the phrase [voluntary] “follow-up and review,” thereby removing the teeth from the document (Donald and Way 2016). The final draft of these plans is being called the Sustainable Development Goals (SDGs). It is supported by 193 countries and it consists of 17 goals and 169 targets—many more than the MDGs—with the tagline of “People, Planet and Prosperity.”

Murray (2015) suggests that the SDGs will achieve fewer health care successes than the MDGs on account of SDGs’ vagueness and the complexity of guided, systemic change, which has largely eluded global planners. Further, Buse and Hawkes (2015) argue that the integrated nature of SDGs makes isolating health care outcomes difficult, and possibly overwhelming for governments, as they may feel compelled to address the commercial, social and environmental aspects of health and substance abuse that would be necessary to achieve SDG goals. Similarly, Donald and Way suggest that the vagueness of the SDGs will drive the three largest global donors (US and UK governments and the Gates Foundation) “to remain strongly committed to the MDG health agenda in the poorest countries,” rendering the SDGs irrelevant in some circles (Donald and Way 2016; Murray 2015; Ruckert, et al. 2017).

It is worth remembering that the notion of “sustainable development” is not new to Malawi or development scholars. In his 2006 introduction to MGDS I, President Bingu Mutharika suggested that "The MGDS represents a policy shift from social consumption to sustainable economic growth and infrastructure development, particularly in rural areas through the development of rural growth centres” (Malawi 2006), and President Muluzi aimed at “promoting intersectoral relationships; ensuring greater community involvement in health delivery; and strengthening coordination between health providers”[3] (National Economic Council 1998).

It may be the case that some of the confusion surrounding the SDGs results from the term “sustainable development.” Iewlunmor and colleagues note that "the conceptualization of sustainability has received remarkably little critical attention,” and Keshajeev suggests that “sustainability” often serves as a euphemism for withdrawing humanitarian assistance and transferring financial responsibility onto host nations (Iwelunmor, et al. 2016; Keshavjee 2014). Additionally, scholars largely ignore definitions such as the one provided by Martinussen—“a process that fulfills present human needs without endangering the opportunities of future generations to fulfil their needs” (Martinussen 1997)—and critique programs as ‘unsustainable’ if they change or move. Admittedly, however, it may be impossible to fulfill Martinussen’s definition, as we cannot predict precisely what will happen in the future. Like the notion of “development”, it seems that “sustainability” can refer to any number of things, including individuals, communities, projects, outcomes, the derivative of projects or outcomes (i.e. changes), or the second derivative of any of these metrics (i.e. changes of trajectories). Without a consensus on what we are tracking and how we are tracking it, a grounded, historical approach to development will be indispensable.

Unfortunately, calls for ‘sustainability’ may also serve donors’ nostalgic desires for ‘unchanged’ and ‘native’ settings, or reflect a lack of faith in the adaptability of persons in developing countries. Indeed, the voices of Malawians who work ‘on the ground’ are rarely heard in such discussions, as Packard (2016) points out that the lives and experiences of people

---

[3] A major difference between 1998 and subsequent aims was that in 1998 the government formally sought to “Strengthening links with traditional medicine through provision of research and development in traditional medicine, promoting interaction between traditional and clinical practitioners" (ibid). I was unable to find any similar pronouncements in Malawi’s major subsequent plans.

involved in global health efforts have been largely ignored, as researchers focus on institutional and outcomes measures. Given these issues, it may come as little surprise when Juliet Iwelunmor concludes that "the literature on sustainability in sub-Saharan Africa is "fragmented and underdeveloped"" (Iwelunmor, et al. 2016). The cause of these issues, Easterly suggests, is diminished hopes from Western donors:

> "There is today a much less confident West compared to the MDGs heyday. The rise of the rest is so much more evident now than in 2000. Per capita GDP growth in low- and middle-income countries since 2000 has been rising much faster than in the West, even in sub-Saharan Africa. Africa now has twice as many cell-phone subscribers as the United States, after remarkable growth that had nothing to do with Western development aid. Remittances from the diaspora and foreign direct investment are together twice as large for Africa as foreign aid… If there is something to salvage from the SDG debacle, perhaps it is the idealistic advocacy for "universal respect for human rights and human dignity," not as a 2030 "target," but just as an increasing recognition of poor people's rights for self-determination… Such advocacy is needed to accept and respect the mainly homegrown rise of the rest… the decline and fall of the pretensions of foreign aid only tell us to not put our hopes in U.N. bureaucrats or Western experts. We can put our hopes instead in the poor people we support as dignified agents of their own destiny" (Easterly 2015).

Editors of the Economist suggest that the SDGs "is being set up to fail. That would be not just a wasted opportunity, but also a betrayal of the world's poorest people." (Economist 2015). As evidence of the unfeasibility of the SDGs, the authors suggest that the goals would require 15% of annual global savings, while donors currently provide a mere fraction of the 0.7% of GDP that they promise (ibid). More modestly, Margaret Kruk suggests that the SDGs will fail to meet their goals because healthcare problems frequently require more complex and longitudinal care than is aimed at in coverage-based goals—especially regarding HIV, mental health and noncommunicable diseases—meaning that innovations will be needed *within* healthcare networks (Kruk, et al. 2016). Kruk laments that, "whereas data on health-care use greatly improved in the MDG era, we know little about the quality and effectiveness of care in lower-income countries" (ibid)—all topics to be discussed in subsequent chapters.

On the other hand, it has been suggested that the SDGs are particularly well suited for sub-Saharan Africa because of their foci on “food production and security, energy, employment, infrastructure and industrialization, sustainable cities, as well as on addressing implementation challenges and financing” (D’Alessandro and Zulu 2017). Some noteworthy goals of the SDGs, pertaining to this project, include Goal 1, “End poverty in all its forms everywhere”; Goal 3, “good health and well-being”[4]; Goal 5, to “achieve gender equality and empower all women and girls”; Goal 8, “promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all”; and Goal 17, “Strengthen the means of implementation and revitalize the global partnership for sustainable development” (UN 2016). Especially noteworthy for discussions in future chapters is Target 3.1, which includes “Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States” (ibid).

When considering sentiments and effects (or lack thereof) of SDGs in Malawi, we should bear in mind that the SDGs are said to exist in a climate of neoliberal policies, and that important items like trade policies are largely omitted from SDGs—offering support to Moyer’s conclusion that “the age of treatment… is bounded less by time than it is by economics and geopolitics” (Donald and Way 2016; Moyer 2015; Ruckert, et al. 2017). D’Alessandro and Zulu suggest that for sustainable development to be meaningful at this time, new financing mechanism must be developed, and plans will need to account for the diminished role of states—points that those persons whom I interviewed seem to wholeheartedly support (D’Alessandro and Zulu 2017). Taking policy coherence and coordination seriously, Catherine Mann suggests, will require

---

[4] With targets related to maternal and child health, communicable diseases, noncommunicable diseases, responsible use of alcohol, drugs and sex, medical and research coverage, environmental safety

breaking down academic silos and finding ways to more productively distributing resources, rather than seeking to accumulate resources within a given project or disciplinary boundary (Mann 2016). While seemingly nebulous, this goal (SDG#17) may be imperative to progress across the board, as conflicts or inconsistencies between local, national and/or international aims became apparent soon after the MDGs were unveiled, and history has displayed how incoherency handicaps global health efforts (Dohlman 2016; Durand and Scott 2016; Mann 2016; Sambo 2014). Malawians are no strangers to wrestling with these topics. In 1998, Malawi's National Economic Council wrote:

> "It is generally agreed that a miscellaneous group of projects, each unrelated and uncoordinated to a master plan for the development of the economy as a whole, would take a country nowhere and may lead to chaos. In spite of this understanding, the concept of long-term strategic thinking has so far been missing from most development management efforts of countries such as Malawi." (National Economic Council 1998).

Similarly, in the 2012 MGDS II "*expected* that all stakeholder institutions including donors, development and co-operating partners will continue to align their activities and support to this national development agenda, MGDS II" (emphasis mine) (Malawi 2012). Thankfully, this does not require inventing organizations at each scale. Francis Omaswa tells us that:

> "Africa has well-established coordination structures in the health sector. We have the African Union one of whose objectives is 'to work with relevant international partners in the eradication of preventable disease and the promotion of good health on the continent'. The African Union Commission (AUC) has a department and a team led by a Commissioner for Social Affairs with Health Specialists. There are five Regional Economic Communities (RECs), which have active health secretariats for East, Central, West and Southern Africa. There are also two WHO Regional offices in Brazzaville and Cairo. The UN family and other partners in Africa also have a coordination structure known as Harmonization for Health in Africa (HHA) with the secretariat based alongside the WHO African Region. On top of these, there are specialized African health institutions that act as centres of excellence in various fields and are in official relations with the AUC, RECs, and the WHO Regional Offices and routinely play the role of expert resources to these bodies. There are also active African Professional Associations in various health specialties. There are universities, research centers and academies of science with potential to act as additional African resources... [However,] both the good and the bad [coordinating institutions] are all too often undermined and bypassed by international organizations" (Omaswa 2014)

Even if these organizations are not undermined, it may be the case that coordination of technical plans is not enough, as Omaswa (2014) argues that technocrats have let down Africa, as they attend meetings and sit on their data, rather than carrying it forward with the impetus necessary to make changes. **“**Building trust between donors and aid recipients is the key to a productive relationship,” Omaswa suggests, as are “individuals of high caliber who are committed to genuine development… Mutual respect and clear separation of roles and responsibilities” (ibid). We may think of this in Weberian terms: bureaucratic governance is good for some things, but it is indifferent to affective, social or identity-based problems—i.e. the things that build and maintain trust and inspire people to work toward a common goal (Weber 1958). For international development, each may be needed, and it is exploring both.

This general aim of coordinating services across multiple scales has been a focus of medical anthropologists for decades. In 1986 Baer and colleagues advocated a multi-scalar approach to understanding healthcare, ranging from individual to “micro-social” to “intermediate social” and “macrosocial” (Baer, et al. 1986). At the time of writing, Baer and colleagues were fairly radical in their approach to healthcare research, but since then, many scholars in the global community have followed suit, with medical anthropologists turning toward Global Health policies—which are said to differ from “international health” in the sense of global health being *trans*territorial—and expanding their foci to include noncommunicable diseases and cancers (Inhorn and Wentzell 2012). Taking a step back from the issue, Didier Fassin suggests that “global health” offers little in terms of new ideas compared to ‘public health’ or ‘international health’, and he argues that “global” is most often determined nationally or even locally—making local research indispensable (Fassin 2012). These trends in Medical Anthropology have been part of "an explosion of interest in health in Africa in the last 20 years;” however, “this outpouring of good will has… created misunderstandings as well as harmony amongst partners and, sadly, led in some situations to competition and zealotry about aims and methods" (Omaswa and Crisp 2014). Following the lead of Feierman and colleagues, this project seeks to make "local knowledge viable and salient in settings of policy and programme development, practice and evaluation"— facilitating discussions and raising anthropological questions that can move the ball forward (Feierman, et al. 2010).

CHAPTER 3: Setting and Methods

June 15, 2017, Morning Report at the District Hospital

7:35am. I sit up against the back wall, in a white, plastic patio chair, during this morning's handoff. Physicians and more senior clinical officers surround the table in front of me, and students sit in chairs to my left and right. Everyone is silent, except for the night nurse who reads from the ledger for male ward. Four men were admitted last night, one death in the ward, 33 total in-patients.

Most clinicians look down at the table or at their cellphone—some on WhatsApp, some surfing Facebook and the news. My mind jumps from the clinician's report to a rhythm flowing in from the windows. *Thump-thump… woo-eee… Thump-thump… ahhh-eee… thump-thump… woo-eee… thump-thump.* What on earth is going on? I ask myself. Are patients in the Nutrition Ward drumming like this? Is the staff singing in the wards? I have witnessed the staff singing at other facilities, but never at this District Hospital. Is this what the staff do when they don't come to morning handoff? Is there some kind of in-patient ceremony that I am unaware of? *Thump-thump… woo-eee.* It's getting louder. If someone brought a steel drum in here, I think, there must be a community education performance later today—perhaps I will sneak out to see how it goes. *Thump-thump… wee-ahhh… Thump-thump ahhh-woo.* Are they marching through the hospital? How can anyone in this room be paying attention to the ward report with this a clamor coming from outside, I wonder. Am I the only one who hears this, or is everyone else just ignoring it? *Eeee Thump-thump ahhhh.* My brain finally locates the doppler effect of the thumping. They must be coming toward us from down the central hallway. *Thump-thump.* They are right outside of the annex. *Thump-thump ayyy-weee.* They have moved past us. Where have I heard that sound before? Why is it different this time? *Thump-thump ahhhh-wooo.* I feel like I have heard that "drumming" multiple times now. This "drumming" is far from the deep sound of wood and goat skin drums that accompany rural festivals. This "drumming" is much higher pitch.

As the thumping and whaling continue toward the posterior of the complex, it hits me. This is no celebration ritual. The ‘beat’ of the thumping is the result of the combination of the pace at which people walk, the width of poured concrete sections, and the width of the cart—each junction causing a “thump” of the cart that is being pushed. The pitch and amplitude of the “drum” are a function of the ‘instrument’: a metal gurney, loaded with a body, that is being pushed across cement floor to the crematorium located behind the education annex. I had heard whaling at the crematorium most mornings, as whalers convened in solidarity with whomever had lost a loved one, but why did I not recognize it this time? The pitch is different today—much higher than normal.

With all of this noise, I had lost track of morning report until the whalers and stretcher had passed out of the hospital, across the sidewalk and into the mortuary. When I re-enter attention, the nurse was reporting on an adult male with suspected sepsis and meningitis, who was given IV fluids and diazepam. The male ward finishes up their report and it is announced that neither the Female Ward nor Pediatrics will be in this morning, as they are both too busy.

After morning report, I ask a clinician about the sound, why it was different than normal, and she informs me that there was a death in Pediatrics last night. That’s it, I realize; that is why the pitch is different. The small child’s weight barely dampens the resonance of the gurney. I had learned how to discern a tune.

Learning biomedicine, Byron Good tells us, is about retraining one’s senses and learning to perceive the world in new ways, whether that be learning to distinguish tissue types by palpation, learning to visualize tissue in three-dimensions by looking at a two-dimensional image, or envisioning histologic patterns based on auscultation or descriptions of symptoms (Good 1993b). As it turns out, learning about biomedicine also involves entraining one’s perceptions into the sociality of life. On subsequent days, I heard the "drumming" again and was far less puzzled—although no less disturbed. Such semiotics, it seems, cannot be identified, described or analyzed without experience—without 'field work'—and once the 'lesson' is learned, it may be impossible to 'unlearn' this semiotics. The same seems to go for other senses: the semi-sweet smell of dirt and smoke[5] that, by my experience, is uniquely Malawian; or the feeling of walking over a pile of empty rice husks along the Shire River; the sound of minibuses recruiting passengers in the pitch-black morning; or the smell of nsima[6], pumpkin greens and infected wounds that wafts from a ward during lunch. These features help create the reality of biomedicine in Malawi.

Healthcare Network in Malawi

Services at public facilities in Malawi are free for patients—this budget is covered by the national government and donors—and 99% of women and 98% of men across the country do not have private health insurance (National Statistical and Icf 2017). Malawi's public health system is set up as a tiered referral network, whereby numerous rural health centers (roughly 330) feed into district hospitals (24 throughout the country), which feed into central hospitals (4 throughout the country). There are 28 districts in Malawi; not every one has a district hospital, but each district has multiple health centers. With each step up the referral network, there is typically an increase in the training level/credentials of clinicians. Medical assistants work in health centers—these personnel typically have two-years of training after high school. Clinical officers (and maybe a handful of physicians) work in district hospitals. Clinical officers have three-years of training after high school, plus they fulfill an intern year of further training within a hospital.

---

[5] Presumably from the endless chore of sweeping into piles the fallen leaves, flowers and shards of sugar cane pulp that have been spit into the gutter, and then setting it on fire.

[6] The staple starch in much of Southeastern African cuisine, made from corn starch and boiled until its consistency transforms from a liquid porridge to a soft putty.

Central hospitals are staffed by more physicians than any other facility, and central hospitals have the greatest abundance and diversity of diagnostic and treatment equipment.

Public facilities are supplemented by roughly 175 CHAM[7] facilities, and a smattering of private hospitals and clinics. Woven into this network are numerous NGO and research projects, most of which are based in and around urban centers and focus on infectious diseases and maternal health. In addition to these biomedical facilities, pharmaceuticals are sold in public markets, and an assortment of 'traditional healers' practice throughout the country.

Public healthcare is run by the Ministry of Health (MoH), which, as one might imagine, is also organized in a tiered fashion. At the top of the pyramid is the Principal Secretary at the MoH, below whom there are at least 15 Directors—for such topics as Administration, Finance, Human Resources, Clinical Services, Research and Quality—each of whom has a staff and reports to the Principle Secretary. From there, information and plans are integrated at the zonal-level. Each Zonal Coordinator supervises a set of districts. Districts can be loosely thought of as states. Barring vacancy of the position, each district is administrated by a District Health Officer (DHO), who is responsible for coordinating services across the district. In practice, this often means delegating tasks to specific individuals, most notably the District Medical Officer (DMO), who further delegates to 'coordinators', who earn a bonus above their baseline pay. Coordinators manage programs such as HIV testing and counseling, malaria control, and circumcision, and then they all report back to the DHO. Services are also coordinated within each facility. At rural health centers, that responsibility most frequently falls upon a medical assistant—meaning that MAs function like small-scale DHOs. However, the medical assistant also has to see patients—often over a hundred in a day, I am told—so she has little time to fuss over implementation,

---

[7] Christian Health Association of Malawi (i.e. mission-based)

quality indicators, meeting with local chiefs, or generating public health strategies. As one DHO told me in our interview, “most of the [MA’s] time is spent putting out these fires.” In addition to these intra-government coordination efforts, NGOs, researchers, mission-based facilities and non-medical organizations must be integrated.

Research Plan

This project seeks to explore Malawian healthcare personnel’s thoughts, feelings and experiences regarding development efforts, career pathways, job satisfaction, and their practice of biomedicine. To understand how these phenomena look within Malawi’s stratified health care system, a variety of personnel, in a variety of settings, must be interviewed and observed, so that no single group monopolizes the conversation concerning programs, responsibilities, patient care, progress toward development goals, or outlook for the future. Additionally, Malawi’s dire healthcare situation suggests that insights be gained into those areas with the greatest needs. For that reason, the Southern Region was selected for this study, as it is the most heavily populated region in the country, and it is lagging in many social and medical indices, including orphanhood (14% of children in the Southern Region are orphans—one or both parents are deceased—compared to the national average of 12%), educational attainment and teen pregnancy (National Statistical and Icf 2017). Additionally, HIV prevalence in the Southern Region is more than double the other regions (12.8% in the South versus 5.1% and 5.6% in the North and Central, respectively) (ibid). I selected three research sites within the Southern Region, one at each step in the referral ladder: a Central Hospital, a District Hospital, and a set of rural clinics. The diversity of these sites afforded important opportunities to gather information on perspectives, experiences and clinical variability. These locations differ in many respects, including personnel, finances, amenities, resources and workplace culture—differences which represent much of the spectrum of variability throughout facilities in Malawi.

Differences in workplace culture seemed to be embodied in the different ways in which I was greeted at the three organizations. At the Mobile Clinics, I was welcomed with open arms by each of the clinics. I interacted with all members of the organization, and clinicians were eager to share their daily routine, thoughts on clinical decisions, and reflections upon organizational development. At the District Hospital, I was initially treated with relative indifference by those clinicians and staff with whom I interacted, but with interaction and trust, they opened up to me and included me in their social and professional gathering after they understood my intentions. The District Hospital hosted a small number of expatriate physicians who were assisting with a Family Medicine training program, and a group of 'permanent' clinicians who provide Pediatric HIV-related services, along with a host of revolving visitors who perform research, medical outreach, or provide or receive training. At the Central Hospital, I was interrogated by personnel within each department that I visited—who was I, what was I doing there, and did I have the necessary clearance to be there? The Central Hospital had a wide variety of permanent and visiting programs that provide educational services and supplement government programs, And they are rightfully skeptical of visitors' credentials, as I met visitors who were hoping to do good, despite having gotten none of the requisite clearance.

The Mobile Clinics

Figure 2: A clinical officer delivers a "health talk" to patients waiting to be seen at a Mobile Clinic

The Mobile Clinics that I worked in are predominately NGO-funded and administrated, and they offer free care to all patients who present. The NGO is USA-based and was established in the year 2000, for the expressed purpose of helping to breakdown stigmas associated with HIV. Personnel are now making major strides to achieve the 90-90-90 goals[8]. For funding, the NGO fundraises in the USA, and they partner with other international NGOs and DHOs, who share funds or malaria and HIV-associated medications that are provided by the Global Fund. The Mobile Clinics provide out-patient, primary care services to patients of all ages, sexes and genders, and they intend to reach the most remote areas containing the most densely-populated, underserved populations—although the precise location of each Mobile Clinic was decided by a village chief, who was approached by the NGO regarding whether she or he had a need for their services. A result of chief-selected facilities is that Mobile Clinics often operate out of pre-existing buildings that lack many of the amenities that one might expect in a biomedical clinic (e.g. electricity, running water, chairs, tables).

Each clinic is staffed by a four-member team consisting of one clinical officer, a nurse, a nurse aide, and a driver. The Mobile Clinics were designed to operate for 4 hours each day, and

---

[8] The UNAIDS goal to have 90% of the population tested for HIV, 90% of those who are positive on appropriate medications, and 90% of those who are medicated having a suppressed viral load.

to see *up to* 50 patients, although I never saw a clinic serve so few people, as the *lowest* number that I saw was about 150 patients in a day. In the rainy season, Mobile Clinics are known for seeing upwards of 400 patients per day. At the time of this research, there were seven clinical teams, with six of the seven clinicians being males, and each team visited a different village each day of the week (Monday through Friday). Thus, each village was visited once per week, on the same day each week—meaning 35 villages were served per week. Occasionally, additional clinics are held on weekends, so that more male patients can be seen. Male-focused clinics are advertised within the communities in the weeks leading up to their establishment.

These clinics provide an important opportunity to gain insight into the thoughts and experiences of clinicians who serve on the frontlines in some of the most remote areas with some of the highest patient caseloads in the country. Additionally, the diversity of patients (men, women, old, young) and facilities (e.g. with or without electricity or running water) provide valuable opportunities to observe and discuss variabilities in care. Also, the different compensation and supervision structures of the Mobile Clinics, as compared to public facilities, provide valuable examples for comparing personnel's experiences with job satisfaction and career outlook.

Mobile Clinics extend into two districts, each of which borders Mozambique. Communities surrounding these clinics speak predominantly Chichewa and Chilomwe, thereby offering clinicians (who mostly speak Chichewa and English) fluency with most patients. One of the districts in which these clinics operates has a district hospital, while the other does not (this absence is a point of leverage for the 2019 presidential election). Both districts have CHAM facilities and health centers—so patients do, in theory, have other options for biomedical care, although accessing those other services may require that they walk tens of kilometers and pay a fee. It is noteworthy that since the time of my fieldwork, one of the Mobile Clinics has been turned-over to the public network, to be run (in a modified form) by the DHO.

Regarding daily activities, each morning around 7:30am, Mobile Clinic staff convene at one of three locations to have a meeting, load up an ambulance with a table, chairs, diagnostic equipment (thermometer, BP cuff, scale, rapid malaria and HIV test kits, STI test kits) and medications, and then depart, in the ambulance, for a Mobile Clinic. Malawi is known as being a particularly religious country, and once per week, staff pray as a team before they depart. When ambulances arrive at the destination, village volunteers (along with a throng of patients who have arrived early to reserve a spot in line and hear the "health talk") unload the ambulance, gather water, and help set up the clinic. "Health talks" are delivered by the clinical officer or nurse each day, and they last about 20 minutes, focusing on topics ranging from safe storage of medications, to diabetes or HIV prevention. These topics are chosen by the staff. Similar to Ippolytos Kalofonos's and Kenneth Maes's observations, volunteers are not paid, although they are seen as indispensable to the clinics' success (Kalofonos 2014; Maes 2015). Once all of the patients have been seen, staff pack up the ambulance with supplies and return to their office, where they unload their supplies for safe keeping. Ambulances are stored in secured locations in the evenings.

The District Hospital

Figure 3: Entrance of District Hospital (photo edited to remove name)

The District Hospital that I worked in is a public facility (i.e. free to patients) located in a city near Lake Malawi, in an area with a large proportion of Muslims who are known for polygynous, matrilineal families. I note this because Muslims are a minority in Malawi, comprising roughly 14% of the general population. The population of the District Hospital's catchment area is roughly 1.4 million persons. Among those personnel with whom I spoke, district hospitals are notoriously some of the most difficult places to work in Malawi, as they are expected to treat or stabilize anyone who comes in the door. This site therefore provides an important opportunity to observe a variety of clinical interactions and high patient caseloads.

The District Hospital offers both outpatient and inpatient medical and surgical services. Physicians and clinical officers have a rotating call schedule, and, on any given day, many perform a mix of medicine and surgery. Additionally, clinicians may rotate through departments, which include: Female and Male inpatient wards, Obstetrics and Gynecology, Tuberculosis Wards, Nutrition, Pediatrics, Radiology, Surgery, and a host of special programs that operate on specific days of the week (e.g. palliative care, HIV testing and counseling, voluntary male medical circumcision (VMMC)). Additionally, personnel were in the process of establishing emergency/triage services, and they recently began hypertension, diabetes and palliative care clinics. As far as diagnostic equipment, the District Hospital offers X-rays and ultrasound imaging, limited blood work (complete blood counts and peripheral smears), and they have equipment to collect vital signs.

The Hospital is staffed almost exclusively by male clinical officers and physicians, with only two female clinical officers and three female registrar physicians. Perhaps most importantly for this study, this hospital is the hub of a national experiment to train registrar (i.e. resident) physicians in a rural setting, as part of national efforts to increase physicians' distribution throughout rural facilities. Additionally, the District Hospital hosts a number of nurses, nursing assistants, laboratory technicians, dental assistants, pharmacy assistants, medical students, physician interns, clinical officer interns, and nursing students.

Physically, the hospital is designed with a long, central corridor and wards extending perpendicularly. Sea green paint covers the bottom third of the cement walls, and a pale yellow is neatly painted on the upper two-thirds. The floor is concrete, and decades of swept and mopped sand (an endless activity for housekeepers to rid the floor of the city's main sediment) gives the floor a polished appearance—my shoes squeak whenever I walk down the corridor. The hallways between the wards have windows that extend from my waist up to the ceiling, and at the entrance of most wards is a stenciled message, at eye-level, which reads: "HIV OR ANY DISEASE MAY NOT KILL YOU IF YOU FOLLOW DOCTOR'S ADVICE". Out of the windows to either side can be seen women and children laying on colorful zitenji (a vibrant fabric) in the sandy courtyard. At the front of the hospital, running perpendicular to the central corridor is a 35-meter-long hallway that lacks windows and

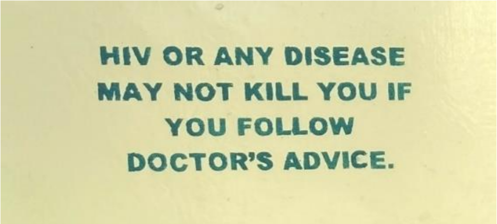

Figure 4: Sign painted numerous times on the wall of the central corridor at the District Hospital

is lit by a single lightbulb, which dangles from wires that have escaped from the ceiling. There is a national campaign to cut back on electricity usage, as Lake Malawi and the Shire and Zambezi rivers are drying up, and with them goes the country's only source of domestically-produced electricity, resulting in days-long electricity blackouts in different regions of the country. This hallway is clearly leading the effort at conservation with its lone LED bulb, I think. Lining each side of the hallway are benches stamped with "USAID" (United States Agency for International Development) and "ART/ANC" (antiretroviral therapy/antenatal care) that are fully occupied by women, children and men.

The predominant languages in the surrounding areas are Chiyao and Chichewa, which occasionally presents clinicians with some difficulties in communication, as only two of the clinicians at the District Hospital are fully fluent in Chiyao. Among the District Hospital personnel I spoke with, this area is known for a general apathy toward formal education, as adult males commonly partake in entrepreneurial activities. Clinicians and administrators working at The District Hospital suggest that they (most of whom are Christians) occasionally feel like 'outsiders' among the wider community (who are predominately Muslim) and have worried about their personal safety.

The Central Hospital

Figure 5: New construction at the Central Hospital (photo edited to remove name)

The Central Hospital that I worked in is located in Malawi's main financial and commercial city, which has a population of over one million people. The Central Hospital is arguably the most advanced medical facility in the country, as it houses numerous Malawian and expatriate clinical and nursing students, has a wide variety of medical and surgical specialists, along with high-tech pieces of equipment (e.g. Malawi's only MRI machine), and a parade of Malawian and expatriate researchers who work in and around the hospital. The surrounding population largely speaks Chichewa, but the catchment area for the Central Hospital stretches across the entire Southern Region and into the Central Region (meaning over 8 million people), so clinicians encounter a variety of languages and cultures. An administrator for the district in which the Central Hospital is located describes the district as small in surface area with a huge population and an adult HIV rate that is nearly double the national average. The city in which The Central Hospital is located was universally described by personnel who work at the Central Hospital as a place where they would like to be—the climate is a little cooler and the mosquitoes are thought to be fewer, as it is at a higher elevation.

During our interview, a Central Hospital administrator shared that this hospital was initially designed to provide only inpatient medicine, but it has had to add outpatient services as well, because there is no district hospital within this district. Physically, the Central Hospital compound is massive by Malawi's standards, with a brick wall extending around the perimeter and a tarmac road that wraps around many of the buildings. Adjacent to the Central Hospital is the College of Medicine (CoM), which is Malawi's only medical school. Outside of the compound, dozens of women and men set up stands to sell chips, candy, fruit and bread, fry potatoes and chicken, and cut vegetables to create a popular salad made of cabbage, tomatoes and vinegar. Walking around inside of the compound but outside of the hospital, one may be struck by the juxtaposition of the beautiful tropical flowers, and the stench of leaking sewage, of the decaying plaster walls on old wards, and the pristine façade of new, donor-funded buildings—and there is plenty of each, as donors selectively support programs at the Central Hospital. Inside the hospital, clinicians bustle about in the wards and in the long, covered walkways between buildings, as patients and guardians stand in the hallways and lay in the courtyards, some on grass, others on dirt or concrete.

Within the Central Hospital, I spent time predominantly in Obstetrics and Gynecology, which I am told is the busiest OB-GYN facility in the country; Pediatrics, which is the busiest department in the hospital; and the Adult Trauma Center, which is analogous to an emergency department and is often the first stop for patients. These departments were chosen for their variety of facilities and practices. Within each of these departments exist a series of wards, such that the surface area of all of, say, the Pediatric buildings, begins to approach the size of the entire District Hospital.

Methods

Given my desire to gain insight into how and why medical services and development activities are understood, carried out, and assessed by clinicians, administrators and students, ethnography was my approach of choice, and my main methods were semi-structured interviews and participant-observation. This study also follows George Marcus's call for multisite ethnography, which seeks to understand the integration of communities and institutions within a broader social network that includes processes of globalization (Marcus 1998).

As Blacklock argues, for some questions, qualitative data allow deeper understanding of personal experiences and may provide evidence for causal links, "which quantitative studies, by their nature, can only imply" (Blacklock, et al. 2014). Open-ended interviews and participant-observation avoid some pitfalls of survey- or lab-based research, whose pre-determined foci may omit subtle distinctions, unforeseen elements, or—as will be discussed in later chapters—propagate conceptual shortcomings (Bernard 2011).

This project was approved by Michigan State University Institutional Review Board and Malawi's National Health Science Research Committee (with support from the College of Medicine and District Health Officers and/or Research Committees within each district). Trips to "the field" were made in May-September of 2011, 2013, 2015, 2017. During the 2011 trip, I worked as a research assistant to Dr Andrea Freidus, on a project that sought to explore the activities and thoughts of visiting medical students, as part of her larger project that looks into humanitarianism and voluntourism in Malawi. 2013 and 2015 trips were for my own preliminary research. During these trips, I further familiarized myself with the setting, made acquaintances, heard about those topics most relevant to clinicians and administrators, and gathered historical background. Beginning in 2017, I began formally collecting interviews and systematically recording fieldnotes.

Participant observation

In 2017, I spent roughly 300 hours observing clinical interactions across the three sites. At Mobile Clinics, this consisted of roughly 70 hours of observations, with a minimum of 75 and a maximum of 150 clinical encounters/patients for each of the seven clinical officers. At the District Hospital, I completed roughly 150 hours of observations with 12 clinicians (clinical officers and physicians); and at the Central Hospital, I completed roughly 80 hours of observations with 10 physicians. At the District and Central Hospitals, I imposed no minimum number of clinical encounters to observe, as numbers varied significantly between departments. Within the District and Central Hospitals, I mainly spent time observing medical encounters and abstained from observing any surgeries. My decision to avoid surgeries was twofold: 1) I was interested in clinician-patient interactions, and when a patient is under general anesthesia, there is minimal interchange, and 2) Scheduled surgeries infrequently occurred while I was at the District Hospital, as they were frequently displaced from the operating theater by Obstetric emergencies.

Prior to beginning observations, I met with the staff at each site to introduce myself, discuss the methods of anthropological research, inquire into their clinical priorities and concerns, ask permission to shadow, and answer any questions that the staff had about me or this project. Extended site visits facilitated sampling when clinicians were settled into their routine and no longer as sensitive to my presence. Additionally, socializing with the staff outside of work seemed to expedite their comfort in speaking candidly about their experiences, thoughts, and plans for the future.

Observations consisted of "shadowing" clinicians as they carried out patient exams, performed procedures, filled out paper work, conducted grand rounds and individualized instruction. Before choosing to shadow any clinicians, I attended meetings and observed group behaviors in an effort to identify those clinicians who appeared to be 'leaders' within each setting. I also took institutional rank into account, rather than strictly professional credentials (e.g. physicians and clinical officers, rather than medical assistants or nurses), as different cadres practiced in each of the three settings. The hope behind this decision was to hear from those persons who have the most insight into clinical matters. Focusing strictly on physicians, for instance, would have precluded observations in Mobile Clinics and curtailed observations in the District Hospital. While my observations focused almost exclusively on medical consults which involved gathering histories, physical exams and formulating or check-up on treatment plans, I also observed pre- and post-operative care and minor procedures, especially in the maternity ward.

I used standard ethnographic data collection methods of taking detailed, descriptive fieldnotes which document the activities of interest and their social and physical contexts. Fieldnotes were taken either at the time of the observations or immediately afterwards, when they were handwritten into a notebook or typed into a computer. In addition to documenting sensory (touch and/or visual) experiences in each clinical setting, I recorded elements of clinical consults, such as numbers of patients seen, clinician and patient age and gender, patients' chief complaint(s), time spent with each patient, tests ordered, treatment provided, treatment that a clinician had *wanted to provide* (if all options had been available), and proportion of workday spent performing different tasks. These methods help illuminate aspects of medical practice and clinicians' lives that are missed in both outcome-based and interview-dependent studies, as real-time observations may reveal phenomena and patterns that clinicians do not, themselves, reflect upon, thereby uncovering aspects of practice that the researcher had not foreseen. Additionally, observations were made of patient traffic and "front-end" staff, as they check-in and triage patients, record vitals, and dispense medications. These non-clinical observations were critical for understanding what happened within clinical consults.

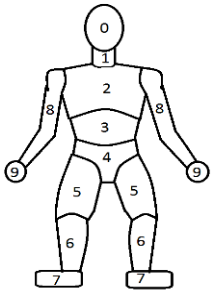

Figure 6: Regions distinguished by touch code

In addition to these standard participant-observation techniques, in an effort to gain additional insight into the variability of examinations and expressions of affiliative behaviors (Field 2014) between clinicians and patients, I operationalized my study of interpersonal touch and gaze by modifying and supplementing a coding scheme that was developed by Jourard (1966). I divided the body into 15 segments (10 parts, with some bilateral) (see illustration at left) and recorded all interpersonal touches which took place within clinical interactions. In addition to tracking where persons were touched and how many touches occurred, I recorded the sequence and simultaneity (indicated by underlining or groups of simultaneous touches) of touches and a host of associated details (example tables below). This information was used to triangulate other observations and interview data.

Touch Initiator			Orientation of clinician to patient			Location of Touch			Touch Type	
C	Clinician		F	Front/head-on		A	Anterior		Palp	Palpate
X	Patient		B	Back/behind		P	Posterior		Per	Percuss
M	Mutual		S	Side/next to		R	Right		Mob	Mobilize
						L	Left		Stab	Stabilize
									Rest	Rest hand

Table 1: Features distinguished by touch code

In some instances, such as in a hypertension clinic, clinicians did not regularly touch patients, rendering the touch code relatively useless for those consults. For those cases, I developed and tracked a ternary code for gaze within each consult, as gaze within clinical interactions has been shown to be an additional index of affiliative behaviors (Street and Buller 1987). The code consisted of three mutually-exclusive options: 1) At some point in the encounter, the clinician and patient shared eye contact; 2) At some point in the encounter, the clinician glanced at the patient, but no apparent eye contact was made (such glances were often at a part of the patient that was not located on the face); 3) Encounters whereby the clinician did not even look at the patient during the consult. These observations were used to supplement interview and other observational data.

Interviews

The goal of interviews was to gain insights into healthcare personnel’s thoughts on development efforts and career prospects within Malawi’s healthcare system. Additionally, I wanted to learn how they think about clinical interactions and specific patient populations—in effect, I wanted to see how Malawian healthcare personnel think about the multiple-layers of analysis that frequently go into anthropological studies. Semi-structured interviews were chosen to provide informants with maximal opportunity to share their unique perspectives and experiences related to the topics under investigation. Interviews were conducted in English with a purposive sample of clinicians and health care administrators, and a snowball sample of medical students. Each interviewee was fully fluent in English, as is common among educated Malawians. Specific questioning strategies were developed in the early stages of the project, and then revised in an iterative process throughout the project, as new information was gathered and institution-specific issues became apparent. All subjects were permitted to answer as extensively as they would like.

	Total Number	%
Participants	33	
Facility		
Mobile Clinic	10	30%
District Hospital	9	27%
Central Hospital	8	24%
Student (COM)	6	18%
Job Title		
Physician (clinician)	9	27%
Clinical Officer (clinician)	10	30%
Physician (Administrator)	6	18%
Nurse (Administrator)	2	6%
Medical Student	6	18%
Sex		
Female	7	21%
Male	26	79%

Table 2: Demographic Information of Interviewees

Interviews lasted an average of just over 72 minutes, with the longest lasting just over 180 minutes, and the shortest lasting just under 33 minutes. I interviewed at least six clinicians from each of the research sites, along with six total medical students, and six total administrators, as six has been shown to suffice for nonprobability sampling of knowledgeable informants regarding inquiries into well-defined cultural domains (Bernard 2011). Additionally, 33 total informants fits well within the standard of "30-50 interviews for ethnographic studies," although it has been argued that a well-designed ethnographic study can be done with as few as 10-20 knowledgeable persons (ibid). As H. Russell Bernard argues, "in-depth research on sensitive topics requires nonprobability sampling," which he characterizes as "informed informants, not just responsive respondents" (ibid).

I selected participants from each research site and its corresponding administrative office, if the office was off-site. I interviewed all seven clinicians at the Mobile Clinics. I interviewed two of the three Mobile Clinic administrators, plus a DHO from one of the districts in which Mobile Clinics operate. I chose these administrators because they are the most experienced and senior positions within the NGO that runs the Mobile Clinics. I chose the DHO because I wanted to gain better understanding of how Mobile Clinics fit into the surrounding healthcare network. I had gotten to know most of these personnel during each of my previous trips, so they were relaxed around me. Furthermore, I created this project with some input from the NGO regarding which problems they find to be most relevant, so they were eager to participate.

I purposefully selected interviewees from the District Hospital following weeks of observations in meetings and around the wards. As was the case with observations, I selected clinicians based upon their institutional roles and their personalities—I sought those who spoke up in meetings or displayed leadership qualities. Additionally, because of the District Hospital's unique position as a training facility for registrars, I sought registrars who were based at the District Hospital. While the vast majority of providers at the District Hospital are males, I felt it important to include a female perspective, so I intentionally recruited one of the female physicians. The District Hospital does not have specific 'hospital management', so I chose administrators based upon their combined position within the district and the hospital. In this case, I interviewed the DHOs (there was turnover during my stay) and the DMO. These are the most senior-ranking medical administrators in the district, and each has direct responsibilities for the District Hospital.

I followed the same sampling guidelines at the Central Hospital as at the District Hospital, although the size of the Central Hospital precluded my observing any hospital-wide meetings. Instead of observing how all clinicians interact together, I observed how clinicians interact within each department before I approached informants to request observations and an interview. The Central Hospital has a more even distribution of the sexes, so I intentionally interviewed half men and half women. The administrative structure of the Central Hospital is also different from the District Hospital, as the Central Hospital *does* have specific ‘hospital administrators’, *and* the Central Hospital has separate administrators for the district in which the hospital is located. In order to gain insight into the functioning of the hospital, itself, and the hospital within the broader healthcare network, I chose to interview a senior hospital administrator and the DHO.

The final group I interviewed were medical students at the College of Medicine. By interacting with students in the wards, it became apparent that their insights into the healthcare system were more tightly circumscribed to their activities in medical school. I selected the first student I interviewed because she displayed those pro-social and leadership qualities that I looked for in providers. Subsequently, I employed snowball sampling to interview medical students on campus, with special attention to interview at least one female student.

All interviews were conducted in English. To begin each interview, I sought to establish rapport by asking each informant about her personal path to her position. Subsequently, I asked about daily activities at her place of work, about career pathways and job (or school) satisfaction, and then I completed each interview with general questions about Malawi's national healthcare system and informants' perspectives on development efforts—which efforts they have participated in, what they feel are some successes and failures, and what they think should be done moving forward. Regarding daily activities, I asked students about their experiences in medical school and in the hospitals, as well as their outlooks for their careers. I asked clinicians questions about the nature of their job, the relationships that they form with staff and administrators, what they think goes well or poorly for them clinically, and how they interact with patients. I asked administrators about their participation in policy construction, facility evaluation, interactions with clinicians, patients and the broader community. It is worth mentioning that none of the persons with whom I spoke worked within the Central Ministry of Health (MoH), so they were all 'peripheral', to some extent—meaning that they have limited experience with how the Central MoH constructs policies or determines budgets, so they were left to speculate based upon their own experiences as outsiders. Those persons who shared that they had participated in national and international planning came primarily from the NGO or District and Central Hospital administration—this latter group were physicians by training, contributing to a situation whereby physicians, who constitute a minority of clinicians in Malawi (compared to clinical officers and medical assistants), have a more prominent voice in policy construction. Of those clinical officers with whom I spoke, only those who serve(d) on a specific committee within the District Hospital were involved in national planning meetings, in the context of joining a District administrator at national meetings[9].

Thanks to preliminary research visits, I had a firm understanding of local cultures and vernacular, such that I was able to gain insight into my topics of interest—and to elicit

---

[9] For example, such committees exist for Voluntary Male Medical Circumcision (VMMC) and HIV Testing and Counseling (HTC).

information on *their* topics of interest. Specific questioning strategies were developed for interviews and revised in an iterative process throughout the project, in order to permit exploration of unforeseen topics and emergent patterns. Examples of topics that proved to be more important than I had realized going into the field include national decentralization and various notions related to brain drain. All informants were permitted to answer interview prompts as extensively as they would like. This method has been validated in both anthropological and health care improvement literatures (Bernard 2011; Provost 2016). Throughout the study, the researcher reviewed responses to all interview questions to assure they obtain the intended information, and items were added, reworded, refocused or deleted as appropriate. Interviews were tape-recorded and transcribed.

Data Analysis

Data analysis was ongoing throughout the study. I began Initial analyses in the first weeks of data collection, as I listened to audio recordings, created interview summaries, and reviewed fieldnotes. As data analysis progressed, I discussed findings with participants in order to gain further insight, correction and/or clarification. I predetermined some themes and adopted others as trends emerged. Once I completed all interviews and observations, and I had returned to Michigan, I sent interviews to GoTranscript for transcription, after which I proof-read each transcript.

As I received transcripts, I sorted and coded them using Dedoose, a software package for analyzing qualitative data. I created 217 codes—many of which were nested—and applied them 1828 times to facilitate the identification and analysis of themes, as well as to make sense of underlying logics between themes. Next, codes were reorganized into hierarchies to make sense of all identified themes, and all excerpts within each theme were reviewed to identify additional patterns. Throughout this process, themes were condensed, combined, split, pruned and compared to the literature and field notes, in an iterative fashion.

I used observational data to both supplement and lead analyses and descriptions. Operationalized variables supplemented fieldnotes and interview data regarding facility planning, “successes” and “failures,” as well as insights into clinician-patient interactions. The analyses of these variables were both thematic and statistical. For example, I calculated a simple prevalence of different types of clinical gaze within a hypertension clinic, and I noted trends in interpersonal touches between clinicians and patients of different ages.

Finally, comparisons between sites facilitated the identification of themes and analytic categories. In total, data from interviews, fieldnotes (operationalized variables and general descriptions) and literature were used to corroborate one another and situate practices and policies within their broader, historic and cultural contexts.

Note on Style

Physicians, clinical officers, students and healthcare administrators compose a small, tight-knit community in Malawi. I asked each person about personal and potentially-controversial topics. In order to protect those persons who so graciously allowed me to spend days and weeks with them in clinical settings, and those who agreed to sit down with me for an interview, I made some efforts to conceal identities. Perhaps most obviously, I use pseudonyms throughout this dissertation. In some settings, there may have only been one female or male who could have fit the category of which I speak, thereby giving away the informant’s identity; thus, I try to neutralize this identifier. Outside of explicit discussions of sex and gender, I use the pronoun “she” in all cases, to protect the informant’s identity, and to break from the trend of defaulting to male. Where I felt it to be relevant, I specified in which facility and department a clinician works—for instance, if responses regarding supervision differ markedly between facilities, I note the how the trend varies per facility—otherwise I omit this information, to conceal identity.

CHAPTER 4: Developing Notions of Development

“There's such a critical shortage of human resource. *It’s killing people*. I want to say it’s crippling the system. It’s killing people. There are deaths that are directly or indirectly due to the lack of human resource. I think more could have been done. I really feel like the life of a Malawian, sometimes it's like it’s equivalent to a life of a fly… If I don’t manage my drug budget well, or I don't remember to buy anti-rabies, a kid gets bitten by a dog, comes to the hospital, there'll be no anti-rabies. They can’t afford to go anywhere else. That kid dies. Within that situation what was his life worth? *He's not even a statistic because our system doesn't even record that death.* It’s so messed up. It's not even a statistic. You look at American Black Lives Matter and all these things; they always say, ‘an African-American black man is just another statistic! I don’t want to be another meaningless statistic!’ Malawi is at another level. Some people are not even statistics… *A Malawian life just has to matter*. It has to matter.”
--District Medical Officer (2017), from interview

“Diversity is essential in spite of the fact that it precludes universal acceptance of a single gospel. And if individuals are to retain that measure of initiative and flexibility which they ought to have, they must not be all forced into one rigid mould”
--Bertrand Russell (1969), *The Autobiography of Bertrand Russell,* Postscript

Morning Rounds: *28 of June, 2017*

Following morning report at the district hospital, at 9:30am, I head off to find Mphamvu, a senior clinician in the male ward with whom I had dinner the previous night. We greet one another with smiles and chat about his 5am workout at the local gym. He had skipped morning handoff—a common practice at the District Hospital—and is already busy aspirating a septic knee and disposing of its putrid, pinkish contents into a small, red bucket that is otherwise used for building maintenance. This is the second time that I have seen this exact bucket used for such a purpose—the previous time was to collect the pleural fluid from a man with Pott’s disease (he had fluid in his chest cavity that likely developed from tuberculosis in his spine). The man with the septic knee has been in the hospital for seven days, having been sent from the over-crowded prison a couple blocks away. He is HIV-positive but off treatment “with no reason,” Mphamvu tells me—a frustrating situation that Mphamvu has come to expect. The patient will be re-started on ART (antiretroviral therapy), and his antibiotics are continued.

We head to the next patient in the adjacent bed, a young man with acute-onset confusion and a ‘sterile’ lumbar puncture (a culture of his cerebrospinal fluid did not grow any bacteria) who had stopped taking his ART “long ago”, for reasons that neither Mphamvu nor his mother knows. His mom sits on the bed next to him, fanning him with a handkerchief as he lays asleep, his dark skin glistening with sweat. After Mphamvu addresses his issues, we walk over to the lab, to check on the results of a patient’s MRDT (malaria rapid diagnostic test)—it is positive, and the patient tells us that he received a single dose of medication rather than a full course; time to restart it.

Each of these patients is suffering from an infectious disease (tuberculosis, malaria and likely HIV or CMV, respectively), as is common in Malawian hospitals and deservingly attracts international attention. Their situations are dire, but they have a decent chance at survival thanks to numerous local, national and international efforts, and the dedicated care of guardians and hospital staff.

Onward we move, from patient-to-patient, and at 10:22am a student training to be a clinical officer intercepts us and calmly tells Mphamvu that a very sick patient has just arrived. Mphamvu diverts our path and walks over near the entrance to the male ward, where a gaunt man in his fifties is laying supine in a hospital bed, surrounded by his wife, son and brother. Another clinician tells us that the man had been suffering from confusion since yesterday, and then fell unconscious last night, so his family brought him in this morning. Mphamvu notices that the man is coughing, tells me that he suspects aspiration pneumonia, and decides to move the patient into the side bay, so that he can receive oxygen. We scramble to rearrange patients and retrieve necessary equipment from around the ward. Mphamvu drags an IV pole into the side bay, and, with help of the student, props the patient onto his side to avoid (further) aspiration.

The student wraps an automated blood pressure cuff around the patient's right arm and tries to get a reading (he cannot, presumably because the patient's blood pressure is too low). Mphamvu puts an IV line into the man's left arm, starts fluids, and checks the patient's blood sugar: 280, which is especially high given that the man has not eaten since yesterday. No fluid is flowing through the IV tube, so Mphamvu ties a glove around the patient's arm, to accentuate his veins, and methodically puts in a second IV line.

The family stands silently at the foot of the bed, the student and I along the side, and Mphamvu sits on the mattress, examining the patient. "No vitals," Mphamvu says in English, his eyes fixed on the bed and his face showing no emotion. He glanced up at me and flicks his head, signaling for me to check. I feel the patient's right radial pulse and whisper "52", then, realizing that cannot make sense (if his blood pressure is very low, his heart rate should be fast, to compensate for low blood flow), I check his brachial artery: nothing. I check his carotid: nothing. "I got the same," I whisper, as Mphamvu's large, dark eyes stare intensely back at mine. Stoically, Mphamvu gets up and sits on the neighboring bed to squarely face the family. He asks about the patient's personal information and recent history, as the student feverishly scribbles into the patient's chart. Once sufficient information has been collected, Mphamvu tells the family that the patient has passed away, and the family breaks into tears—the patient's wife exits the ward and heads into the central corridor, where she begins wailing and is soon joined by others, who wail in solidarity. The patient's son leans forward onto the bed railing, lowers his head and cries, while the patient's brother pulls out a red blanket, covers the patient and tightly tucks-in the blanket around the patient's body, crying throughout the process. The son silently walks to the door, touches the handle, lets go to wipe his eyes, takes a deep breath, and then opens the door and leaves the ward.

Mphamvu silently removes the nasal cannula, tape and IV line. “I don’t know what else we could have done,” he whispers to me. “Yeah,” I respond, “looks like you did all that you could.” “Yes,” he responds, “they said that he was vomiting last night. I should tell the nurses… I just want to end my day now.” We leave the room and turn toward the nurses’ office, when Mphamvu is intercepted by a man with a distended abdomen who asks if he can be seen now. Mphamvu emits an exhausted chuckle and responds, in a soft voice, “we will help you soon,” as he side-steps the man and is intercepted by an elderly man who requests that Mphamvu sees his son in a side bay.

Thanks to steadfast efforts of people like Mphamvu, critically ill patients in Malawi have a chance at survival that would not have been possible 15-years-ago; however, healthcare in Malawi continues to change, and, as with other developing countries, increased recognition of noncommunicable diseases gain is shining light on a “double burden” of disease in developing countries, whereby populations are beset with high burdens of both infectious and noncommunicable diseases (Price, et al. 2018). Such processes reflect historic and current condition in Malawi, and they shape the ways that communities and healthcare personnel conceive their experiences. While emergencies are triaged on the wards, debates linger in far-off offices about whether global health is “good” or “bad”; whether plans should be “grass-roots” or “expert-driven”; or what should qualify as “development” (Lock and Nguyen 2018; Martinussen 1997). Rather than organize this chapter along the lines of these debates, I aim to explore topics of development as they are conceived by those Malawian personnel whom I interviewed and spent time with in the hospitals and clinics.

When I asked administrators, clinicians and students for their general assessment of development of healthcare in Malawi, they did not mention anything about ‘modernity’ or ‘dependency theory’; rather they responded in ways that can be loosely separated into two camps: 1) a focus on quality of care, and 2) a focus on the ability of various governing bodies and organizations to implement plans and ti meet the desires of patients and staff. I will begin by discussing the former, move on to the latter, proceed with a discussion of the most popular policy among those personnel whom I interviewed and talked with, and then bring the argument full-circle with a discussion of quality of care.

Notions of Quality and Development

As with notions of “development” or “sustainability,” when we speak on quality of care (QOC), it helps to know if we are all talking about the same thing. The WHO defines QOC as “the extent to which health care services provided to individuals and patient populations improve *desired* health outcomes” (emphasis mine), thus making it clear that QOC is a normative concept (WHO 2018). In light of how QOC *by definition* varies with desires, we may reasonably expect that studies into QOC have taken place broadly throughout the world, so that development plans can be crafted accordingly. Unfortunately, a WHO-GHWA report notes that QOC is “either ignored or sits at the margins of discussion” in developing countries (WHO 2014). Accordingly, my aim in this section is to sketch how these Malawian healthcare personnel conceive of QOC, and how they feel that it interfaces with national and international activities.

Part of the opacity involved in discussing QOC in developing settings is that it is unclear at which level it varies—by country, facility, specialty of practice, or individual. To get a sense of this scalar component, I informally talked with personnel in each hospital and clinic where I spent time. In those informal conversations, personnel spoke of QOC in terms of outcomes, efficiency, accessibility of necessary materials, and correspondence between patient and provider ideals (i.e. ‘giving patients what they want’ and ‘doing our job like we want’). Additionally, during interviews, I asked informants about how they thought of quality of care. Once again, I heard a variety of responses, which can best be summarized by a registrar at the Central Hospital who replied that "quality of care depends on which side you look at it from"—a response that, when considered with the set of diverse interview responses, seems to suggest that QOC may not be a 'cultural' or 'national' variable, but rather a much more idiosyncratic concept that varies with personal experience and the institutional priorities. In addition to those QOC items mentioned during casual conversations in the wards, interviewees suggested that QOC includes greater qualifications of providers who are treating patients, and a wider spectrum of ailments that can be treated at a given facility, which would have been unmanageable in the past. For example, that same registrar at the Central Hospital whom I just mentioned shared that, "when I was an intern, I would be on call alone… just one or two interns," whereas now they have "all levels of care: intern, registrar, the senior registrar and then consultant—everyone being around and helping out." She suggests that this change has brought about greater QOC, although she doubts that such improvements are already visible in national outcome statistics.

Because development implies a passage of time—starting as one thing and *developing* into something else—I (arbitrarily) posed 10-years-ago as a reference point and asked interviewees to judge current QOC in comparison. Somewhat to my surprise, when talking about *changes* in QOC, responses showed less variation, as informants expressed pride in that some national statistics have improved (e.g. maternal mortality), or, alternatively, suggested that QOC has actually gotten worse, on account of rapid population growth that is out-pacing investments in staffing and facilities. Looking at changes in Malawi's population growth over the past decade, we see a 35% increase in population with 12 additional years of life expectancy at birth (Bank 2016). That said, interviewees backed up their references to national statistics with reference to their experiences in the wards. For instance, during our interview, an administrator at the Central Hospital shared:

> "You have seen inside the hospital; the walls are still congested because they are still the same size that we had maybe 20 years ago. The population has increased and people want to access the tertiary services, and then you get so much congestion, and from time to time the infrastructure will break down because it is old. We have not improved the infrastructure in sync with the development of the health workers in terms of having specialists, or even in sync with the increase of the population."

Similarly, when I asked a physician (who lauded increases in quality of care thanks to the availability of more specialist clinicians) about whether working *conditions* had changed along with increases in QOC, she replied, with a laugh, "no… the working conditions are still the same old ones"—and then, ironically, she swatted at mosquitoes that were buzzing around her office.

Along with concerns surrounding population growth, during our interviews, clinicians and administrators suggested that a growing recognition of NCDs (e.g. hypertension, diabetes and some cancers) is bringing new challenges to delivering quality care. During our interviews, I asked personnel at each facility about what, in particular, made NCDs so challenging. They mentioned four socio-institutional trends that hampered them in providing high QOC for NCDs: 1) personnel have not been taught about the latest NCD guidelines; 2) facilities lack diagnostic and treatment modalities; 3) facilities do not adequately keep track of or incentivize the treatment of NCDs; and 4) donors are uninterested in funding programs aimed at the prevention or treatment of NCDs. In this context, NCDs were repeatedly referred to by clinicians as "neglected"—a conception that seems especially unfortunate given that the region must already deal with a set of "neglected tropical diseases" (i.e. a set of diseases specific to the ecology of the tropics). Experiences like Mphamvu's, in the opening vignette—whereby she was left feeling helpless in the face of a catastrophic outcome that likely stemmed from diabetes—help us to understand how, on a personal level, growing recognition of NCDs can affect perceptions of

QOC. In such instances, personnel must face an unfortunate situation that *these* neglected tropical diseases (i.e. NCDs) often present acutely, thereby highlighting ways in which what qualifies as a “chronic” or “acute” ailment varies with place and time.

In Malawi, growing recognition of overcrowding and NCDs has been accompanied by calls for improved primary care services. The Ministry of Health (MoH) and College of Medicine (CoM) have responded by creating a Family Medicine registrarship program, whereby physicians can earn specialty training in Family Medicine, and they will then be deployed into district hospitals, with the hope that they will stem “referral bypass”, whereby “people seeking medical services avoid clinics, due to the poor quality of infrastructure and the shortage of medical workers, drugs and medical supplies” and instead access secondary and tertiary care centers (the Malawian government estimated that 85% of patients treated in secondary and tertiary care centers could be handled in a primary care setting) (Malawi 2002). This registratship training is happening at the District Hospital, so I was able to interact with and observe the registrars in and around the hospital. Unfortunately, these registrars expressed doubts during our interviews regarding whether their training is up to par, because they lack adequate supervision, integration into the hospital, and material support, and questions linger regarding whether clinical officers should be the ones receiving Family Medicine training, rather than physicians. An administrator for the Family Medicine training program shared during our interview that:

> “What I find most troubling is the fact that we are moving slowly in terms of having people to change mindset, to know that the primary care settings are the most needed… Things don't happen in tertiary levels. They happen here… even at our medical school, we train our students for hospitals. We don't train them to be able to function and integrate in these kinds of settings.”

In Mobile Clinics, on the other hand, clinicians complained during our interviews that administrators were still deciding if and how they should approach NCDs, as the clinics offer a limited number of antihypertensive medications, no testing or treatment for diabetes, and no screening or treatment for cancers. Mobile Clinic administrators expressed during our interviews that they were working with district health administrators to figure out which services to provide.

Finally, within interviewees and casual discussions (group and one-on-one), clinicians and administrators suggested that continued popular support for traditional healers (THs) may be hampering QOC. Those who spoke of this impact focused on two mechanisms: 1) THs delay access to biomedical care, especially regarding prolonged labor, and 2) traditional medications can directly harm patients, as herbs are not dosed according to precise measurements. For female patients, clinicians at each facility casually implicated traditional healers in cases of botched abortions and septic uteri. Especially at the District Hospital, clinicians often suggested that male patients with cirrhosis had likely ingested traditional herbs (implying that the herbs had caused their cirrhosis). Additionally, at each facility, elderly patients were suspected as having visited traditional healers for body aches, and pediatric patients were suspected to have been taken to traditional healers for changes in mental status or seizures. Differences regarding gendered- and age-based-treatments will be discussed at greater length in Chapter 7.

Moving Past the Sustainable Development Goals (SDGs)

Building from interview discussions of QOC, and hoping to gain some insight into goals for the future, I asked personnel about their outlooks for the next decade—what *will* be done, and what *should* be done. Somewhat to my surprise, all interviewees—at each facility—expressed hopefulness toward the future of Malawi’s healthcare system (not to be confused with hope for their own, personal futures, which will be discussed at greater length in Chapter 5). As one DHO shared during our interview, “we have problems, but I think there are more opportunities which we can take advantage of.” Another DHO told me that “we have always been hopeful because we've actually seen the potential. There’s a younger generation of physicians who now know people. We have been there talking about things, issues that people have always wanted to discuss, but no one has ever discussed it." I ask her what it was about this up-coming generation that made her feel as though it was more likely to succeed, and she proposed that increasing numbers of physicians was bolstering collegiality, whereby "the focus is changing from me against you, to you and me against them." This point is worth repeating, as it encapsulates many of the responses that I heard during interviews: these personnel express trust in the individuals around them, but—as will be seen, below—they do not necessarily trust healthcare institutions, nor do they trust that individuals have control of their own futures. A DMO echoed this sentiment in our interview, drawing a biblical metaphor about the new generation being the new wineskins for ushering in a better future, and she added that personnel "need to be given opportunity to influence… [so that] the country will move forward, and then all the [Malawian] expatriates will come back, will work, and build the country." Ironically, this person has since left Malawi (contributing to a cycle of brain drain that will be discussed more in Chapter 6).

In posing the question to personnel of what they think should be done moving forward, my expectations were that responses would be split between two groups, in accord with Keshavjee's arguments about the prevalence of debates between quality and quantity of healthcare services (Keshavjee 2014). Thus, I expected that responses would be split between: 1) those interested in prioritizing expanded services to more people, and 2) those interested in prioritizing higher quality services for those people currently served. However, my expectations were incorrect, as interviewees expressed a much more integrated understanding of the quality and quantity of services. For example, during our interview, a clinician working in a district hospital set quality and access within the same equation, in that she suggested that "the quality factor depends on how accessible are the health services," as many people must walk tens of kilometers to reach a facility, and they must frequently leave before dawn to get a spot in line. However, interviewees suggested that the Central MoH sees things differently. For instance, during our interview, a DHO shared "I feel like [the government doesn't] value quality; they are more quantity over quality… You need to see 1,000 people? That's fine, but how am I doing on the 1,000? That's a different story… [and coming to terms with this imbalance] is a pill which it's going to be hard to swallow, but some people need to know, and some people need to work on it." That said, a national "Director of Quality Management" position was recently created within the Central MoH, and it was filled by a person whom, I was told by an administrator, is focusing mostly on infectious diseases. In contrast to what was described as goals for "government", interviewees frequently noted that they would like the balance tipped toward quality, if that meant adequate supplies, more staff, reliable electricity, and facility-based care rather than mobile clinics. It is also noteworthy that each medical student I interviewed reported that her education had not included anything on quality improvement processes, and each DHO reported that formal quality improvement processes were not discussed in the district. Nevertheless, interest in formal quality improvement measures was shared by all administrators whom I interviewed, with some referencing buzzwords like "implementation science" and "systems strengthening."

As discussed in Chapter 2, the SDGs are the latest iteration of large-scale, international efforts aimed at global development, and while academics and policymakers have debated at length about the merits and demerits of these plans, the views of Malawian healthcare personnel—especially clinicians—have gone unexplored (or at least unshared), leaving a critical vacuum for understanding how these plans are interpreted and acted upon by local personnel. I asked each interviewee about her thoughts on the SDGs, with the hopes of learning about how institutions have adapted to the new development scaffolding. The short answer regarding what these personnel thought of SDGs' impacts is: thus far, not much, and certainly not as much as the MDGs. One of the more internationally-oriented persons I interviewed, an administrator for the NGO, shared during our interview that the MDGs and 90-90-90 goals[10] will continue to guide their operations, but the Mobile Clinics will alter their practices (in unspecified ways) to align with SDGs.

Clinicians I interviewed were less interested in discussing the SDGs and more interested in discussing their daily practices, career prospects, and specific issues. That said, some did provide general commentary on the SDGs, which included calling them "quite generic" and suggesting that the SDGs' lack of country-specificity will lead to greater disparities, as wealthy and poor countries will shoot for the same goals—which one interviewee suggested was not fair—and that there is little actionable langue in the SDGs regarding international support. During our interview, a physician from the District Hospital suggested that the SDGs may follow the path of previous international declarations, which may not be saying much:

> "I'm only *hoping* that we'll be able to achieve them because, for example, some of them to do with the health and things like that, looking at how the health system is funded in the country, you tend to wonder whether we're going to be able to manage those. Even when you talk of the Alma Ata Declaration, where people decided that the national budgets should be not less than 15% to go to health care, and you come and the budget is disbursed, and it's only 9.9%, and yet that's where we need more money to be pumped in… On the other hand, I think as a country we've really tried to improve—for example on HIV and AIDS, we've done quite good. I think we're one of the countries that people admire… Many countries have come to learn from us."

In speaking of these large-scale development plans, interviewees overtly expressed a sense of distrust of national government personnel, with one clinician suggesting that "Malawi is

---

[10] This goal was posed by UNAIDS to get 90% of people living with HIV to know their status, 90% of those people to be on proper treatment, and 90% of those people to be virally suppressed, by the year 2020, in order to 'end' the epidemic by 2030. This agenda will be discussed at greater length in the following chapter.

just like other African Countries: mostly, the development of the countries is dependent on the national politics, because if a president is in disagreement with the donors, then the donors pull out, Malawi suffers. When the donors come in, at least we are a bit level.” In the context of sustainable development, interviewees were willing to (categorically) critique international NGOs on the grounds of short funding cycles, unreliable interventions, and high turnover of projects and personnel, leaving Malawian personnel feeling insulted and betrayed. For instance, a physician at the Central Hospital asked, “Why should you bring in a different level of care or give more opportunities… when you're not going to be able sustain it—that you're only going to give it for two months, or maybe six months or a year, or however long your study or [project] is happening, and then when you're done with it you just disappear and everything goes back to status quo?” She then answered her own question with “You haven't really done anything. You have done something for your own means. You have got your end, and now you're back [home].” Regarding the activities of international NGOS, another physician whom I interviewed spoke of “incentive-based initiatives,” whereby a hospital was told to hit certain targets (e.g. immunization rates), with each success being converted to a monetary value that could then be used to ‘purchase’ necessary equipment. Unfortunately, the physician told me, the donor did the actual purchasing and ended up cutting corners by providing substandard equipment. The worst of these stories involved the procurement of a generator for the District Hospital (an especially important item for nighttime surgeries, like C-sections) that “took a year just to get,” and then “when the generator came, it wasn't even a new generator, it was some busted old generator that had been working for years, and if you look at the price that they had quoted it was so high.” I was told that the hospital returned the generator, and the NGO reacted with astonishment that the ‘entitled’ staff had rebuffed their ‘gift’. Additionally, interviewees spoke of donors taking over existing projects, injecting finances to improve outcomes, and then departing: **“**You find the moment that partner goes, their program dies,” a physician told me. Thus, what had been a semi-filled domain (as public services were providing some services) was left totally empty.

In light of such criticisms, it may seem reasonable to suggest that that “donors” and “partners” should remove themselves altogether; however, that route was not supported by any of the personnel with whom I spoke. Rather, a popular desire was for NGOs to work more closely with local administrators. For instance, one physician suggested during our interview that NGOs’ funding and planning should be funneled through the district, so that the salaries of all personnel—both government and NGO—can be equilibrated and all programs can integrated. A DHO suggested during our interview that such a dramatic change will not happen because **“**if [NGOs] come through the ministry, that means they’ll undergo as much scrutiny as I do [she laughs]. Most of them are not willing for that to happen.” An administrator for the NGO-run Mobile Clinics, on the other hand, suggested during our interview that NGOs seek independence because they do not want their successes to be attributed to other programs’ activities. As selfish as this may seem (and the NGO administrator criticized it as such), such desires are not baseless, as each DHO told me that she will “chase” NGOs from the district if they are not hitting their numbers or having some other kind of deliverable, and if results are not clearly attributable, ‘evidence’ may be hard to produce.

Concerning Coherence and Coordination

8:30am at the District Hospital, a soft-spoken physician gives a wide-ranging presentation on “Integration of Chronic Disease/Care” to thirteen clinicians during morning report. The presenting physician describes differences between horizontal and vertical interventions—with the latter being heavier on research, specificity, defined timelines, and more characteristic of the interests of international organizations; and the former as extending across disciplines and generally operating across longer timelines—and concludes that the two approaches are "not mutually exclusive; they complement each other," with vertical having a tighter relationship to national and international bodies, and horizontal having a tighter relationship to local planners and providers. Indeed, she suggests that it would be *inappropriate* for plans to be fully coordinated at the international level, as when viewed from that level, only abstractions can be known. One must *be* local to understand what is happening locally, she suggests. Disadvantages of acting through local, horizontal organizations, she suggests, include issues with transparency for the general population, as such interventions often involve less discrete metrics than vertical interventions. She also warns that an integrated approach may further weaken programs within a weak system.

The presentation sparked a lively debate among the clinicians in attendance. Some people suggested that the hospital infrastructure must be improved before any significant integration will be possible (e.g. improved sewage system), while others located the heart of problems in the outpatient department or suggested that anemic admissions forms and breakdowns in handoffs between shifts and departments were to blame for substandard services. The presenting physician responded that "there is more than one form of continuity," (a topic to be discussed in Chapter 6) and that each should be considered when designing systems, including what happens *before* a patient gets to a healthcare facility, so establishing a specific sequence of what should happen may be impossible. As discussed in Chapters 2 and 3, the sheer number of organizations and coordinating bodies involved in development efforts in Malawi (e.g. UN, AU, numerous government sectors, Malawi's healthcare referral network, NGOs, CBOs) and how SDG#17 focuses on coordination in development, determining a precise sequence by which all of these bodies should engage is a problem that quickly becomes unwieldy.

The hopefulness conveyed during the interaction that followed the presentation at the District Hospital was heartening, but that is not what I want to focus on here. Rather, I would like to draw attention to the appreciation that these clinicians held for the different aims and capabilities of different institutions, and to suggest that it is worth exploring efforts that are happening more locally. To explore these topics, I asked each person that I interviewed what they knew and thought about local efforts to coordinate projects and institutions. For starters, I was told by a DHO during our interview that Village Development and Health Committees act "like a bridge between the hospital and the local people, the local community." I got to know the head of the Village Health Committee (VHC) in one of the districts where the Mobile Clinics operated, and she shared with me that issues that enter the radar of the VHC include procuring needed materials for the district hospital and addressing the cleanliness of hospital grounds and health centers' hours of operation. The DHO of that district described the VHC as indispensable to her district goals, and she suggested that the VHS clears ideas with her, and vice-versa. Thus, these are cooperative endeavors, and district administrators cannot behave as though they 'own' these processes. This trend has been observed elsewhere, as Høg (2014) argues that HIV scale-up efforts in Mozambique are surrounded by political rhetoric of ownership, but, in practice, they function via logics of coordination, and Daniel Esser argues that conceptual ambiguities and "a cacophony of claims asserting the importance of 'ownership'" do not correspond with real changes in relationships" (Esser 2014). I raise this point to qualify assertions such as those made by Ruth Prince, which claim that "transnational and nongovernmental organizations often bypass national ministries of health and state institutions, leaving the state a weak role as "coordinator""

(Prince 2014). While I support Prince's suggestion that bypassing national agencies can weaken efforts, as there is plenty of empirical evidence demonstrating that possibility, I want to point out that local efforts also bypass national ministries, and I want to reconsider whether a "coordinator" role is a sign of weakness. As with the human cerebellum, I suggest that healthcare coordination involves both positive and negative modulation of activities, as well as gating some activities until the correct style or sequence is achieved. Full coordination toward a prescribed target appears to be a highly complex task that remains beyond the capabilities of current organizations (as exemplified by the ambiguity of SDG#17). However, that may not be a cause for concern. Just as VHCs cannot direct the UN, international plans are hardly the final word for local personnel, which permits appropriate generalization and specialization across governing bodies. For instance, a DMO explained in our interview that:

> "What happens is the international policy will be locally adapted. Take an example when we were drafting the management of severe acute malnutrition. WHO said *this*. We sat and looked at it and said, 'this can't work for Malawi, but *these* things can,' and then we wrote out the local one. Then we got together and said, 'How do we apply this in our local context?' We don't really run into conflicts because we contextualized whatever we're doing… Things we run into are small, then afterward you say, 'guys, you can't tell us how to manage patients; you're not here.' It's not really a problem [laughs]."

By her experience, large organizations are not hawkish about making funds contingent upon strict adherence to donors' priorities. This appears to be a critical difference between how district and central administrators interface with international organizations: if district personnel deviate and customize, there are no major repercussions; however, if central administrators do so, the IMF may freeze their budget (as discussed in Chapters 2 and 6). Additionally, a DHO shared during our interview that the current system *sometimes* works quite well, as when donor activities are channeled into the dire needs of the district. Not only does that alleviate suffering, but it also frees-up district budget space, so that moneys coming from Central MoH can be allocated elsewhere. One DHO sardonically commented on such arrangements as "I guess that is also an advantage: you have room to decide what to do with the money that comes from government, regardless of how little it is."

As discussed in Chapter 2, contentions surrounding coordination and policy coherence may be nowhere more apparent than debates surrounding NGOs' operations, which are characterized as something between usurping or supplemental, depending on the source. On the positive side, one DHO told me during our interview that she would continue to use Mobile Clinics if the NGO departed and left its funds with her. Her district has a population of around 600,000 persons, and she told me that "the standard that Malawi is using is people should be within eight kilometers walking distance to a health facility;" however, approximately 240,000 of those people are outside of that 8-km radius, so care must be brought to them, via mobile clinics—or so she reasoned. Since my fieldwork, the NGO *did* eliminate support to one of its Mobile Clinics, and the DHO did keep it going (in a reduced form).

Importantly, it is not just scarcity that requires robust coordination to achieve development goals. Rather, as with human nutrition, conditions of uncoordinated abundance can also have detrimental effects. Anthropologists have been documenting such cases for decades, as when foreign interventions are offered without local inputs, and results fall far short of aims. Two examples from my latest fieldwork are worth sharing: 1) a new pediatric surgery and intensive care center that was built on the campus of the Central Hospital; and 2) a new maternity hospital that was built near the District Hospital. The pediatric facility within the Central Hospital was sponsored by a prominent international celebrity and opened to much fanfare, as its advanced surgical suites and ventilators offered unprecedented possibilities for healthcare in Malawi. Unfortunately, inter-department conflicts, physicians' egos and increased workload (for some) have handicapped performance and tarnished the building's appeal for many of the physicians with whom I spoke. I toured the facility and was impressed by its aesthetics, as world-renowned muralists were brought in to beautify its walls. However, nearly all of the beds remained empty, while across the street, other pediatric wards overflowed with patients. During our interview, a physician who relies on the new facility described that the main conflict surrounding the new facility arose between Pediatrics and Surgery departments, with Anesthesia caught in the middle. She provides an example whereby “one of our patients died in the ICU, then [Surgery] said, ‘Why did you bring this patient? You’re increasing mortality’… but the patient needed ICU, hence the fact that they’ve died.” Another physician who regularly accessed the facility suggested to me in our interview that “People are still handling it with gloves… In terms of major decisions, they still have to go through [a well-known surgeon who orchestrated the building’s construction]… even decisions as in when a patient leaves… [or] maybe it is a patient who he operated on, or he's already treated and thinks nobody else should handle. That patient is going to stay there until Professor says so.” Without clear protocols, personalities and a sense of ‘ownership’ may trump cooperation and productivity. This physician suggested that the situation is especially frustrating because “There are certain [medical] things that [surgeons] don't look at… At the beginning it was really annoying for some of us. We felt like we're never going to go there anymore because you shouldn't be treated like that,” and rather than making their job easier, “that facility opening means that it gave us three other wards to go and look at,” and they needed to pay special attention in there because “most of the people who are there are more used to working with adult patients,” so they miss pediatric-specific concerns. Frustrations reached the point where some clinicians avoided the new facility and questioned the appropriateness of the whole endeavor.

The next example of ‘abundance’ can more accurately be described as pseudo-abundance. In 2016, a brand-new maternity hospital was constructed down the street from the District Hospital, but it remains vacant as of April 2018, as district administrators cannot secure enough nurses to staff the facility as a result of budgetary shortages and an IMF-imposed freeze on government salaries. It is also worth noting that the hiring freeze is taking place in the context of what a DHO described to me in our interview as a 40% vacancy rate in healthcare positions across the district, meaning that the district is looking to hire over 80 new personnel (issues related to clinician shortages will be discussed in greater length in Chapter 5). In April 2018, questions were revitalized about the opening of this facility, as the antenatal ward at the District Hospital burned down in an electrical fire. No patients or staff were harmed in the fire, but services were wiped out, thereby increasing the likelihood of devastating maternal and neonatal outcomes.

Not only does the vacant maternity hospital handicap maternal services, there is a pileup of people relying on the space that will be available once maternity services leave the District Hospital. The people waiting in line for the space included a dedicated surgeon who had been unable to perform surgeries at the District Hospital because emergency obstetric cases continually took priority, displacing cases that she had scheduled; integrated healthcare services for addressing emerging NCDs; and an income-generating private-wing, which administrators hope might supplement the hospital’s budget. Unfortunately, because of the tremendous demand for space and services, even when the maternal hospital does eventually open, the DHO predicted in our interview that it “will not actually decongest the hospital… Because now we operate based on space… Anyone who we feel is slightly better goes, but in any other setting, this person needed to be in the hospital. It will just mean patients staying longer in the hospital.”

By sharing these examples that related to public hospitals, I do not wish to imply that the NGO that runs the Mobile Clinics has remained static or free from challenges. As mentioned above, it recently unloaded one of its Mobile Clinics onto the public health system. Additionally, in 2015, the NGO increased its integration with public services. It seems that there were three major causes for this change: 1) change of administration, from someone with a background in humanitarian aid, to someone with a background in nursing and public health; 2) mission creep, from an organization focused on HIV/AIDS, to an organization which provides a variety of healthcare services; 3) increased interest in forming cooperative relationships with DHOs. An administrator for the NGO explained during our interview "that our programs are in line with the global strategic plan, the Millennium Development Goals, and I also make sure that we work within the policies of the government… From there, that's when now I coordinate them with the staff on the ground." The NGO now receives free HIV test kits from the DHO (provided by the Global Fund), park its vehicles within the hospital grounds (to take advantage of hospital security services), and is working on plans to receive malaria test kits, malaria treatments, and family planning kits from the DHO. These recent developments suggest that prior descriptions of "projectification" and "NGO-ization" of healthcare efforts across developing countries (e.g. the work of Reynolds Whyte (2013)) may need to be updated, as public facilities and NGOs seem to be evolving in a dialogical fashion.

Struggles with Remote Planning and Funding

With so much reliance upon distant persons and organizations for 'successful' coordination of services, I was curious about how personnel view their interactions with national planners, and I asked each administrator and clinician I interviewed about her experiences with constructing or negotiating national and/or international plans[11]. Interview responses from public administrators can be summarized by the words of a DHO, who told me that central government officials "want to exert their political power, and I wanted to maintain a professional integrity." Her takeaway from such experiences was to "just do not stoop to their level, because once you do that… you look like them, not the other way around… There's always that fight, because they *feel like* they're the ones who make decisions, but I'm the technocrat. *I know*. I do things based on evidence." While a desire for "evidence" was shared by all of the healthcare personnel with whom I spoke, "evidence" was not their top concern. For all public administrators with whom I spoke, the top items on their list of healthcare concerns were two-fold: funding and staffing (the latter of which will be discussed at greater length next chapter). While both elements were in short supply, funding provided the added difficulty of extreme month-to-month fluctuations. One DHO noted during our interview that her budget swung from MWK78 million for a month down to about MWK11 million (nearly 86% cut), in a district which serves well over one million people and which had already been struggling to make ends meet. The kicker to the whole process, administrators told me in interviews, is that they are given no justification for the amount that they receive, nor are they allowed to appeal for more.

To keep districts and facilities running, public administrators informed me in interviews, they adapt by making sacrifices: drug stocks are kept to a minimum; pencils, pens, stationary, clipboards, flashlights, soaps, salaries and locum pay are withheld; and services are cut, which can include ambulances to surrounding areas. In the words of an administrator from the Central Hospital, "we need to prioritize and, indeed, we cut out most of the things," she exclaimed, as she chuckled at her terrible situation. She continued, "you just allocate to run the hospital, but

---

[11] As mentioned last chapter, all interviewees work outside of the Central MoH and their opinions have been formed accordingly.

not extras." "Extras," then, means whatever is deemed *less* necessary (not unnecessary). During my time at the District Hospital, because ambulance services had been cut, I observed patients being carried in wheelbarrows, or having held onto the rear rack of a bicycle for what they explained had been tens of kilometers to get to the hospital—risking their lives as they migrate along the shoulder of dark roads.

Following cuts in services, the experiences of those public administrators whom I spoke with can be summarized by the words a district administrator, who told me in our interview that they frequently become "the punching bag in the presence of the politicians and the people you are supposed to save… They shoot the messenger when they don't see a service being delivered, and they blame the immediate leader, yet it's not your intention." An ultimate cause for these hardships, they suggested, is that the budgets that they are given are likely watered-down by government corruption (including within the government's Anti-Corruption Bureau). During our interview, a clinical officer working for the NGO called corruption "pathetic" because it hits hardest on small-scale farmers, who "harvest maybe three or four bags a year of maize or cassava, which is nothing… [and] they can stay maybe for a month without having MK$ 5,000 in their pocket [roughly USD$6.66, at the time of interview]." This clinician suggested that government corruption caused stock-outs of medications in public facilities, which drove patients to the Mobile Clinics, as their supplies were more reliable. Clinicians at the NGO suggest that their 'picking up the slack' for public facilities was especially acute following devastating floods in 2015, which exacerbated hardships that the public system was already facing due to a corruption scandal involving the National AIDS Commission who reportedly purchased a fleet of vehicles that were not within its agreed-upon budget, which prompted the Global Fund to freeze their support, at a time when many donors' had already withdrawn national budgetary support following the 2014 Cashgate scandal (Banda 2015; Dionne 2014).

Adding to challenges of what they describe as corruption, district health administrators whom I interviewed suggested that members of the Central government lack the requisite technical competence to create a healthcare budget, as there are no medical personnel who are currently involved in planning at the Central MoH. Furthermore, clinicians and administrators from both the Central and District Hospital suggest that personnel at the Central MoH are out of touch with what happens in public hospitals, as central government officials never use public facilities. A DHO provided an example during our interview:

> "When a DHO like me is saying, 'Guys, the shortage is really bad'… they don't know the implications. They don't know that in the wards we have beds, and then we have what we call *floor beds*, which is to put mattresses down and the patients are lying on the floor [because there are not enough beds]. They don't know what it means to 'do a round' in your ward that's packed. That picture is not in their heads. When they're making all these decisions, they don't understand what it's like… And then they will be talking about quality care… they'll be coming to say, 'People are just ordering MRDTs[12], running tests for malaria instead of assessing the patient.' I have *no time* to assess the patients. So they are making those administrative decisions to say 'people are stealing malaria tests.' Okay, but we are not *stealing*, we are *misusing* them, and we are misusing them because we have no time to assess patients."

Faith and Controversy in Decentralization

The situation described thus far paints a picture of healthcare personnel operating within highly uncertain environments, in which they cannot fully rely on support from their national government or NGOs, so they hope for some functional combination of the two and ultimately put trust in themselves. Of all of the large-scale plans mentioned during interviews and discussions on the wards, the one that attracted the most hope for the future was decentralization—a process that can broadly be defined as reorganizing government such that the

---

[12] Malaria Rapid Diagnostic Tests

central government cedes some of its authority and responsibilities to local governing bodies (Belrhiti, et al. 2016). Decentralization has been a formal goal of Malawi's national government since 1998, as it was supported by (the business-minded) President Bakili Muluzi, amidst Malawi's democratic transition from Prime Minister Kamuzu Banda, at a time when such policies were being pushed across the developing world. Indeed, decentralization is set to affect each aspect of public healthcare, including medical education and NGOs' operations (Malawi 2012; Omaswa and Boufford 2010).

My research suggests that personnel's support for decentralization can be broken down into four idealizations, each containing significant uncertainty and countervailing components, which align with the words of a Central Hospital administrator from our interview: "it might have its problems, but that is the way to go." The first idealization involves *improved resourcing* of medications and supplies at the district level, as the DMO, DHO and District Commissioner (DC) are expected to closely monitor, order and allocate medications for the district, rather than having to work through the Central MoH. Those persons whom I spoke with expressed hope that this will improve processing time and responsiveness, as personnel harped on 'slow processing time' for anything that must be sent through central command. Indeed, Claire Wendland notes that resource shortages are often the first thing that Malawian (and Western) clinicians mention about practicing medicine in Malawi—a process which she calls thinking through a "deficit model" (Wendland 2016). Whether this is a "model" or simply an observation of disconnects between plans, demands and resources can be set aside, but the fact remains that personnel in each of the settings where I spent time were acutely aware of the problem. For instance, a DMO shared during our interview that "because of our lack of resources… we've mopped the hospital without soap. It's not unusual to get to that sort of state. It's bad, seriously bad. The ground laborers… we haven't paid them for two months. They obviously get demotivated; it’s part of why the grounds don't look clean.”

The second idealization involved suspected *decreased likelihood of corruption*. While I cannot say whether nods to corruption (as mentioned above) are reversions to common critiques about leadership in Africa, or whether such sentiments are a reflection of actual corruption (Transparency International (2018) ranks Malawi’s government at 122/180 countries in terms of government transparency); however, this would not change the fact that the perception exists, as each day during my 2017 fieldwork at least one of the national newspapers or national radio stations ran a story covering corruption. Unfortunately, evidence provided by Omaswa and Boufford (2010) from other African settings suggests that decentralization may simply decentralize corruption. Evidence of this possibility can also be found in my interviews, as a DMO shared her feelings that “it’s difficult to be able to practice integrity in this [District] setting. Honesty, truth, not taking advantage of people, not taking money you shouldn't take—it’s not easy... There is corruption at every last level.” Indeed, the World Bank suggests that challenges for decentralization extend beyond *what* must be done, to *the sequence* by which things must be done, and that "the risks of proceeding with fiscal decentralization before addressing existing weaknesses in [public financial management], frequent recourse to cash rationing and widespread perception of corruption are high and therefore would need to be mitigated" (Bank 2012).

The third idealization involved *improved human resources*; and manifested differently in the three settings of my 2017 fieldwork. Many of those who supported decentralization in my interviews, particularly at the District Hospital, did so on account of how it will presumably improve the reliability of their salaries and locum payments. In terms of staffing, interviewees expressed two major hopes: 1) increased number of skilled providers and support staff (a topic discussed at length in Chapter 6); and 2) administrators having the authority to discipline staff. This latter point may appear as a sort of Foucaultian yearning for enhanced governmentality, discipline and punishment (Foucault 1977); however, Markku Hokkanen (2007) points out that contextual differences between Foucault's Europe and Malawi make any applications of Foucault's theories within African settings tenuous, at best. That said, administrators at each facility *did* express during our interviews that they would like to channel employees' behaviors away from absenteeism and malpractice, thereby more tightly policing institutional norms. I was told during interviews with district administrators that under the current arrangement, within public facilities, disciplinary requests are submitted to Central MoH; and then, after a drawn-out review process, they are frequently denied. The effect of this, I was told, is that an administrator may be left with an 'employee' who does not *actually* work there—the person just consumes some of the national (and district) budget for salaries, without providing services. To get around this issue, district administrators told me in interviews, they rarely even tried to fire people, instead opting to take a path of less resistance: reassignment. Through this route, personnel will be sent to a different facility, where they simply become someone else's problem. "You don't have much weight," a Central Hospital administrator told me in our interview, "but you are the one that has to make sure that they are running… It is quite hectic, and we operate more-or-less on emergency mode. That is why I think I wouldn't really prefer to continue working in this capacity for a very long time." In another interview, a different DHO expanded this sentiment regarding attractions of decentralization, stating that "I may [stay in my job for the next five years], because we just decentralized now."

Far and away the most popular reason for those persons whom I spoke with supporting decentralization was a hope for *local accountability*. "Power to the people," was declared by multiple clinicians—with rings back to liberation struggles of the 1960s—and hopes were expressed that by going this route, both leadership and staff performance will improve. As a Central Hospital administrator said in our interview, programs will be "directly answerable on the ground" and permit "input into the resources that you need… unlike now." She suggested that decentralization will be organized such that a board will supervise hospital management, who will supervise the staff; and, conversely, management will be held accountable to the staff, and the board will be accountable to management. While such systems seem intuitive, implementation may be trickier than planning, and it is unclear whether decentralization will multiply administrators, thereby only reducing geographic rather than institutional distance between administrators and front-line personnel. Additionally, decentralization raises important questions about the future of Malawian democracy—a system that has proven resilient in its young life, since 1994—as it is unclear to what extent communities will have input. In this vein, Francis Omaswa and Jo Boufford suggest that caution should be taken toward decentralization because:

> "the capacities that need to be strengthened for effective implementation of decentralization are diverse and involve not only leadership, but also the adequacy of structural, organizational, and human resources. The demand for democracy is moving beyond the vote, to embrace issues of citizens' participation in development planning, service delivery, public accounting, and budgetary management. This paradigm shift in the practice of democratic governance especially at local levels, has created a strong need for capacity in terms of knowledge, skills, attitudes, networks, and institutional and structural arrangements that are capable of supporting and sustaining engagement of citizens and action for local level development." (Omaswa and Boufford 2010).

In addition to these 'technical' challenges for decentralization, Kenworthy (2014) draws us back to notions of governance, as she suggests that decentralization involves a tricky mix of democratic and neoliberal factors. Democratic intentions, she suggests, are held by those 'on the ground', whereas neoliberal intentions are projected by central governments and donors who delegate tasks without ceding authority to local governments who, they argue, are 'lacking expertise' or display 'improper accounting procedures'—reasons whose roots, she suggests, date back to 'indirect rule' of colonial governments (ibid). In this vein, Andrea Freidus argues that "in southern Africa, the neoliberal logic of decentralization and privatization set in place by the World Bank and IMF has led to a deliberate shift in social service provision away from the central government toward local governments, NGOs, churches, and the private sector," in a process that is understood to necessarily punish the poorest members of society, particularly those in rural locations (Freidus 2010). Such concerns were shared, in muted terms, by some personnel with whom I spoke. For instance, during our interview, a DHO stated that "initially the problem was systems planning… Only that this time around, the answer will be, 'you guys are supposed to pay for yourselves,' and it will be difficult," as she expected that fingers will be pointed at poorer districts to support themselves, whereas wealthier districts "will employ people and incentivize them… so it means that [a poor district] needs to have more money to make people come to live there." She followed this up with a suggestion that, "this ground is not going to be level any time soon. That's a very big discrepancy… Decentralization is not a one shoe fits all." She further suspected that if poor districts as expected to support themselves, "then no one is going to live there." I asked her for her thoughts on how that cycle could be broken, if wealthy districts attract all of the professionals in a setting where professional are already concentrated to urban areas, and she suggested that it will work itself out:

> "The market [will be] saturated. There's a lot of people looking for work, which is a good thing, and a lot of people actually willing to get pay cuts out of it. But then, they'll be a lot of poaching as well. If we can just get people to understand that there's a few good clinicians in [a poor district], tell them, 'you can come to this side, we will be able to offer you this, this, and that,' they will leave [to go to the poorer district]"

In other words, something like a race to the bottom for employees, or a slightly modified restatement of Adam Smith's 'invisible hand' (Smith 2015), whereby employees are expected to distribute themselves according to what is best for society, while the rich may get richer and the poor (a majority of Malawians) may get poorer (if we think of wealth in terms of personnel). Therefore, it seems as though decentralization may exacerbate one of the major issues that personnel have with the current centralized system, and one of interviewees' primary concerns regarding QOC (i.e. staffing shortage).

Among those personnel whom I interviewed, the general understanding for how decentralization will be financed seems to be that each district or facility will source as much of its own funds as possible, which should cover costs and be reinvested in services. Within this general strategy, there were multiple options being considered for precisely what policy/tactics to employ, and simplistic notions of 'everyone should pay' and 'nobody should pay' were rarely mentioned, let alone taken seriously by most of the healthcare personnel with whom I spoke. The closest suggestion to a blanket fee that I heard in interviews or in passing came from a clinician who suggested that persons accessing some facilities should pay a fee of $MK 200 (about $USD 0.25) for each visit. The clinician who suggested this compared the cost to a standard fee of $MK 2,000 to $MK 5,000 that is commonly charged by traditional healers—a line of reasoning that Keshavjee (2014) tells us has been presented elsewhere, and he is quick to point out that both utilization and outcomes plummeted when universal fees were implemented that were comparable to those charged at traditional healers, leading to argue that user fees for poor people are neoliberal and examples of 'dogma over data'. While I do not doubt the evidence that Keshavjee presents, my experiences—and, more importantly, the thoughts and hopes of Malawian personnel—make me question whether his conclusions exhaust all reasonable possibilities. For instance, in our interview, a Central Hospital administrator expressed hopes to experiment with various strategies. She elaborated:

> "we are allowed to create a paying service site of the hospital. I think if we can strengthen that paying site and ensure that it is working, it could generate quite a lot of money. For example, for this hospital, we argue that it is our doctors who are running the private hospitals. Most of those patients would prefer to come directly here if we had the amenities to make sure that they are able to be admitted in a very good room, very nice food, the doctors are there, and also make sure that when the doctors see them, maybe they are also compensated more or less close to what they could have earned in the private. Then this also should be able to generate a bit more money. And the other element, that is being talked about nationally even, is expanding the insurance base, which might include civil servants being on the insurance and being able to pay for health services. So, if we can look at this holistically, I think part of the response is the insurance and improving the bank services… [and] each department, in the ideal situation, is supposed to have a paying wing."

These proposals of insurance and private wings would seem to self-select the most affluent Malawians for healthcare inputs; however, personnel expressed no illusions that this would be a simple process or that it would be 'solved' on a first attempt. Bearing in mind the warning provided by Keshavjee (2014), that "cost sharing" often serves as a euphemism for user fees for poor people, and the discussion of neoliberalism in Chapter 2, we should also consider Amy Dao and Jessica Mulligan's conclusion "that local differences matter and health financing policies can have very different impacts on access to care, social inequality, and the role of government" (Dao and Mulligan 2016). More specifically, Dao and Mulligan point out that the effects of cost-shifting strategies are variable, "sometimes it can transfer the burden of paying for care onto individuals and households, but it also has the potential to collectivize how we pay for care when risk pools are deep and robust and when larger organizations like cooperatives or state governments help finance the costs" (ibid). Likewise, Kelly and colleagues suggest that "it is all too easy to conflate 'public' with 'free' and 'open', and in turn to assume this means 'accessible', when this is manifestly not the case," (Kelly, et al. 2017); therefore, we should not romanticize the services and accessibility that are already known to be problems in Malawi.

Messac notes that Malawians are well-aware that free healthcare has been offered for decades, and they have demonstrated a history of political struggle on this topic, which he interprets as evidence that fees for healthcare at public facilities are un-Malawian, stating that it goes against "context and cosmology, political history and moral economy," and that governments have refused to institute such fees "precisely because Malawians have already 'had a say' in the delivery of services. The debate over healthcare user fees began long before the neoliberal era of privatisation"—a point which, he suggests, Malawian scholars have missed (Messac 2014). Importantly, Messac also notes that the Malawian public dramatically changed between 1934 and 1964 regarding its desire for public healthcare, leading him to suggest that "as the care delivered in the hospital changed so, too, did the rights and responsibilities that defined the moral economy" (ibid). Based upon these premises, Messac attacks Malawian intellectuals on the grounds that they "demonstrate that both the antipolitics machine and the de-moralisation of economies are at work in Malawi," meaning that they are failing to recognize the moral stakes in this issue, and he suggests that any desire or mystery surrounding user fees "helps to erase from view fundamental social and economic concerns and political activities of the 'target population'" (Messac 2014). While I respect Messac's strong assertions about interconnections between economics and morality regarding user fees, my findings suggest that his conclusions fall short on three counts, and that these shortcomings provide important insights into broader discussions of development and neoliberalism: 1) notions of a singular 'Malawian' culture fail to appreciate the diversity of views and proposals that exist within Malawian society; 2) research based primarily upon discourse analysis of historical and policy documents may overlook a central voice in healthcare, namely, care givers, who *currently inhabit the healthcare system* and have limited input in Malawian policies; and 3) reliance on historical sources may contribute to anachronistic suggestions or other errors of logic that fall into the same trap as evolutionary spandrels—namely, ideological hindsights that infer causes and intentions that do reflect the sequence of causal events. Those personnel with whom I spoke were keenly aware of the politicization of user fees; however, their lack of sympathy for politicians' longevity in office led them to the opposite conclusion from Messac—namely, to support healthcare institutions' independence from the national government. For instance, during our interview, in the context of discussing her ideas for some patients paying for care, a physician frankly stated, "the first thing is, I know, politically, it's probably suicide;" however, that did not dissuade her, as she immediately followed it up with,

> "I think at some point we need to start paying for healthcare. Our hospitals need to be able to generate their own income, and then use it on their own. Maybe it'd be a drastic move, or a disaster move to pay for care, but still maybe if they were paying just a little bit, they don't have to pay a full amount, maybe a subsidized amount, then the hospital can generate its own income so that there are certain things it can do on its own—not only wait for funding from government… I think that system doesn't work because it goes back to the same thing where government gives you as it sees fit or as it can manage… The services are not so good in the government hospital because the people who patronize the government hospitals are not the people who make the decisions about them"

Not surprisingly, this situation was sometimes described with desperation, as another physician suggested during our interview that "if we continue running our system the way it is now, where we rely only on support from other people, come 60 years from now, our children will still be facing the same challenge that we are facing now." Patients already suffer, healthcare personnel struggle to make ends meet and frequently face blowback, she reasoned, so why accept current levels of suffering, and why give politicians immunity? It seems that in her eyes, it is a choice between living with a festering wound or attempting a risky operation that could lead to dramatic improvement *or* worse suffering, and that it might be worth the risk.

Risk taking—and potential associations with neoliberalism—do not stop there, however, as personnel at each of the facilities that I visited aspired to entrepreneurial activities ranging from computer programs for track pharmacy supplies, to starting private clinics, to forming a coalition of clinicians to build a clinician-run hospital. I was told by an administrator, in our interview, that the investing physicians span a couple decades in age, and they are working with investment groups in Malawi to look into their options of stocks, bonds, mutual funds, etc., to increase their wealth and build enough collateral to qualify for a large loan, with which they could build said hospital. I questioned her about her inspiration to undertake such an endeavor, and she replied:

> "I think it's from where we are coming from. We know the demand which is out there in healthcare, and we know the gap which is existing, so why not entrepreneur into something huge that we're familiar with? … We've left non-medical people to handle our health service… Most of the hospitals are not being run by doctors. If you go out most of the private clinics, someone owns them… so why don't we make our own hospitals?"

Such endeavors may be interpreted in a variety of ways, including: 1) as locals continuing a line from Bretton Woods to Bamako, to current ideologies that tacitly accept hegemonic plans for neoliberal changes; or 2) as radical leftists planning to create worker-run facilities, to free themselves from the oppression of exploitative owners; or 3) as consistent with both (to a limit) and neither, as these aspirations germinate from locally-specific contexts and cultures, with roots that run through the history of Malawi and the personal histories of each person with whom I spoke. The view from the ground, I suggest, supports the third option. Based on what I heard in interviews and conversations, and what I saw in the wards, these are deeply personal matters, rather than abstract, ideological arguments. It would be misleading to suggest that the persons I interviewed are callous capitalists yearning to reap maximal profits on the backs of poor villagers; rather, these are the people who live and work with their patients, and whose families rely on their services. For instance, a DHO explained her entrepreneurial activities as being fueled:

> "Out of necessity, because by the end of the day, you have to survive. I mean you wouldn't expect my own child not to go to a better school, because the public system is very poor indeed. If I really need the future of my kids to be okay, then I have to send them to a private school. Or even a kindergarten you wouldn't really pay less a certain, probably half of my salary, even more, just for a term's fee of my child, which I can't afford, you see? I have to supplement with these kinds of efforts. In Malawi, we also have bloated families, extended families. We have very tight bonds of relationships. My uncle's children I would keep them in my household, my sister's children, my mother's sisters children—and now coupled with the HIV thing also brought in a lot of problems, some would be orphaned and you wouldn't leave them like that; you would take them. Even if you are not staying with them under one roof, you would still assist them elsewhere where they are for fees and upkeeps. So that calls for a lot of thinking outside the box."

Applying an over-arching framework based upon neoliberal or leftist ideologies would appear to reflect the worldview of the applicant of the theory, rather than those persons with whom I spoke. My research suggests that these are reasonable people who see a set of problems and opportunities within their environment, and their interpretation is heavily colored by skepticism toward distant authorities. We may think of their aspirations as consistent with a WHO report that highlights the importance of employees in creating workplace innovations and improvements, noting that universal health coverage will require efforts *from those people who live and operate within the local context* (WHO 2014).

These results could also be interpreted as an alternative 'solution' to Keshavjee's question of why "neoliberal" policies continue to be proposed within global health circles (Keshavjee 2014). Rather than institutional and ideological hegemony, as suggested by Keshajvee, what are called 'neoliberal' policies may be supported via different aims and intentions, making them spandrels of developmental processes. In other words, these clinicians operate within environments and histories that are different from other studies, yet they arrive at suggestions that *may appear* to align with explanations proposed for other sites. By assuming that the causes of these processes generalize, intentions are interpreted as homologous to one another—that is, deriving from the same source. However, I am suggesting that this situation is more accurately understood as an analogous manifestation—deriving from different origins that happen to lead to a proposal that shares some features with what have been deemed neoliberal measures. Thus, support for decentralization is the result of a different causal sequence, and characterizing them as simply ‘neoliberal’ or ‘leftist’ and suggesting that they follow in a direct line from previous policies is making the mistake of evolutionary spandrels. This is not to suggest that we dispense with caution or critical examination. What I am suggesting is that we respect the context-specific nature of this issue.

To make better sense of how this analysis differs from others, I suggest that we look back to QOC. Since 2007, the Institute of Healthcare Improvement has dealt with QOC as a triple aim: reducing inputs, improving outputs (population health), and improving patient satisfaction (Berwick, et al. 2008). This model facilitated some advances in healthcare; however, a more recent model has been proposed by Bodenheimer and Sinsky—the quadruple aim—which incorporates inputs, outcomes, patient satisfaction *and* provider satisfaction [see diagram, left] (Bodenheimer and Sinsky 2014). It is worth noting that the simplistic model of four pillars of healthcare quality leaves much to be desired, as healthcare is not a closed system, yet that does not take away from the utility of the model in this instance. To appreciate the utility of this model, we may look at shortcomings of other arguments. For instance, Keshavjee and Messac, who each come from a social justice perspective, place too much weight on patient satisfaction and outcomes (Keshavjee 2014;

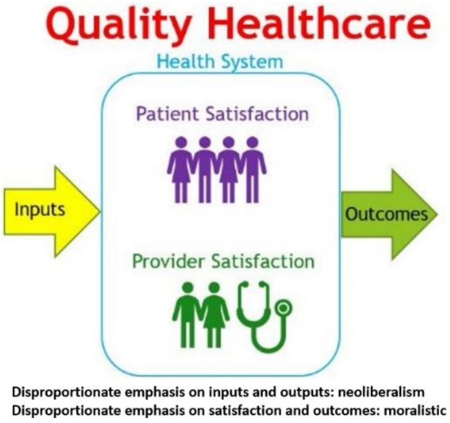

Figure 7: Models of QOC

Messac 2014). Let’s call this a “moralistic” approach. On the other hand, Linda Hunt has explained that a neoliberal model, which both Keshavjee and Messac attack, places too much emphasis on reducing inputs and achieving specific outcome measures and loses track of patients in the process (Hunt, et al. 2017). Taking a more holistic approach, I suggest, includes all three of those elements *plus* the satisfaction of healthcare personnel, and the ramifications of omitting the wishes of healthcare personnel, as we will see next chapter, can have dire consequences for health systems.

Summary and Conclusion

Hardship and success dance along a delicate line in Malawian clinics and hospitals. Amidst challenging work environments, those healthcare personnel with whom I spoke described varying notions for what qualifies as “development”, meaning that there is no universally ‘Malawian’ notion that drives healthcare personnel. Rather, these persons focused on providing quality care, which they recognized as inextricably linked to the accessibility/quantity of care, and they spoke of changing trends in healthcare and the broader society, which included their relations to the central government and international organizations. Regarding the central government, these personnel were deeply frustrated staffing and funding levels, which they attributed to incompetent and corrupt governance systems. Regarding international organizations, personnel spoke of unreliable donors who would turn on a dime, leaving projects vacant, which used to be covered by local efforts. Those persons with whom I spoke were generally underwhelmed with the impact and aspirations of the Sustainable Development Goals, and they noted many successes and failures of cooperation, with some dependent upon national or international organizations, and others dependent upon more local support. Overall, they expressed a view that each of these parties should be involved, as they can each play important roles.

The large-scale program that garnered the most support from those personnel whom I spoke with was decentralization, a process whereby oversight and financing will be shifted from the central government to the district- or Central Hospital-level. While the program was idealized in a number of ways, personnel also recognized its potential shortcomings, which include simply transferring corruption from the national to the district-level and exacerbating inequalities between districts regarding funding and personnel. When viewed alongside interests in and efforts toward entrepreneurial activities and a desire to have patients pay for care, support for decentralization could be interpreted as yet another manifestation of neoliberal policies, as though it is a goal that follows in a straight line from Bretton Woods to Malawi. However, I suggest that such an interpretation would seriously misrepresent intentions and events ‘on the ground,’ thereby forming a sociocultural spandrel. Rather than suggest that those persons whom I spent time with embody a neoliberal agenda, I suggest that they are deeply invested in their communities and families, and they are willing to entertain a variety of ideas in the hopes that they and their colleagues can precipitate lasting improvements within healthcare. By expanding our notion of what qualifies as relevant elements of healthcare networks—from incomes, outcomes and patient satisfaction, to these three *plus* the perspectives and satisfaction of local healthcare personnel (and the relevant history of organizations and institutions)—not only do new opportunities emerge for improving healthcare systems, but we gain fuller insights into how the persons responsible for delivering care and creating innovations have been systematically neglected, often by those with the best of intentions (e.g. in the arguments of Messac and Keshavjee, discussed above). Taking this approach does not mean ridding ourselves of a critical lens. Rather, it requires that we expand our understanding of what is happening ‘on the ground’ and modify our theories to account for empirical data. In this vein, I suggest that we take William Easterly’s advice to heart, that “People in low- and middle-income countries must now be recognized as equals, the authors of their own development” (Easterly 2015).

CHAPTER 5: Struggling to Care

“*Put a man in the wrong atmosphere and nothing will function as it should. He will seem unhealthy in every part. Put him back into his proper element and everything will blossom and look healthy. But if he is not in his right element, what then? Well, then he just has to make the best of appearing before the world as a cripple*."
--Ludwig Wittgenstein (1980), *Culture and Value*

“Quality provision of care for pregnant women and newborns in health-care facilities requires competent and motivated health-care professionals and the availability of essential physical resources, such as clean water, essential medicines, equipment and supplies. In addition, evidence-based practices for routine and emergency care require functional referral systems between levels of care, as well as information systems that enable review and audit to take place”
--World Health Organization (2018), *Maternal, Newborn, Child and Adolescent Health: Quality of Care*

Adult Trauma Center, Central Hospital, August 31, 2017

Escaping from the hot, morning sun, I walk past a plaque from the era of the Rhodesian Federation and enter the Central Hospital’s Adult Trauma/Emergency Center (ATC) at 7:46am, expecting to be early for 8:00am rounds. Finding no one in the ward, I go into the break room, where three clinicians are relaxing after their night shifts—in outpatient, surgery and ATC departments, respectively. They inform me that today’s clinician has not arrived and that she will be shorthanded, as the department only staffs five total clinicians to cover all day and night shifts, as compared to the 8-10 clinicians that they tell me should be in ATC at any given time. At 8:40am, Dr. Ndakatulo arrives, wearing sea green scrubs and a long, white coat with grey crocs. She is an eccentric woman who writes poetry and expresses herself through her hair, which is adorned with brilliant magenta curls today. She drops off her bag, and the two of us saunter to the back corner of the department, where a bloodied man lies on a hospital bed. He had gotten into a bicycle accident this morning and has yet to regain consciousness, but his vital signs are stable, so we go to the first patient in the short stay bay. The morning nurses have not yet recorded vital signs on any of the patients. Ndakatulo rolls her eyes at the inconvenience and requests that the nearest nurse collects blood pressures on each patient. By 8:56am, the first patient's blood pressure has been taken, so Ndakatulo steps in to evaluate her. "Loads of wheezes," Ndakatulo comments to me about the 33-year-old female patient, "it might be asthma, might be COPD; she has been cooking using firewood since forever." We meander to the next patient, and then the next—Ndakatulo with her clipboard and me with my mini notebook. At 9:23am, Ndakatulo auscultates the chest of the third consecutive patient with suspected asthma. Standing beside the patient, with one hand resting on the patient's shoulder, she flicks her head to draw my attention to the growing crowd of men, women and children who are walking and jogging toward an ambulance that pulled up to the ATC entrance. 'Technically, I think that I am supposed to handle this, but I am too busy,' she comments to me.

Attracted by the commotion, a clinician from a neighboring department joins us and shares that she heard rumors that a pair of men had been caught stealing a pig and were then beaten to death. Ndakatulo shrugs, unimpressed by the whole ordeal, and continues with the current exam. The crowd of onlookers jostling and craning their necks to get a glimpse into the ambulance overwhelms the clerks at the front desk, and at 9:45am the ambulance pulls away from the front entrance and drives around to the side bay. With clipboard in hand, Ndakatulo grabs a blank incident report sheet and lumbers down the hallway, dragging her crocs along the white, tiled floor. As we approach the ambulance, the driver hops out and flips open the rear doors, revealing a male corpse lying supine on the floor of the vehicle, the top of his head facing us, and his feet extending toward the cab of the vehicle. Rigor mortise has set in, and all of his limbs are elevated—hips are flexed to 30-degrees, as are his knees, such that his shins run parallel to the floor. His shoulders and elbows are each slightly flexed, such that his hands are elevated roughly 30cm from the floor. What remains of his clothes are ripped and charred, and I can hardly distinguish melted skin from the apparent mixture of dried dirt-and-blood. The man’s face is smashed and burned so badly that his features are largely erased. I can’t help but wonder whether his loved ones would be able to identify him—and hope that they do not have to do so. His eyes are open and a large chunk of his burnt scalp has fallen onto the floor, exposing a section of moist, pink flesh. His shirt is mostly missing, and his pants have been ripped off, exposing his charred genitals and scratched legs, which are also covered in dirt. My horror at these sights is matched only by the smell—a noxious mix of dirt and burnt flesh. I reflexively hold my breath until I run out of air, at which point I pull my shirt over my face and inhale through my mouth, and then drop my shirt so as to feign a sense of normalcy. Unwavering, Ndakatulo takes a few steps closer, extends her head into the ambulance, and then turns to me and, with a blank look on her face, nonchalantly says, “this is how I work. It is only the two of us [referring to another clinician who did not come into work today], so I have to do this.” Unable to articulate words of support while holding my breath, I offer a commiserative smile and say nothing. Ndakatulo nods to the ambulance driver, turns and shuffles back to the short stay bay, where she fills out a report. Discussing the incident later, she tells me that the incident failed to move her. It was simply work as usual.

After seeing the remainder of patients in the short stay bay, Ndakatulo announces that “it has been a hectic morning,” and that it is time for her to take her lunch break, at 11:28am. She returns around 2pm and tells me that she is looking for another job, one that does not wear her out so much. In hindsight, as impressive as was the corpse, I am equally as impressed by the apparent mundaneness of the whole event for Ndakatulo. I asked her about it the next day, and she explained how after many shifts, she just runs through the motions, describing herself as operating with ‘zombie-like’ energy. Kate Mandeville and colleagues inform us that senses of isolation, frustration and exhaustion are not unique to Malawi or other sub-Saharan African (SSA) countries, as 27 of the 30 countries with the fewest physicians per capita are in SSA—a region which faces some of the harshest healthcare and economic conditions on the planet (Malawi 2012; Mandeville, et al. 2016).

This chapter focuses the experiences of Malawian healthcare personnel like Ndakatulo—persons who deal with chronic shortages of staff and resources, yet are expected to operate compassionately in the face of challenging situations. Following chapter 4, this chapter descends in scale to focus on how personnel interface with institutional (employer and educational) and cultural factors related to career pathways, job selection, and broader social expectations. Facing up to these issues, ex-UN Secretary General Ban Ki-Moon writes, "Almost 60 countries, most of them in Africa, face such critical shortages of health workers that they cannot provide basic health care to all of their people. The time has come to focus on supporting and retaining the true lifesavers in every nation" (WHO 2008). Similarly, ex-Director General of the WHO Margaret Chan writes:

> "Health workers are the cornerstone and drivers of health systems. The shortage of health workers is unanimously accepted as one of the key constraints to the provision of essential, life-saving interventions such as childhood immunizations, safe pregnancy and childbirth services for mothers, and access to treatment for AIDS, tuberculosis and malaria. Health workers are also critical to our preparedness for and response to the global security threats posed by emerging and epidemic-prone diseases and the consequences of climate change. Without prompt action, the shortage will worsen and health systems will be weakened even further" (WHO 2008).

I will approach this discussion through an analytic lens of shortages of healthcare personnel, and then I will move to discuss more synthetic, cultural implications. Regarding shortages of healthcare personnel, it seems that there can be: (1) too few to begin with; or (2) there can be enough, but they do not (or cannot) function as needed. This latter group can be subdivided into those who are physically absent—who may either leave altogether (i.e. “brain drain”) or remain “in practice” in name only, with little time spent actually working (i.e. “absentees”)—or those who are physically present but otherwise unable or unwilling to do what is needed—a group that we may refer to as “disempowered” or “burned out”. These distinctions are not meant to represent mutually-exclusive phenomena, as it seems clear that Malawi is dealing with a mix of these forms; rather, this breakdown is meant to facilitate discussion and understanding. I will discuss each of these categories in their stated order, starting with some of the history and current training programs, then moving to absent workers (brain drain and absenteeism), and then to disempowered and burned out workers. Following these categorical discussions, I build a more integrated discussion about what these processes may tell us about biomedical culture and human adaptability.

Baseline Shortages and Capacity Building

The arrival of Dr David Livingstone, in 1859, along with the activities of subsequent missionary physicians, is remembered for introducing biomedicine to Malawi. In the three decades following Livingstone, missionaries dominated the biomedical scene, until 1891, when Dr Sorabji Boyce, an Indian by birth, served as the first *government* doctor. At this time, “British Central Africa” (BCA), as Malawi was known, had a population estimated at 1 million people (King and King 1992). This early period was marked by uninterest in biomedical services among Malawians —after all, missionaries had been dying at greater rates than locals, so why would they be sought for care?—and a sense of European superiority, held by Europeans, who thought that Africans simply could not comprehend their practices.

The earliest Malawian biomedical personnel were recruits from low social status or were freed slaves, who were attracted by church missions and displays of medical or surgical feats, with the first Malawian wound dresser in BCA trained in 1896 (Iliffe 2002; Lwanda 2002). John Iliffe informs us that "as they struggled to gather modern skills, some auxiliaries enlarged their role into a honourable career. This attracted men of higher social status into medical employment" (Iliffe 2002). This transition of status led to John Gray Kufa becoming Malawi's first "hospital assistant," in 1898, as he took over a health center and dispensary (King and King 1992). The colonial government was so impressed by locals' responsiveness to Kufa that, in 1904, hospital assistantship training was formalized into a three-year program, and wound dressers were trained for six-months (and Kufa went on to be known for his role in the Chilembwe rebellion, discussed in Chapter 2). Even in these early years, as continues to be the case, debates arose about whether standardized, high-*quality* training should take top priority, or whether the *quantity* of clinicians is most important (Hokkanen 2007). While all Africans were systematically subordinated and limited in their training, the situation was especially harsh for females, who were largely excluded from trainings, as some male missionary physicians refused to work with female clinicians (McCracken 2012).

At the time of World War I, 7 of the 11 government doctors (all of whom were expatriates) were sent off to war, and hospital assistant training was expanded. In 1917, the first Malawian became a physician, as Dr. Daniel Malekebu graduated from Meharry Medical College in Tennessee, and he was soon followed by Dr. Kamuzu Banda (Malawi's first Prime Minister and President) (King and King 1992; Lwanda 2002). The colonial authorities prevented Malekebu from returning to Malawi until 1925, when they deemed it safe (for colonists) that he re-open John Chilembwe's mission (Lwanda 2002). On the heels of this move, The Sanderson Report was released by the colonial government, which concluded that "the extension of the Health Services is entirely dependent on the formation of a local staff," but it was not until a decade later that the first government-run training facility was opened, in Zomba, with the aim of training wound dressers, nurses, midwives, laboratory assistants and sanitation workers (King and King 1992).

Soon thereafter, World War II shook the nation’s medical system, as 9 of 18 doctors (mostly expatriates) were sent to the war, along with their wound dressers and some hospital assistants (King and King 1992). This loss of personnel created a vacuum in health facilities, for which the government trained more Malawians, who eagerly joined and were permitted to expand their scope of practice in the absence of senior clinicians and supervisors (ibid). Despite such advances, however, clinical training of Malawians was limited by multiple factors, which included an overall dearth of government health services, limited exposure of most Africans to formal education (it was not until 1940 that a secondary school was opened in Malawi), and European racism against Africans (King and King 1992; Lwanda 2002; Ngalande Banda 1994). John Lwanda tells us that the Malawian government quibbled about whether Malawian doctors should be allowed to treat white patients, whether their pay should equal their European counterparts, and whether they should be allowed to use the same facilities as their white colleagues—as evidenced by the fact that the colonial government did not train or employ a single African doctor or healthcare administrator until 1953, and African physicians, like Dr. Austin Mkandawire, were forced to function as hospital assistants into the 1960s (King and King 1992; Lwanda 2002).

At independence, in 1964, there were 5 Malawian doctors in the country, a figure that rose to 12 by 1970. Lwanda tells us that President K Banda "personally despised fellow African doctors" (Lwanda 2002), and I was told in casual conversations with Malawian physicians who trained during K Banda’s administration that he had refused to open a school for training physicians in Malawi because he demanded that Malawi's program be on par with programs in Europe. In the late 1970s, clinical officers first received training in Malawi. Unfortunately, the country lost around 10% of its healthcare workers to AIDS in the 1980s, leaving the total number of Malawian doctors at 25 in 1992 (Mills, et al. 2011). In 1986, 20 Malawians were sent abroad for medical school, with plans to return in 1991, following the opening of Malawi's College of Medicine (CoM) (Broadhead and Muula 2002).

Since its opening, enrollment at CoM has increased from 25 to 105 by 2014 (Bradley, et al. 2015). This is part of a larger push within SSA to expand medical education, "with 58 new medical schools established since 1990 and many existing schools mandated to expand enrolment" (Mandeville, et al. 2015). Despite the growth of these programs, Malawi's government recognized that training programs would not meet soaring demands, as population growth and improved access to care were out-pacing clinician training programs, and clinicians were continuing to leave Malawi's workforce (Mulwafu, et al. 2014). In 2004, on the heels of a report showing that Malawi had the lowest physician:patient ratio in the world, and coincident with large-scale expansion of HIV services, Malawi's Ministry of Health issued a 6-year Emergency Human Resources Programme that "included a 52% salary top-up (nearer 30–35% after tax), [plus] other financial incentives such as continuation of free accommodation and transport to work (although a planned rural bonus was never implemented) and tripling the number of medical students at CoM," (Mandeville, et al. 2015; Zijlstra and Broadhead 2007). In addition, CoM added graduate medical education programs (ibid). In 2010, the Medical Education Partnership Initiative was founded to bolster the number of providers and service quality, with the expectation that clinicians will serve "as custodians of World Health

Organization (WHO) guidelines” and champion preventative health measures (Mandeville, et al. 2015; O’Hare, et al. 2015)

In 2016, construction broke ground on a second (donor-funded) medical school in Malawi. Students at this new school began taking classes at CoM and are set to transition to the new school once they can be accommodated. During my most recent fieldwork, I heard murmurs of the formation of additional medical schools, with uncertain implications for hopeful medical students, who face rising tuition costs (accelerated with de-linking, as described in Chapter 2) and suspect that the quality of their training is depreciating as limited resources are stretched across more students.

Research by Mandeville and her teams (Mandeville, et al. 2012; Mandeville, et al. 2015) has begun to explore the preferences of Malawian medical students, as part of attempts to increase clinician retention. Malawian medical students have been shown to differ in important ways from medical students in the USA (Good 1993a); for instance, Malawian students have lesser expectations for and dependence upon high-tech equipment, and they show greater concern for political-economic aspects of medicine and patient wellbeing (Mullan, et al. 2011; Wendland 2010). Importantly, the morale of Malawian medical students has been shown to depreciate throughout their training—a trend that runs counter to American medical students (Bradley, et al. 2015; Wendland 2010). Mandeville and colleagues have shown that Malawian students’ top priority after graduation remains specialty training, and they suggest that “indiscriminate expansion of postgraduate training to slow emigration of doctors from sub-Saharan African countries may not be effective unless doctors' preferences are taken into account” (Mandeville, et al. 2016). Similarly, Wendland (2016) critiques development efforts for treating trainees and other healthcare personnel as black boxes, as though their thoughts and preferences are irrelevant to development.

A central goal of Malawi's training programs has been to increase the number of clinicians in rural areas, with the Family Medicine registrarship (equivalent to a residency program) leading the way. This program has not yet produced its first graduates, but my interviews and discussions with trainees suggest that its future is uncertain, as institutional investments in technologies for those physicians is scant—and could be for naught, if physicians continue to migrate at their current rate, thereby supporting the suggestion of Mulwafu, et al. (2014), that a critical mass may be needed before substantial investment can be justified. Additionally, physicians, especially specialists, need more resources to practice near their capacity than, say, medical assistants (MAs), so investment may be a precondition for physicians practicing rurally. That said, efforts are also being made to increase the number of MAs and clinical officers, who provide the bulk of care at health centers (some of the most rural facilities) and district hospitals throughout the country (O'Hare, et al. 2015). Additionally, because of lower costs of training and decreased likelihood that they will emigrate, clinical officers are now being offered specialty training in disciplines such as surgery and internal medicine. Muula calls clinical officers and MAs "inevitable" given Malawi's history, and suggests that "Were it not for the mobilization of clinical officer and medical assistant cadres, the often reported Malawi success story would not have been told" (Mulwafu, et al. 2014; Muula 2009).

Unfortunately, in 2016, a sour taste was put into the mouths of no fewer than 38 CoM students (around 1/3 of the class), as they were told that they could not sit for their annual exams because of their inability to cover (rising) tuition costs. In response, students went to radio stations in Blantyre and complained that "they are chasing us from school because we haven't paid fees," in the words of one student whom I interviewed. The event sparked public outcry and a response from The Higher Education Student Loans and Grants Board, which covered the tuition of the 38 medical students and released a statement expressing that they "found it important to come to the rescue of these students considering the importance of uninterrupted studies to the students, the college and the nation."

Of symbolic importance, the political actions of students run counter to a popular narrative that Malawians are 'culturally passive,' as I have frequently heard during my first trip to Malawi. In our interview, a DMO called this a 'yes bwana' culture, and suggested that it has prevented clinicians from taking large-scale, organized action. By my experience, it appears as though any large-scale strike would be a distant response, as only one clinician with whom I spoke hinted at "walking", although the Malawi Doctor Society (MDS) and Medical Doctors Union (MDU) have been politically active (including getting the students' tuition paid). Likewise, clinicians at the Mobile Clinics have organized to bargain with management.

This ebb and flow of training and support programs reflects changing relations between clinicians and the state (Coburn 2006; Freidson 1970; Kleinman and Sung 1979; Leslie 1980; Timmermans 2005). John Iliffe argues that this relationship is much different in East Africa as compared to Europe or USA, as private practice has not played a prominent role in settings where missionary- and state-sponsored services dominate the playing field (Iliffe 2002). In such settings, Iliffe argues, any single issue (e.g. 'power' or knowledge) is insufficient for understanding professionalization, and he goes on to suggest that the inability of the state to provide monopoly status to biomedical providers places ambiguity at the core of professionalism in East Africa (ibid).

Similarly, it would *not* be fair to characterize Malawi as a place of individual complacency, as every person I interviewed expressed a desire to increase her training, save for three administrators. In Malawi, increased training currently typically happens by one of two routes: 1) going to back to school to earn a higher degree (discussed above), or 2) attending seminars, at which participants collect per diem pay.

The issue of training seminars and per diems has far-ranging effects, and there are few issues that I came across that were more polarizing for clinicians and administrators. Administrators in the public hospitals shared during interviews that as long as the wards are covered, they generally allow clinicians to attend trainings (each of which may provide clinicians with an extra week's-worth of wages for the trainee). Unfortunately, the compensation scheme for seminars acts against easy coordination, as personnel are compensated in proportion to the distance which they must travel to seminars, thereby encouraging personnel to attend conferences that are farther away, leading to more time off. During my time at each hospital, miscommunications with trainings, unpredictable patient flows, family tragedies, and other unforeseen events frequently contributed to short staffing. During my months at the District Hospital, personnel complained in meetings and casual conversations that they were particularly short-handed because so many clinicians were at training sessions or assisting in the provision of special projects (e.g. a measles vaccine campaign, for which stipends were provided). I had assumed that the reason for the seminars and campaigns must be that the hospital invited extra activities during the slow months. I soon learned that my assumption was incorrect, as an administrator explained to me that the flood of extra programs coincides with the summer of the northern hemisphere—from where most of the NGOs derive, which conduct the seminars—as that is the most convenient time for NGO's personnel to travel, *and* it also happens to coincide with the end of the fiscal year, by which they must have carried out the programs for which they received funding. From my observations of NGOs in these facilities, it seems that those individuals involved in administering the programs likely buy-in to the importance of whatever they are doing, although, as Claire Wendland notes, there was not always clear overlap between the topics of trainings and the daily work of clinicians (Wendland 2010).

One could argue that the importance of disseminating information on the newest guidelines and treatments is trivial in a setting where so many people die from illnesses that could be effectively treated with older regimens, but such reasoning runs counter to much of biomedical culture expressed by those persons whom I interviewed, in which providers expect to deliver ‘what’s best’ for patients, rather than what may merely be adequate for a lot of people.

Without training seminars or a vibrant academic culture in rural areas, clinicians told me in interviews that they learn about updates from friends, their own readings, or they may volunteer at other facilities during their personal vacations. I was told that updates slip through those coarse filters, and that once missed updates are later discovered, the experience can be devastating. During one interview, a clinician from the Mobile Clinics described the epiphany as “like suicidal, because it's like your future is at stake, because if you are not doing the right thing, your license can be revoked. At the same time, you are not doing the right thing, because… you are endangering the community, the patients.” This situation was especially contentious at the NGO, where clinicians expressed that they feel isolated, and management does not support their attending paid seminars. In justification of their reasons for not allowing clinicians to attend seminars, an administrator asked during our interview, “how about the child who has fever in the community? Do you want us to leave that child to convulse and die?” Such questions, it seems, represent a zero-sum conceptualization of training: if a clinician gains training during the day, then patients go untreated. Clinicians expressed a different conception of trainings; namely, as investments in themselves and in their future care of patients. Mobile Clinic clinicians' told me in interviews that their suspicions surrounding the lack of support for their training were bolstered by the organization sending their data officer for advanced training, when she had not even requested it—in contrast to denying clinicians who had requested further training. An administrator justified that decision during our interview on the grounds that the data officer had "been handling that job almost alone for some time, trying to compile those reports and we could actually see that [she's] been hard working."

Brain Drain & Absenteeism

Brain drain is commonly defined as emigration of trained professionals from less-developed to more-developed countries—this can be thought of in contrast to 'unskilled' emigrants who have been well documented in Malawi's history—and it has received a great deal of attention from scholars and policy makers since at least the 'liberation era' of the 1960s, when scholars argued that brain drain is principally an economic issue, whereby developing countries pay for and lose (in effect, donating) clinicians to wealthier countries, where those clinicians can earn higher salaries (Kannappan 1968; McCracken 2012; Mills, et al. 2011; Wright, et al. 2008). Cometto refers to brain drain as "one of the most controversial aspects of globalization… at both the technical and political level," while Karan suggests that "the most concerning aspect of medical brain drain is its self-reinforcing impact on health care systems that are already weak: as a health care system weakens, bright physicians and health care workers tend to leave; the more who leave, the more the health care system is weakened," which, as of 2013, was resulting in increased emigration and decreased physician-density throughout much of SSA (Cometto, et al. 2013; Karan, et al. 2016). Potentially compounding this issue, in an article published in Malawi's

The Nation newspaper, Dionasius Pathera suggests that brain drain serves as “a safety valve” that releases those individuals who might otherwise spark change or revolutions because such changes require a certain opportunism that can only be capitalized upon if a person is in the setting (Pathera 2014). Pathera states that “Africa is bleeding” and suggests that “it is not surprising that Malawi and other African countries are complaining about brain drain. It is of our own making, as warning signs have been there all along” (Pathera 2014). John Lwanda strengthens this historical case, arguing that the roots of the Malawian medical brain drain lie in colonial and postcolonial society, with economic, political, social, racial, and classist factors shaping the expectations and culture of biomedicine in Malawi (Lwanda 2002).

In following this socio-historical thread, I do not wish to deny the role that current experiences or personal finances play in brain drain, as physicians I interviewed reportedly make MWK 243,000 per month (equivalent to roughly $USD 334/month), and clinical officers I interviewed reportedly make about half of that (around $USD 166/month). While each of these amounts are greater than the average income of an adult Malawian, they were far from satisfying for any of the persons I spoke with. For instance, a district administrator joked during our interview that “You get that 300 dollars and you pause. You’re like, ‘it feels like a government district funding meeting all over again’,” as he erupted into loud, frustrated laughter. Meanwhile, a clinical officer called the arrangement “really embarrassing,” during our interview, “because when everyone is working, you expect to develop, and you expect to meet your needs… It’s pathetic… a *huge* demotivating factor.” Compounding frustrations, as was mentioned last chapter, locum pay was withheld for months, creating situations whereby these clinicians struggled to cover their rent and utilities. Frustrations with pay extended up to the district administrators whom I interviewed, as a DHO explained during our interview that, “Usually, you get appointed to this administrative position without the actual promotion, so you do the job… that's a grade or two above your initial entry grade, but you haven't gotten the promotion… you're not being paid for the job that you're doing." She had served as a DHO for over four years, but she was still paid as though she had just finished her internship year. Within district settings, I was told during interviews, turnover of at least one administrator (DHO or DMO) generally occurs every year or two, thereby disrupting district plans and destabilizing personnel's expectations (within the district of the District Hospital, both the DHO and DMO left while I was there).

During each of my interviews, all informants told me that they were familiar with the term "brain drain," so I asked them what it meant to them, what they thought were its causes and effects, and what was their assessment of people who "drain". Definitions for "brain drain" included standard notions of national emigration, but also included rural-to-urban emigration and switching from a public facility to an NGO or research project. I had encountered each of these uses of the term brain drain during my 2011-2015 trips to Malawi, and they continued to be applied in a way that characterized movement away from public and rural facilities; however, in my 2017 interviews, I encountered new definitions for what qualifies as brain drain. As one DHO stated in our interview:

> "there are two types of brain drain in Malawi: the silent and the active one. The active one is the one that everybody, you and I, may know… people moving to other countries or other places for greener pastures. But there is this silent brain drain, where they think we are there in the system, but we are not actually there [laughs]… By the end of the day, human beings have to survive. They will find their ways of surviving. Either I'll have to do business to supplement my income, or I have to attend to various trainings and opportunities in Malawi. Running from one facility to another, one district to another, just because maybe you will get some top up [i.e. extra income], at the expense of job, duty… The nation would think we have doctors in the facility, yet they are not there. That is the silent brain drain."

Another term for this “silent drain” could be absenteeism, and those with whom I spoke suggested that stagnant salaries and yearly reductions of benefits are only making this worse. A more concrete example of “silent drain” provides us with insight into how it affects coworkers and patients.

District Hospital, Male ward, 9:20am: A 37-year-old man—a father, husband and subsistence farmer—presents with his brother. They had been waiting at the hospital since 7am, after having left home on a bicycle taxi at 3am, in the pitch dark (the patient had sat on the rear bike rack and was supported by his brother and the biker for around 4 hours during the commute). The patient was suffering from a painful, half-volleyball-sized abdominal hernia, which he had been dealing with for about 4 years. Until recently, he had been able to manually reduce it (push it back under his abdominal muscles) and had been satisfied with treatments from a traditional healer (who, he told me, gave him a liquid concoction to drink). Five days ago, the hernia had become acutely painful and the man could no longer reduce it. Unfortunately, he had to delay coming to the District Hospital because he needed to raise MWK 2500 (equivalent to USD $3.44) to pay for the bike taxi.

After a brief examination, the clinical officer was confident that he needed surgery for what was likely an ischemic bowel, and a clinical officer intern was sent to recruit an anesthesiologist for the surgery. As it turned out, the anesthetist had left the hospital to ‘pay her home electricity bill,’ so the surgery was postponed. At noon, I ran into the intern once again, and she told me that the anesthetist had arrived, but now she could not find either of the surgeons, as both had already gone home for the day—this was common for the surgeons with whom I spoke, as their daily surgeries were regularly cancelled/displaced because of emergencies from labor and delivery or a lack of support staff. Painfully familiar with this dilemma, the intern initiated a referral to a central hospital for the patient's probable strangulated hernia. For good measure, she added to the referral a man who had been stabbed in the stomach three days ago and was still waiting in the ward to be taken to the operating theater for an exploratory laparotomy (a surgery to clean the wound, assess and repair damage). In this case, not only was the care of patients critically delayed, but the anesthetists and surgeons added to one another's frustrations, and the intern expressed a sense of abandonment and hopelessness to me, as she was unable to perform the operations herself, nor could she get someone else to do so.

Another definition of "brain drain" that was described to me during interviews involved personnel feeling underutilized or forced to function below their level of training. One physician described this process during our interview as "you start off becoming a scientist, [but then] you become a technician—just protocol, not to think about it. For me, I also consider that brain drain." Similarly, during our interview, a young administrator bemoaned that "the job causes you to stop thinking and to just be stressed and frustrated over time… the thinkers stop thinking, and they just become a part of the problem." This conception of "brain drain" is similar to what Aisha Lofters, et al. (2014) called "brain waste" in another setting, as, in their study, professionals migrated to high-income settings and took jobs performing menial labor, rather than practicing to the peak of their abilities. However, in this case, "wasting" or "draining" happens domestically (a connection to the next section of this chapter, whereby personnel are present but cannot or will not fulfill their duties). It may come as no surprise, that both of these personnel expressed during our interview that if people feel useless, or as though they are performing below their abilities, that they should find work elsewhere.

Each Malawian I interviewed noted that she was at least aware of moralizing arguments against leaving, as though health care personnel should 'gut it out' and stay to 'serve their people', but out of all of the people with whom I spoke, only one student expressed feelings that that those who leave are 'selfishly' seeking greener pastures. Other than that one student, each interviewee sided with 'draining' personnel, blaming a flawed system rather than individuals. For example, during our interview discussion of moralistic arguments against emigration of healthcare providers, a DMO shared:

> "You know that quote that says 'until you walk a mile in my shoes,' that whole concept? I listen more when I can relate, when there is a connection, but other times I'm like, 'you guys are just saying that because you don't want to do the work. I'm not saying come and be a doctor in the district, but I want to know what have you done where you put aside your personal comfort, you took up a task that was difficult, but you did it for the benefit of someone else, and you stuck with it?' I'm like, 'once you tell me something like that, that you're doing, then come back to me and tell me… I'm not here to make you happy. I'm here to make a difference, and if you're going to guilt me into trying to make me do the job, especially by bringing that argument,' I'm like, 'there are million-and-one ways to serve'."

Rather than seeing themselves as located in the driver's seat on this issue, those personnel whom I interviewed conveyed that they are simply responding to their environment in ways that improve their lives and may result in them doing more good for others—thus, it may be less an issue of *where* or *whom* they serve, but rather *that* they serve and *how* they serve.

Following from interviewees expressing mixed feelings regarding whether they worked for the government/public facilities, I asked each interviewee whether she felt that the government values clinicians. A few personnel provided tempered responses—something along the lines of 'they are trying their best'—however, most expressed strongly that the government does *not* appropriately value clinicians, and many clinicians shared horror stories of neglectful treatment. Among the most striking examples that interviewees provided of the government treating them poorly included physicians being evicted from their government-provided housing, with no warning, because the government stopped paying their rent. During our interview, one physician described her internship year, when she got evicted, as "one of the most difficult times of my life… We were neglected. We were not taken care of," as she had no salary *and* no house to live in. Another physician shared:

> "Because I'm a medical officer, they need to house me, because my pay is crap. If they didn't give me a house, I honestly cannot afford to be living on my own… The landlord had been telling the ministry of lands that they would kick us out, and they hadn't even communicated this to me… Like, 'Do you care about my wellbeing at all?' Assuming I had a family, where would I put my kids? Where do I put my stuff? Even me as a human being, just on my own, what do you want me to do next?"

Unfortunately, this issue of eviction and disappointment was not the most striking example in recent history. In 2015, 20 of 48 CoM graduates went to practice medicine in Lesotho, as Malawi's government reported that it could not afford to pay their salaries for internship year. By law, Malawian physicians are required to complete their internship in one of two central hospitals before they can sit for their licensing examination; thus, if they cannot do an internship, they cannot practice medicine in Malawi, so they are left to sit around, unemployed, or go elsewhere. Reflecting upon the mass exodus of interns, a physician told me in our interview that "it was just very apparent that the government is not taking health workers seriously, and they don't want the most qualified person to see the patient, which is very sad because that's what everybody wants. Everybody wants to be seen by a doctor." Ultimately, it took public outcry and an ultimatum from MDU and MDS for the government to reverse course and make offers to the interns—offers that came too late for the 20 who had left (Ngwira 2015). In such instances, 'brain drain' seems to be built into national planning; although, we would be remiss to stop there, as the IMF-freeze on Malawi's loans precipitated the government's hiring freeze (Muula 2016). A DHO drew an analogy to explain this situation, if clinicians are blamed for leaving: "It's like opening a tap, and putting in a bucket with holes. There will still be some water in there… but they'll blame the water [for leaving], 'There is too much water coming into the bucket!' No. No. No. The problem is the bucket can't hold enough of the water" [laughs]. In other words, as this DHO understands it, the origin of the problem is not healthcare personnel, it is their environment and institutions. She went on to suggest that physicians must either be supported, or the intake of medical students must be reduced, *if* the goal is to stop brain drain.

Burnout

The next form of short-staffing may be thought of within a concept that has received much attention throughout parts of the 'developed' world but has been largely neglected within 'developing' settings; namely, burnout. Far from being an issue of clinicians "foolishly" absconding from their responsibilities, as Omaswa (2014) critiqued elsewhere, this is an issue whereby intelligent, dedicated individuals can no longer reliably function at a level to which they aspire. Burnout is frequently defined by a triad of exhaustion (physical and emotional), depersonalization (i.e. reduced empathy for patients) and a reduced sense of personal accomplishment (DeChant and Shannon 2016). Reflecting upon her burned out employees, a DHO shared during our interview that:

> "When people are in that state, they don't really provide quality care in the situations where there could have done better. Maybe the resources were there, maybe the time was there, but because they just don't feel like putting in a decent effort anymore. Then the patient suffers. It is an issue of concern to me, especially in the outlying health centers."

The standard tool of quantitative burnout research is the Maslach Burnout Inventory (MBI), a 22-item, Likert-type survey which provides a quasi-quantitative measure of burnout. It is worth emphasizing that burnout is a non-binary, spectral issue, and one cannot say definitively whether a person is burned out or not based upon the MBI; rather, determination depends upon how a person interprets her situation within the context of her work (DeChant and Shannon 2016). Furthermore, decontextualized, survey-based studies into burnout impose a bureaucratic framework onto something that is deeply affective. Adding insult to injury, in a 2014 metanalysis of international burnout by Dewa, et al. (2014), authors noted that no studies had taken place regarding clinician burnout in sub-Saharan Africa; thus, the region has been largely omitted from discourses and interventions regarding burnout. I was able to find three studies of burnout in Malawi, two of which use the MBI in a pseudo-diagnostic sense of making a claim about prevalence, and the third sought to understand the insights of (mostly nurse) providers involved in obstetric care (Bradley, et al. 2015; Kim, et al. 2018; Thorsen, et al. 2011). Rather than follow in that path of inferring from surveys, I went straight to the source and directly asked people about their understandings of and experiences with burnout. I found linguistic differences may be part of the reason that researchers avoid studying burnout in Malawi. In the words of one physician from our interview, “burnout *does* exist, but we don't have a [Bantu] word for it, and because we don't have a word for it, it's difficult to describe.” Only some of those personnel with whom I spoke had even heard of the term, although each eagerly told me about experiences of exhaustion, frustration, futility and apathy. Another physician suggested during our interview that a lack of attention to burnout in Malawi is because:

> “It's a cultural thing: if you say burnout, people will just assume you're being lazy. ‘What do you mean you cannot work? What do you mean you cannot function?’ I mean, even if I had burnout, it wouldn't even occur to me to seek help… You just keep going—that's the Malawian way, just keep going until you drop… As long as you're in the ward, people don't care. You're there, so it's fine.”

Attention to similarities with laziness highlights how interpretations of behaviors are colored by wider Malawian cultures, as authors in Western settings note that burnout shares dimensions with depression rather than laziness (Bianchi, et al. 2017)—not that either is more correct, just that emphases are different, with Malawian society possibly being less likely to associate these behaviors with psychiatric diagnoses. Within the interpretation of laziness, however, we see a tendency to blame individuals and infer a particular intention and cause for what may be a multifactorial, semi-intentional issue (Lancet 2017).

Further complicating matters, and consistent with other settings across the world (DeChant and Shannon 2016), those persons whom I interviewed suggested that symptoms associated with burnout depend upon the policies and workplace culture of healthcare facilities. For example, a DHO shared during our interview that:

> “We struggled here with a situation where, let's say, someone who's on call, they want to go sleep at home and they want to be picked whenever there is a patient. I think that's totally wrong. A patient is supposed to come to the hospital, find the clinician, not even wait… Let's say it's an emergency cesarean section. The patient doesn't need to wait 20 minutes for them to be operated on. The people simply have to be there… [Patients] would have already struggled with transport to get to the hospital whether it's a health center referral, delays in the ambulance. We can't be adding on them waiting for a clinician… We said ‘it's just the standard that we want to set now. We don't care about what happened in the past, how you were working before… This is where we expect you to work’… but clearly we could see people were not pleased with that, which means that the work culture there is a bit different from what I'd expect it to be.”

I share this story not only to highlight the DHO’s thoughts that personnel were disgruntled with her policy change, but also to convey the DHO’s disappointment with the workplace culture that she ‘inherited’ at her district hospital. During our interview, another DHO suggested that a “culture of apathy” cultivates and is fertilized by burnout. In her words:

> “I think in a normal circumstance, someone would be worried about poor patient outcomes, but this person who's seeing this number of patients in a day, it will be because they will know it's out of their hands. That's where maybe the apathy might come in. You might not be as sympathetic with poor patient outcomes. It's not like I'm blaming the clinicians, but you're simply used to that situation… it's a systemic issue that has actually built up over a long period of time… Depending on the staffing levels, it differs.”

Regarding differences between facilities, another DHO expressed a thought that I often heard from both administrators and clinicians across the public hospitals and the NGO:

> “The same people, if you employ them in an NGO, they work hard, but if they are in government, they are just lazy. It’s an issue of culture. It’s difficult to change. But if you can take advantage of this new development [decentralization] and change the working culture… they’ll find a different working environment… If people can actually see that if you work hard you are rewarded; if you don't work hard you are gradually managed out of the organization… People will then start responding.”

For those facilities where I spent time in 2017, the most prominent differences in daily activities and workplace culture appeared to surround handoffs[13] and communication. At the Central Hospital, each department rounded at least once per shift, and some departments rounded multiple times per shift—meaning ‘more work’ which was simply accepted as the norm at the Central Hospital. Within the Central Hospital, however, prominent differences existed, as well. For instance, pediatricians extolled their supportive, team environment, whereas those in Obstetrics and Gynecology described a strict hierarchy and harsher working conditions, and those in ATC described the most isolating and autonomous culture.

At the District Hospital, on the other hand, rounds are poorly attended and, in some departments, patients were skipped entirely, to save time. In interviews, personnel let me know that this was a long-standing trend and unlikely to change in the near future. District administrators who had been accustomed to practices in a Central Hospital described being incapacitated in a district setting, where they described work by a spirit of ‘mutual tolerance’, rather than shared workplace culture between administrators and clinicians.

The Mobile Clinics, on the other hand, do not involve any handoffs, and their clinicians expressed complaints about feeling isolated. It is noteworthy that, during interviews, personnel at the Mobile Clinics described fewer symptoms of burnout compared to personnel whom I interviewed at public facilities. This difference seems to result from a combination of factors, which include greater salaries and performance feedback, direct community engagement, and more reliable resources. An administrator of the NGO added that they have never surveyed clinicians regarding job satisfaction, but “if I can measure job satisfaction by attrition rate, I can

---

[13] A “handoff” is a report given between shifts that covers each patient in the service, including what has happened and what ought to happen in the foreseeable future—or, often at the district hospital, what has *not* happened: which medicines were not given, vitals not recorded, patients not moved, patients moved without proper accounting, history or physical exams not done,

say it has improved because I haven't seen in the last two years anybody leaving the clinics—resigning from the clinics.” While this suggestion may seem crude, functional indices of burnout have been shown to include: staff turnover, high vacancy rates, disruptive behavior, lack of engagement in institutional projects or during meetings, and demands “for compensation for everything they do” (DeChant and Shannon 2016).

Symptoms of burnout among public administrators was also common, as each expressed that she was either currently experiencing burnout or had experienced burnout in her position. For example, a Central Hospital administrator shared during our interview that “if the systems were a bit stable, this job could be enjoyable, but you are running an institution with chronic shortages of health workers. From time to time, you hear that there is no staff there even in the night. It's a crisis after crisis.” She continued, “the most troubling is the fact that you do not have control… So to me, you feel powerless at the end of the day because you have to be negotiating with people, beg them or try to influence for things to work, but those are things that were supposed to work in a normal situation.” Another physician reflected upon her time as a DHO during our interview: “I wasn't mentally prepared, I wasn't psychologically prepared... The ministry, the zones, my director, everybody was on my neck to make sure that everything is going well… The stress was not good, I used to have all these physical [manifestations].” Similarly, during our interview, a district administrator reflected upon her thoughts when she just started her job: “I was crazy overwhelmed with the job. I couldn't take it. First weekend was the first weekend I ever thought I was depressed. I literally was in bed the whole weekend.” This sense of burnout was not the case for administrators of the NGO, one of whom told me in our interview that “my job satisfaction is higher [than DHOs] because I have resources. When the staff need medication, I'm able to provide them with medications…. The frustration that I also experienced when I was working in the government, it was big."

Brooks (2017) suggests that 'overwork' is a main etiology of burnout, and those personnel whom I spoke with often mentioned feeling overworked; therefore, we might expect to see a tight correlation between patient caseloads and reported symptoms of burnout. My findings suggest, however, that workload's contribution to burnout is mediated by other factors—notably a sense of achievement and feeling adequately compensated. For example, out of the facilities where I spent time in 2017, the Mobile Clinics saw the greatest number of patients per day year-round, yet their clinicians reported the least symptoms of burnout. Additionally, in the words of one clinical officer at the Mobile Clinics, from our interview, "I know I fit in because they have also given me an extra job… It's pretty challenging… but you grow through that. So, I think it's pretty awesome." This clinician found *greater* job satisfaction with *more* work, not less. On the other hand, a clinician in ATC at the Central Hospital may see one-tenth of the patients seen at the Mobile Clinic in a day, but each ATC physician reported symptoms of burnout during our interview. A student provided insight into this relationship during our interview, when she suggested that, "the more patients you treat per day, and if their treatment is a success, and if the required materials or the required drugs are available for you to help that patient… these things are going to make you satisfied… If we can consider money as well—if money is there, they are going to be satisfied, like *big time*."

The derived importance of caseloads in burnout may also be appreciated by recognizing that deviance in either direction—too much work or too little work—can accompany self-reported burnout symptoms. Strangely enough, 'too much' and 'too little' work were not mutually exclusive conditions. For instance, a DHO shared during our interview that "sometimes you could have a situation where in terms of workload is the same, but their work environment, let's say, sometimes you have a scenario where people don't really like each other, so it becomes difficult for people to assist each other." Similarly, a physician in Obstetrics and Gynecology from the Central Hospital shared a sentiment that was popular among clinicians at both of the public hospitals where I spent time. In her words from our interview:

> "Sometimes, when you are the doctor, you do get to hear or handle every problem. For example, if there are no gloves, I will be told that there are no gloves, but there is never a day I have ever ordered gloves. I don't know where gloves come from. It's a nursing problem. If there will be no drugs, it's the pharmacist's problem, but somehow, I would have to work through that and make sure that my patient is well taken care of. That just demotivates me, a lot. I like systems that do work—so I do my work, someone does their work, we meet and go forward. But if I have to do my work and someone's work, then I will get tired."

In such cases, she doing too much (of someone else's) work and not enough (of one's own) work coexist. A downstream effect of this on patient care was described by a physician at the District hospital, who explained during our interview that:

> "You find that the same work that I could be doing in a short time, you do it longer than you are supposed to do it… The theory that I have on that is, even if a patient has been admitted, but the diagnosis is not known… In the ward you just continue managing them as the diagnosis, but the next day you see them, you still don't have the diagnosis. Tomorrow you will come back and still try to get them the diagnosis. You're doing the same job three times or four times, not making any progress."

In this 'crisis mode' of operation, clinicians were constantly 'putting out fires', such that if a patient seemed stable, management may have been continued, so that attention could be given to a sicker patient or a more pressing issue (e.g. getting supplies), even if most clinical information (including a diagnosis) was missing for the 'stable' patient. In this way, stable patients may function as a sort of buffer for clinicians, and in settings where stable patients are scarce, frustrations may boil over more quickly, as explained by a physician in ATC:

> "I remember one day, myself and [another physician with one nurse] had a lot of patients coming in. There was a high tempo of patients. They were coming, and then they would die, and then they would come in, and then they would die. Others are really sick, and

> then we transfer them quickly to ICU. It was such a bad day. We were just yelling at each other the whole time… I was burned out. I told them 'I'm going home,' and they're like, 'You can't go home.' I'm like, 'Fine, I'll just sit here.' I just sat here, and they're all working on the station, and I'm just barking orders. Later on, we laughed about it, like, 'I'm not going to touch a patient. I'm not going to do that, and you're not going home either' [laughter]… It was a horrible day. When I was getting home, I'm like, 'I really didn't touch a lot of patients today'."

In situations like this, burned out clinicians effectively become part of the 'silent brain drain,' opting to sit at the desk or in the break room rather than seeing patients. During our interview, a registrar suggested that in such situations, staff "become numb" to people suffering and dying.

Sociality of Medical Personnel

Having discussed some of the experiences and reflections of healthcare personnel regarding their lives at work, I would now like to turn to how they grow and are immersed within broader social and personal expectations for what their personal lives *should* be like. I casually discussed perceived social expectations with personnel when we hung out after work, and I asked personnel about social expectations that may apply to healthcare personnel during our interviews. Each person with whom I spoke felt that she was expected to act in certain ways because of her social position. Such expectations covered quotidian aspects of life, such as what to wear (fresh, new clothes, clean shoes and a shiny stethoscope for clinicians), how much money to donate in church, and what gifts were suitable for family and friends—such practices were not described as being *required*, but they were *expected*. Interviewees suggested that expectations also extended beyond individual deeds, as their position granted them responsibilities that derived from their reputations as intelligent and benevolent members of their families and society—expectations that they often, but not always, strived to meet. Because of this reputation, and the thought that clinicians should live a stable life, multiple physicians told me during our interviews that their families pushed them in the direction of medical training, with one sharing that she had actually changed her mind about medicine once she found out that physicians struggle financially, at which point her parents staged an intervention for her and, in her words, “sat me down and basically told me that I'm going to College of Medicine no matter what.” Additionally, interviewees told me that clinicians, especially physicians, were expected to be breadwinners for nuclear and extended families, which can extend to over a dozen individuals. This responsibility can compound the stress that these personnel experience. For instance, looking to her future, one physician shared during our interview that:

> “I'm definitely concerned… You live in a hand-to-mouth situation, and if you understand the Malawian economy, the way it works, you can't afford to do that. Because if somehow you become disabled tomorrow, it means you literally have nothing, and that's why a lot of people right now are in awkward situations, because they didn't save while they were working. But the truth is, they didn't have money to save. That's not an existence… You shouldn't have to live like that as a doctor.”

Similarly, another physician shard during our interview that:

> “I shouldn't be thinking, ‘Oh I don't have enough money to buy groceries.’ I shouldn't be thinking I don't have enough money even simply to fuel my car. If that's the case, then I think I wouldn't blame anybody who is looking to better themselves by doing something else, if they are in medicine, because that's the situation they are given.”

In addition to expectations for financial stability, interviewees told me that their families pushed them in the direction of medicine because of the prestige afforded to clinicians—a factor that students told me CoM buttresses during orientation. From a more historical perspective, John Iliffe notes that physicians “were long the ‘cream of the crop’, the core of East Africa’s modern educated elite… They were among the first East Africans to enter international affairs as equals” (Iliffe 2002). Possibly as a result of this historical trend, I was told in interviews and casual conversations that physicians’ thoughts are often put on par with community elders, and they are expected to engage in discussions of national importance. “They expect you to have a certain level of maturity,” one physician told me in our interview, “that may or may not be present [laughs].”

Tied into responsibility of supporting families, the majority of medical students, district administrators and registrars were in their twenties or early thirties, an age which coincides with marriage for professionals in Malawi. Marriage and courtship frequently came up during casual conversations that we had sitting around after work, after basketball games, or over shared meals or drinks. In general, males expressed that their training seemed to increase their social desirability, whereas females expressed mixed feelings, as many—particularly physicians—found that men were intimidated by their accomplishments. Consequences of this cultural norm (or at least perception of a norm) included that those female physicians with whom I spoke doubted that they will be able to find a partner in a rural area, pushing some of them to settle in more urban areas.

Then there was the marriage ceremony itself, which was shadowed by concerns regarding a trend toward growing extravagancy (including providing transportation, food, drinks, a DJ, and money that they must give to destitute family members, so that the family can have something to gift them). This trend toward high spending was mixed with more 'traditional' practices surrounding marriage (which may include meeting with one's extended family to be taught the intimacies of pleasing one's partner), placing these clinicians at the uncomfortable nexus of 'modernity' and 'tradition'—a position about which we all did plenty of laughing.

Nevertheless, it seems that kinship ties provide a counterweight to potential brain drain, as multiple physicians expressed to me during our interviews that they had remained in Malawi because of family ties. We may be reminded of one of Adam Smith's proposed 'invisible hand' of social bonds that was predicted to prevent capitalists from outsourcing labor, thereby preventing international exploitation—a point which helped propel Karl Marx to fame based on his foresight in this matter. While such bonds held some people in the local context, evidence of brain drain (in its various forms) the limited efficacy of such mechanisms.

In addition to interacting with expectations from Malawian society, personnel must interact with expectations of wider biomedical cultures. Claire Wendland has looked into how Malawian medical students go about this process, and she describes a hegemonic order of biomedicine that is based upon "four central values": reductionistic rationality, authority of nature and the body, technological orientation and individualism (Wendland 2010). Wendland goes on to suggest that this biomedical *economy* (not order, as it is dynamic) differs in Malawi, where students and clinicians hold sympathy, love and political awareness in higher regard than has been described elsewhere (ibid). In Malawi, perhaps more than elsewhere, clinicians are expected to be self-sacrificing altruists who renounce sleep and personal protection to serve those in need. In addition to these values, interview responses and my observations lead me to suggest that efficiency, thoroughness, quality and camaraderie are also important principles in Malawian biomedical practice. I observed displays of camaraderie when a Mobile Clinic held potlucks at the end of each shift and personnel dug into communal containers of nsima (the main starchy food across most of Malawi); when clinicians at the District Hospital hovered over a child who had been failing to thrive, dissected ultrasound images of the child's heart, and teased the physician operating the probe for her lack of control; and in the Central Hospital, when physicians congregated around the tuck shop, warming themselves in the morning sun and discussing patients before dispersing for rounds, to name only a few examples. Such events seem to be standard fare throughout the country, although they also take facility-specific forms. Judging by the amount of smiling, joking, hand-holding and shoulder slapping that goes on in these exchanges, it seems safe to say that such rituals bind people together.

Multicultural Struggles (Conclusion)

Having now discussed each of the categories contributing to clinician shortages, as well as some of the cultural positionality of medical personnel, we may turn back to see how these elements fit together and what insights we can draw from this grand picture. In the most general sense, my 'solution' to this puzzle is that personnel grow and develop within general Malawian culture, which is shaped from the history and contexts described in Chapters 2, 3 and 4 (among other processes), and cultivates in them a set of expectations and ideals for how persons (including healthcare personnel) may 'be in the world'. Then, these personnel gain experiences as students, providers and/or administrators within Malawian biomedical culture, with which they identify and develop a distinct set of expectations, ideals and ways of 'being in the world.' This latter set of expectations involves knowledge, behaviors, standards, opportunities and responsibilities that are distinct to biomedical personnel. Once these personnel are deployed, they must navigate situations whereby reality does not meet their expectations or ideals for their work and personal lives. To manage these contrasts, personnel develop coping mechanisms and adaptations, which include behaviors that contribute to clinician shortages, with burnout serving as a precursor to brain drain. The tricky part to this relationship is that biomedical culture relies on broader Malawian culture, and vice-versa, so they are not, strictly speaking, in conflict with one another. To support this argument, I will revisit each element of this chapter, and then I will provide further insights via social psychological and biocultural lenses.

Looking at the history of medical training, we see that healthcare personnel have been systematically suppressed and subordinated for well over a century, and that only recently—basically since the end of Kamuzu Banda's reign—were they allowed to speak up for themselves and push their agendas. While a host of programs have been created to bolster the number of providers, Malawi is still woefully below levels desired by those personnel with whom I spoke.

Looking at the history of Malawi (as discussed in Chapter 2) and its healthcare personnel (discussed above), I suggest that we could reasonably *expect* that their working conditions would be wretched, that they would be poorly compensated, that they would be forced to live in 'traditional' ways (i.e. with or near extended kinship networks, with limited access to electricity or running water, as most of Malawi's population lives), that their children would have minimal educational opportunities, and that personnel would have a very difficult time serving patients.

However, that is not the full story. In exploring the culture of current of biomedical personnel, we see that much is expected of them in terms of social contributions. They are expected to look and act in a dignified manner, which entails financially supporting themselves and their extended families; they are expected to play a prominent role within their communities, both financially and intellectually; they are expected to display love and compassion toward their patients; and they are expected to go 'the extra mile' to fight for legislation that would help their patients (Wendland 2010). Looking at these social standards for Malawian healthcare personnel, I suggest that we could reasonably *expect* that their working conditions would be facilitative, that they would regularly have surplus money to share within the community, that they would serve the biopsychosocial needs of their patients, and that they would be granted social and institutional support to function as public intellectuals.

Comparing lists of personal-biomedical to socio-historic expectations, we see dramatic differences. However, contrary to Lwanda (2002), who depicts the expectations of Malawian physicians as analogous to their colonial predecessors—elitist and in conflict with Malawian society—I suggest that personal-biomedical expectations are supported by wider Malawian society, which depends upon clinicians to fulfill their roles as providers within extended families, to push for reforms as public intellectuals, and provide them with quality care. Furthermore, as suggested from the above history, biomedical personnel rely on support from the state and Malawian society for maintaining their practices and identity (and, as will be discussed next chapter, they also rely on patient for their clinical interactions).This mutually-dependent relationship is analogous to the argument made by Ferguson (2013a), who qualifies the capabilities approach to development (discussed in Chapter 2) by arguing that a close examination of local cultures and practices reveals how interrelationships and dependencies facilitate survival and progress in some sub-Saharan African societies.

In *Expectancy and Emotion,* Miceli, et al. (2015) explore aspects of human expectation and distinguish between anticipated emotions (what we expect to feel), anticipatory emotions (what we feel when thinking about something, e.g. hope or fear), and invalidation-based emotions (when an expectation was proven to be incorrect). The authors suggest that each of these types of emotions influences future behaviors based upon the attractiveness or aversiveness of the associated feelings (ibid). In anthropology, we might call the entirety of anticipated entities and processes (i.e. the realm of what can be expected) “a world view”, and we suggest that it is heavily influenced by culture. The notion of culture has a long history within Anthropology, but here I use the term in a simplified sense, in which culture is a shared set of behaviors, beliefs and styles of being in the world. Therefore, by culture, I mean those aspects of life which are tacitly agreed upon and widely embodied (e.g. see Ingold (1998) for a discussion of embodied culture). Importantly, this definition excludes those elements that vary widely or are contentiously debated—the ruptures and schisms that some anthropologists include within studies of *changing* culture and challenges to power (Foucault and Faubion 2000). Thus, this discussion of shared expectations is a discussion of cultures.

In cases where events do not match expectations, and there is a goal associated with an expectation, Miceli, et al. (2015) tell us that a response may land somewhere within the spectrum of relief-to-disappointment, depending on the deviation from expectation. The authors suggest that in the case of negative deviation, *disappointment* ensues, which they define as "a negative emotional reaction to the invalidation of a positive [expectation] whose cognitive constituents are an anticipatory belief or goal" (Miceli, et al. 2015). In the case of this research, I suggest that we think of the 'positive expectation' as personnel's expectations to fulfill biomedical *and* wider sociocultural norms. Miceli and colleagues further suggest that "disappointment favors loss of motivation with regard to the intention, which *may* be dropped as a result of the verification that the desired state of affairs is less likely to be realized than initially supposed" (ibid). In addition to a loss of motivation, Miceli, et al. (2015) suggest that the experience may involve "suffering implied by disappointment," itself—or, in the words of burnout literature, "emotional exhaustion" (DeChant and Shannon 2016).

Returning to interview and observational data, my findings suggest that when healthcare systems breakdown (whether that be from absent personnel, delays in hearing back on results from blood or sputum samples; stock-outs of drugs and blood supplies; dysfunctional oxygen concentrators or sphygmomanometers; insufficient quantities of safety goggles, gloves and gum boots to outfit entire surgical teams; or broken lines of communication between departments, shifts and facilities), personnel experience a loss—a feeling as though something that was theirs has been removed—thereby precipitating feelings of *discouragement*, which Miceli and colleagues define as disappointment plus intention (i.e. disappointment involving something into which effort has been placed). Instances of discouragement were not uncommon in what I heard or observed. For instance, during our interview, a district administrator explained this process as "when you get into the system… you see all that needs to change, and then before long, you don't see it, and then before long, you're so frustrated that you don't even want to change it." We should recognize this adaptation as *demotivation*—one of the three components of burnout (DeChant and Shannon 2016).

Under conditions of likely disappointment and discouragement, Miceli and colleagues suggest, *disengagement* "allows the individual to effectively move (whenever possible) to alternative and less demanding intentions and pathways in the same general domain" (Miceli, et al. 2015). We should recognize this adaptation as *depersonalization*, the component of burnout involving lack of empathy and disconnect from patients (DeChant and Shannon 2016). Thought of in other terms, disappointment and discouragement leave clinicians feeling isolated from biomedical and wider cultural mores, effectively creating a form of *anomie* within a profession that, Bodenheimer and Sinsky suggest, "can only thrive if it is symbiotic, benefiting both parties" (Bodenheimer and Sinsky 2014; Durkheim and Simpson 1997). In these ways, burnout and brain drain involve realigning expectations to better match reality on the ground, or switching contexts to better align reality with biomedical and/or sociocultural expectations. Miceli, et al. (2015) suggest that detaching from the original goal serves to reduce feelings of loss, thereby transforming the experience into something like a failed acquisition rather than losing a possession (i.e. not getting something that they never possessed, as opposed to losing something that was theirs). When disappointment and discouragement occur within a social setting (as in a hospital or clinic), Miceli, et al. (2015) suggest, a sense of injustice may grow, as persons sense that a social rule has been broken (ibid). Thanks to Claire Wendland's study into biomedical culture in Malawi, we have an idea of the prevalence of a sense of injustice, as Wendland (2010) suggests that activism against injustice is a central characteristic of Malawian biomedicine. This social justice perspective has played a prominent role in Medical Anthropology since the 1990s, although its tenants have been largely applied to patients and institutions, rather than to providers in developing settings (as discussed in the last chapter).

We may gain still more general insights into these phenomena by examining them through a biocultural lens. Accepting that history cultivated the current environments, that personnel grew within cultures, and that cultures shaped personnel's expectations, that stress and disappointment lead to clear biological changes within individuals, and that burnout has biological implications for patients and communities (DeChant and Shannon 2016), we may think of brain drain and burnout as biocultural coping mechanisms for individuals and groups to deal with discordances between experiences and expectations. In this vein, Hakanen and Schaufeli borrow from conservation of resource theory to posit that "burnout results from long-term threats to one's energetic resources and/or actual loss of these resources after heavily investing in work without appropriate gains in return" (Hakanen and Schaufeli 2012). Paul DeChant and colleagues translate such theorizing into common terms, suggesting that burnout is "a way for the worker to protect him- or herself from intense emotional distress that might interfere with work effectiveness" (DeChant and Shannon 2016).

I must note that not *all* healthcare personnel adapted by displaying symptoms of burnout or brain drain, and, as expressed earlier, these adaptations can be transient. Reflecting upon her intimate struggles, a hospital administrator who expressed that she had experienced burnout explained to me in our interview that "sometimes I feel like it is a miracle that I have survived for so long, but I knew before I came here that I was going into a crisis situation, so more or less I got psychologically prepared by making sure that most of the time I don't carry the job home." In other words, she leveraged coping mechanisms to push through the day and continue in her job. She went on to describe how she reads novels, goes to church, and runs side-businesses to maintain her sense of wellbeing. In this same vein of supplemental adaptations, a DHO suggested in our interview that:

> “It's just fortunate that we Africans are very resilient to tough work. Honestly, that's true. I'm like that. I can walk from here to [points into distance] with something on my head and come back, even now, because of the way I was brought up. It was bad, but eventually I see the good. I'm very resilient and tough. Now, because of that, we hide behind that.”

As we may gather from the insights of this DHO, these coping mechanisms can serve as a double-edged sword: mitigating suffering, but also potentially prolonging hardship—a sort of internalized penance linked to African identity. Similarly, a physician suggested during our interview that:

> “There are ways that probably in your system you might find it hard too, but we sort of have an internal way of accepting things that are not normal and moving forward… Like if your mother dies: in your context, someone knocks off because they can't function, but in our context he's also the only one who is available to help the next mother. You just have to pull yourself up and act as if you don't care, and continue on, but eventually, I think it can catch up with you.”

Such notions of self-sacrifice due to history and identity commonly arose in our casual conversations, especially in groups at the district hospital, which, I suggest, functioned to connect individuals to broader society, thereby mitigating a sense of anomie (but not necessarily doing anything about the compromising working conditions) via a logic similar to Wilhelm von Humboldt’s insistence that we locate the universal within the particular (Cassirer 1961), or the African *ubuntu* philosophy, whereby the individual is formed by society. It is noteworthy that solace was found in reversion to sociohistorical norms, rather than biomedical norms, as the former are much broader and provided personnel with increased opportunities to succeed in formulating achievable expectations, whereas the latter may lead more directly to brain drain.

Biomedicine, on the other hand, has much more tightly circumscribed topics and norms, if for no other reason than it only pertains to a portion of life. Eric Cassell compellingly argues that the ultimate goal of biomedicine is—or at least *should be*—to treat patients' suffering, whether that be with pharmaceuticals and/or psychosocial support (Cassell 2004). Viewed through this lens, the situation of those Malawian medical personnel with whom I spent time becomes especially tragic, as it involves the production and exacerbation of suffering among caregivers, who are enculturated to be engaged and loving. During our interview, a physician summed up the general sentiment of interviewees, suggesting that, "The people who stay are courageous, and I think congratulations to them. Even me, I'm also part of that team because I'm still around, but I don't blame people who leave… That appreciation is not there."

Elsewhere, clinicians are valorized for altruistic behaviors, as in the case of Medicines Sans Frontieres, who were awarded a Nobel Prize in 1999, or the efforts of physician-anthropologist Paul Farmer, who was canonized by Tracy Kidder in *Mountains Beyond Mountains*. Such examples stand out as extraordinary when performed by a Western person or group (who can return back to her comfortable life on the other side of the planet). But what happens when people live in harsh environments, rather than just visit them, and altruism is expected, yet rewards are withheld? What happens when clinicians who are trained in an environment that says 'heart' is what matters are then thrusted into a system that may not employ or promote them (or their peers), starves them of the tools they need to perform, provides them with just enough money to stay at the poverty level (practically speaking, not the outrageously low $1.90/day set by the World Bank), forces them to find side-hustles to support themselves and their kin, and then criticizes those who look for other employment? It seems that an answer is clear: rampant burnout and brain drain.

CHAPTER 6: Too Many Patients, Too Little Time

Care in a Hypertension Clinic

It is a Thursday morning, so the district hospital is holding its hypertension clinic. Patients pack tightly onto the wooden benches that trace the perimeter of the waiting room, and two more benches run parallel along the center of the waiting room, each bench stamped with "USAID" or "ART/ANC"[14]. All of the benches are overflowing with people, some of whom have already been waiting for three hours, having left their homes before dawn to make it to the clinic, which runs on a first-come, first-serve basis. Between the benches, a hospital assistant high-steps, ducks, twists and turns as he progresses on his quest to record the vital signs of each patient. A buzz of chatter fills the room.

The clinic is scheduled to begin at 9:30am, but Chifundo is busy in the female ward. He arrives at 10:00am sharp, and nobody seems to notice. He ducks into an exam room to check for supplies, then heads off to retrieve a stethoscope, returning nine minutes later. Chifundo is a thin man in his early 30s with kind eyes and a small gap between his top incisors. With stethoscope in hand, he moves swiftly through the crowd, his white, short sleeved button-up shirt and blue khakis clinging tightly to his body. After checking with the man who is collecting vitals, Chifundo gives me a thumbs-up over the crowd. I take that as my cue to join him. Once in the exam room, he places a sheet of white paper on the desk, on which he has written the dates of one, two and three months from now, so that he does not have to remember them when he tells patients to return for their next appointments. With all of those patients lined up, and the implicit rule that clinicians cannot take a break until all patients have been seen—every second counts.

Patients enter, one-by-one or with a guardian (for inpatient care, patients are required to provide someone who will take care of personal tasks like laundry and cooking), and they sit on

---

[14] United States Agency for International Development, and Antiretroviral Treatment/Antenatal Care, respectively

a stool positioned just inside of the door. Each patient has already been diagnosed with hypertension and is being treated pharmaceutically. After two patients, Chifundo settles into his groove, and the full routine takes shape: a rapid greeting coupled with an exchange of the patient's health passport[15] and patient-specific number that directs the clinician to a line in the hospital's noncommunicable disease (NCD) ledger. Chifundo then looks over their vitals and current medications and asks whether medications are being taken as prescribed. He then returns the patient's personal items, and the patient departs. Before the door swings closed behind the exiting patient, the next patient is already on her way in. Repeat.

By 11:18am, he has already seen 24 patients. He turns to me and ruefully remarks, "the problem here is that we see too many patients at once." We exchange pitiful smiles. He tells me that these clinics were designed to streamline the treatment and monitoring of NCDs, although they have the unintended effect of consuming the entire morning and exhausting the clinician on duty. To ease this burden, clinicians rotate through covering the clinic, so that the same clinician does not get run down each week. At 11:58am, once the most recent patient has gotten up to leave, he turns to me and asks, "are you tired?" Not wanting to call attention to my back that has become stiff from sitting on the wooden desk for two hours, feet dangling off the ground and torso rotated 90 degrees to the left, I respond with a chipper "I am OK. Are you tired?" "Yes, I am," he responds, with unabashed transparency (and likely knowing that I am feeling the same way). We chuckle at our shared discomfort. At 12:35pm, after the acrobatic assistant who had been checking vitals has already gone for lunch, the final patient comes in. "Coming in very late!" Chifundo remarks, as he stands over her, supporting her left arm and sliding the blood pressure cuff up to her brachium. The woman holds her arm out perpendicularly until the

---

[15] A small booklet that each citizen must carry when accessing biomedical care in Malawi, in which clinicians write diagnoses and treatments from each visit

machine beeps, at which point Chifundo pulls the Velcro strap to remove the cuff. Her blood pressure is 148/102—elevated, but not alarming by local standards. Luckily for her, the hospital currently has her medications in stock (hydrochlorothiazide and aspirin), so Chifundo extends her prescription and she is told to return in two months. If the pharmacy had been out of her medication, as was frequently the case, Chifundo would have chosen a medication from a different class, even if her history (in the ledger) indicated that she had failed to respond to the drug previously. In such cases, no explanation was noted in the ledger as to why medications were switched, which left Chifundo in the dark about medication adjustments.

12:38pm, the last of 52 patients has been seen for hypertension, along with a handful of non-hypertensive patients. Subtracting those non-hypertensives and the time when Chifundo left the room to check on pharmaceutical supplies, those 52 patients were seen over the course of about 123 minutes, averaging 2:20 per visit. These visits were impressively regular, with the quickest lasting 2 minutes, and the longest reaching 4 minutes. Given the clinic's demands of documentation in the health passport and hospital ledger, Chifundo was left writing for most, if not all of his time with each patient.

Months later, I spoke casually with Malawian medical students who had rotated through these clinics. They commended the clinics' superior bookkeeping (compared to other district hospitals) but characterized the interactions as 'here are your meds, now go and do with them as you were told on your first visit,' with little effort spent exploring the patient's thoughts or augmenting their understanding of treatment plans—a trend that has been described in Western biomedical settings that use electronic medical records (EMR) (Bodenheimer and Sinsky 2014; Hunt, et al. 2017) but has been given little attention in settings without EMR, let alone in sub-Saharan Africa. Attention to these features of practices also appears to run counter to anthropological literature on medicine in Malawi, which praises clinicians and medical students on their superior manual diagnostic skills (Wendland 2010; Wendland 2016), as throughout the clinic, there was minimal interaction, let alone advanced physical examination.

This chapter discusses how those clinicians with whom I spent time manage high patient caseloads in their attempts to meet demands from patients, their organizations and the wider communities in which they operate. Following Megan Vaughan's example of tending to the humanity of African biomedicine, rather than 'reducing biomedicine to its theory of itself' (Vaughan 1994), this chapter begins by drawing largely from interviews to discuss ways in which Malawian clinicians and administrators idealize clinical relationships. I then shift to data gathered largely from participant-observation to discuss some of the ways in which clinical encounters fail to meet ideals, along with clinicians' thoughts on the matter. Finally, I discuss some of the heuristics by which clinicians make rapid clinical decisions and provide semi-personalized care that, at first glance, may appear totally impersonal and anonymous.

Ideal Clinical Encounters

Before analyzing any clinical practices or entering into any discussions about ideologies, I wanted to get a better idea of what Malawian medical personnel thought about clinical practices. Claire Wendland and Kate Mandeville and colleagues have explored the thoughts and aspirations of Malawian medical students (Mandeville, et al. 2012; Mandeville, et al. 2016; Wendland 2010), yet there exists a dearth of literature on the thoughts and ideals of Malawian clinicians and administrators regarding clinical practices. For that matter, we do not even know *if* they form 'ideals' of practice, or whether they just go with the flow and take things as they come, struggling to keep up with high patient volumes. Their ideals, if they exist, might be congruent with processes taught during standard biomedical training (collecting information, forming a list of differential diagnoses and then proceeding with a plan); they might be congruent with those described by Wendland (Wendland 2010; Wendland 2012b) concerning Malawian medical students; or they might be congruent with those notions of biomedical ideals as described by Margaret Lock and Vinh-Kim Nguyen, whereby patients are standardized and bodies are thought to be ‘universal’ (Lock and Nguyen 2018)—or all or none of the above.

To explore this topic, I asked clinicians and healthcare administrators whether they form ideals for clinical practices, and if they do, what those ideals entail. I found that each person whom I interviewed *does* form ideals for clinical interactions, and that these ideals pertain to a variety of features of clinical interactions. With that established, we may look more closely at the content of the ideals. Perhaps most generally, an administrator I interviewed envisioned herself as the patient and described her ideal clinical interaction as:

> “When a clinician is assessing me, looking at me, showing that he's listening. When it is necessary, maybe to assess in the form of touch—*must touch the patient*. If it involves examining, *must examine me in a private way*... Then giving me feedback on what I'm suffering from, what the diagnosis is. I would come with fever, but they would say, ‘We have checked. You have malaria. You'll feel better because we're going to give you treatment.’”

In this aspiration, we see elements of verbal and nonverbal communication including multiple modes of sensory feedback (looking, listening, touching), clinical competence, confidence, respect for privacy/dignity, and the necessary medications and facilities.

Adding to this quasi-baseline, a pediatrician shared during our interview that “the more time you spend with your patient, the more you can get out [of] an interaction,” leading her to suggest that “you need to give holistic care; you need to take care of their psyche; you need to find out what their problems are; you need to talk about social issues.” This notion of ‘holistic’ care, sometimes termed “biopsychosocial care” was mentioned during my interviews with clinicians at each site. Emphasizing the ‘social’ of biopsychosocial, a faculty member at CoM shared with me during our interview that the way she understands her practice is that "every patient you see is potentially a public health problem. You see the community through them, through this individual patient... It's a longitudinal competence." The particulars of this ideal were heavily dependent upon intimate knowledge of the local context—a topic which Lock and Nguyen (2018) call "situated biology", as context sculpts what are perceived as physical manifestations. Examples of situated knowledge that colored interpretations, included knowledge of environmental hazards (e.g. schistosomiasis), different rates of circumcision, prevalence of disease (e.g. epilepsy), social stigma (e.g. to provide more psychosocial support), popularity of traditional healers, patients' "tribal" and religious identities, proximity to a permanent medical facility, seasonality (e.g. knowing which foods were available), childhood marriages, neglect of the elderly (e.g. a 13-year-old girl regularly came to a mobile clinic to collect refills of asthma medications for her grandmother, who sleeps with her animals thereby increasing her exposure to irritating, inhaled particulate matter, because she is afraid that someone will steal the animals), alcohol and drug abuse, mob violence, road traffic accidents, and kinship norms (e.g. the death of a husband leading to a malnourished family).

Another clinician shared her perspective on a holistic ideal in that "hospital care is not all about curative; there's also a component of psychosocial whereby it involves counseling for other conditions, like chronic illness, like cancer, where there's no curative therapy… You will just need counseling and being in their shoes, so that they express their views, you express their views, and [you both] come to a common consensus." When I asked her about a particular example she might have, she shared that "if you ask the history, they'll say maybe they really had a quarrel with their husband, or they did get beat up by their husband… [or] they are having stress because maybe they are overworking or maybe their husband is mistreating them" (these gender-based problems will be revisited next chapter).

In describing ideals as widely 'holistic', I do not mean to homogenize responses. There was considerable variation in the extent to which clinicians provided insight into how local tendencies contribute to medical manifestations (and I have no doubt that all Malawians could list many more items than I just listed), as the population of Malawian medical students tends to be skewed toward more affluent segments of the population, and the College of Medicine (CoM) accepts a small number of students from other sub-Saharan African countries. To sensitize Malawian medical students to the range of behaviors and needs of Malawian patients, CoM incorporated an immersive learning experience, called "Learning by Living", whereby students are placed in a district hospital and given a 'host family' to live with for 5-7 days, so that they may learn about daily requirements of village life (and hopefully be more likely to work rurally, later) (Muula 2005). As an indication of the variability of backgrounds of Malawian students, Muula notes that some students felt culture shock from spending a week with a rural family.

Adding to this diversity, clinicians from each facility shared during our interviews that they depend upon patients to form correct diagnoses and expectations for how interactions should proceed—that is, ideally, interactions are dialogical. In the words of one physician in our interview:

> "I want the patient to know what's going [on]—I need them to answer my questions… so [that] I can tailor all that because when you are asking questions your mind is working… You're eliminating things and you're adding things, you're forming a story about whatever condition they have… and when they do the examinations it means that your mind is getting straight there to whatever you're thinking about. Then you do the investigations and the management."

Similarly, another clinician shared during our interview that "at the end of the day… the patient has to understand why they are in the hospital and what we have done. If they are still in the ward, [they have to understand] where we are going and what has to be done, up to the end.” As an example of the importance of ‘being on the same page’ for clinical teams and patients, I sat in on a series of tough discussions during morning rounds in the Pediatrics Department at the Central Hospital, where clinicians pained to develop a more effective communication strategy for the family *and other clinical teams,* to put a halt to invasive procedures that had little chance of clinical success for a child (with sever hydrocephalus and brain damage) who had been in the ICU since birth and was being passed back-and-forth between units. The greatest fear of the clinical team was that the parents’ expectations were so much different from their own, that the child would be put through more suffering without an end in sight. Being on the same page for the ‘big picture,’ it seems, is instrumental to establish expectations for what may happen both proximally and ultimately.

Cooperative aspects of interactions are often described under the banner of ‘establishing rapport’—that is, as constructing a cordial clinician-patient relationship. Given what has already been described of reciprocity and heterogeneity of clinician desires, a nontrivial question arises: when and how do clinicians ‘establish rapport?’ As it turns out, clinicians have both idiosyncratic and shared ways in which they gauge whether more effort needs to be put into establishing trust and openness. For instance, I observed clinicians at Mobile Clinics customize the floorplans and division of labor at each facility in order to gain earlier or more intimate contact with patients. One clinician sat at the corner of the table and positioned patients’ stools as close to her as possible, such that there were only inches separating their knees when seated, so that she could easily reach forward to auscultate their chest or play with children. On multiple occasions, I observed a mother come in with multiple children who needed to be examined, and the mother knelt on the dirt floor to leave the stools for her children. The clinician cracked a joke about the caring mother deserving more comfort and then instructed the family to rearrange, so that the mother sat on the stool and put the smallest child sat on her lap—a change of orientation that precipitated laughter by all in the room. Another clinician milled about with patients before the clinic opened, taking temperatures, making small talk and checking for any alarming clinical indicators (e.g. a person was discovered to have a bloody nose). Another clinician took patient vitals within the consult room (rather than having a nurse do it beforehand), which allowed her to make physical contact with each patient. While she collected vitals, she cracked jokes or asked about the patient's family. Unfortunately, as the day grew on, clinicians showed signs of fatigue, as evidenced by decreased jokes and small talk, and no longer walking around the table to record blood pressures (instead, reaching across the table)—thereby limiting both proximity and physical contact.

While the term 'establishing rapport' seems to put all responsibility on the clinician, as if the patient were merely a passive recipient, clinicians with whom I spoke conceived of it otherwise, with one sharing during our interview that "I would ask a few questions not maybe related to the illness, saying, 'how was home? How is your, maybe, wife or husband?' So, they'll be flexible and say 'Oh, I'm all right and the children are okay.'" This simple give-and-take, which I observed more often in mobile clinics than in hospitals—where patients would come in from the village as opposed to be laying prone in a bed, respectively—involved both clinicians and patients as active participants, and it appeared to go a long way in establishing rapport. Small-talk also seemed to resonate with much of popular culture in Malawi, as it is a common practice all around Malawi to stop and chat with whomever may be passing by (typically walking), with same-sex interlocutors frequently giving high-fives or holding hands throughout much of the conversation.

While such bi-directional communication could strengthen relations, it also had the potential to hamper them, as a clinical officer from the District Hospital expressed during our interview that “the patients here have the fear towards health care, and you can see that there’s [social] distance—just the fear itself will bring in distance.” Her strategy, she shared during our interview, was to allow the patient to close that social distance. She explained that, “I don’t just come in [makes gesture of thrusting right fingers toward stationary left palm]—you let them talk… that means they will be free [i.e. open] to you. The more they’re free to you, you know that they are now reducing the distance,” at which time, she suggests, she may understand what is happening and gain some influence over their behavior.

Clinicians from each site expressed during our interviews that rapport starts with first impressions (introductions, smiles, physically orienting oneself to the patient in such a way that will may be pleasing to the patient). Some of those persons I interviewed also commented on the importance of a clinicians’ attire (e.g. white coat (or not) and stethoscope), which are thought to be seen by patients as items garnering trust (as anthropologists, we know such items for their symbolic and ritualistic importance, in addition to their biomedical utility). Attention to patients’ desires highlights that it is not the case that just anybody, behaving in any way, can set up shop and successfully ‘practice medicine’ on people (as evidenced by the robust failure of early missionaries (Hokkanen 2007; McCracken 2012)). As shown by Hokkanen (2007), throughout the early history of biomedicine in Malawi, something about the clinician’s practices must resonate with the worldview of her patients, and certain kinds of interactions and relationships will only resonate with certain people (i.e. the same approach will be attractive to some, be irrelevant for others, and be a hindrance to still others). In this vein, those clinicians whom I interviewed and spent time with in the wards did not express that they could dominate patients and, short of restraining seizing children, in all of my trips to Malawi, I never observed or heard of patients being physically restrained—nor did the conceptions of healthcare personnel with whom I spoke align with accounts based on notions of “violence” and “power” that draw a hard line between “the body” and behavior (Foucault and Faubion 2000). As Byron Good writes, “medicine is not all war or exploitation, strident claims notwithstanding. It is also a conversation, a dance, a search for significance, the application of simple techniques that save lives and alleviate pain” (Good 1994). Similarly, the work of Georg Simmel provides insight into these relations, as he argues that behaviors are fully contingent (upon sociohistorical contexts) and reciprocal, with neither party ever assuming a position that is wholly active or passive, superior nor inferior, and that “there is, so to speak, nothing contingent about this contingency” (Simmel 1971 [1908]; Simmel 1896). Treating interactions in this way forces us to take seriously the uncertainty/risk that is inherent in each interaction, as each party is interpreting, reacting to and directing the behavior of the other. Unfortunately, Murray Last suggests, anthropologists have been reluctant to address uncertainties or unknowns in daily life, preferring instead to posit behaviors as following culturally-encoded rules, despite decades of awareness that unconscious preferences and chance pervade all of life (Last 1981). That said, from my observations, when given adequate time, most clinicians were intuitively able (and willing) to establish rapport with patients—they joked, offered condolences, leaned in and spoke softly when discussing sensitive topics, altered the pitch of their voice, picked up and played with children—despite deep uncertainties of how, precisely, interactions would proceed. The same fluidity and intuition was not displayed by junior clinicians or students, however, who were known to freeze-up when confronting a situation with which they are unfamiliar.

Where ideals fall short

Given discussions of Chifundo's practice in the hypertension clinic that opened this chapter, it may come as little surprise to the reader that clinical practices often fall short of ideals. Attention to breakdowns in care underscore the importance of heeding Megan Vaughn's call to stick to analyses of actual practices of medicine and to avoid conflating analyses of practice with theories of medicine (Vaughan 1994)—e.g. Margaret Lock and Vinh-Kim Nguyen provide a brilliant overview of anthropology of biomedicine, but they alternate between recognition that practitioners individualize care (in application) and describing 'biomedical practice' as homogenizing and treating all patients equivalently (Lock and Nguyen 2018).

Turning to the thoughts and behaviors of Malawians, a physician shared during our interview that:

> "People are very busy… if you had a line of 70 people waiting for you, you'd want to keep it to the minimum. You'd even want to skip knowing who they are, what their name is, because you want to spare some 30 seconds. I think that's what, *actually*, the reality is on the ground… We hardly talk. We make decisions for them because we think, probably, they are not educated, or they are less deserving."

It is not just the name of patients that may get lost in the fray. I observed a case of a child who was brought into a Mobile Clinic wearing a dress. The child's mother reported that the child had an infection, but it was not until the mother laid the child across her lap and pulled up the dress, exposing an abscess on the child's scrotum, that the clinician was aware that the child's sex—at which point she turned to me with wide eyes, chuckled, and said 'I did not realize this is a boy!' This mode of practicing may be more extreme in Malawi than in most other places in sub-Saharan Africa, as Malawi's clinician-to-patient ratio is near the lowest in the world, but it has existed in many places since at least 1985, when Steve Feierman concluded that:

> "The majority of African patients receive treatment under conditions of extreme medical scarcity. This means that doctors must examine, assess, and prescribe in a very short

> time, to get on to other pressing cases. We can assume that the doctors do their best, but under these conditions patients are often treated like faceless cases" (Feierman 1985).

Indeed, during my time at the District Hospital, I wrote "ANONYMOUS" on the top of my fieldnotes, as the rapid patient-turnover precluded much of the social connection that clinicians seemed to revere. A district administrator suggested during our interview that after weeks, months, and years of being swamped with patients and shuffling through terse clinical interactions, such behavior "actually established itself as if that's the rule of thumb." Another physician shared during our interview that, "I think most patients usually don't act right, mostly, because of the way we treat them… It's not very easy for them to understand things. They need you to take a bit more time which most people don't have."

Given the prevalence of such practices, we may be tempted to stop at Feierman's commentary (above) or to revert to suggestions that biomedical practices and ideologies are 'essentially' dehumanizing and objectifying (Taussig 1980). Such moves fail, I suggest, on two accounts: 1) overlooking nuanced differences between clinicians and patients; 2) overlooking the social, institutional and situational dependencies of practice, thereby mistaking pragmatic decisions for ideologic priorities. For instance, in response to my question of how, precisely, she works with patients to realize her ideals, another physician shared during our interview that:

> "The challenge is in actual practice. Our setting is usually difficult. You find that most of the time you don't practice [extra efforts to establish rapport], and it dies a natural death… You have to have a lot of time… Apart from that, sometimes you find that you don't understand each other with the patient… [and] there are some other patients as well as guardians that are not open to suggestions. They make a decision that 'this is what we want!' You can't change their mind."

My observations and interview data suggest that breakdowns in understanding take multiple forms, the first of which would be encountered by most visitors to Malawi; namely, language barriers. This has been a challenge for biomedical practitioners since early missionaries, as Markku Hokkanen writes that:

> "In the early twentieth-century mission, clinical practice diagnosis was based largely upon a physical examination and short interview with the patient. Patient interviews were often hampered by the doctors' limited knowledge of vernacular languages, and African mission "middles" [i.e. assistants] were crucial to successful translation and communication… symptoms could be demonstrated or identified visually, by touch or with the aid of a stethoscope or thermometer, but interviewing patients remained difficult" (Hokkanen 2007).

While most Malawian clinicians I observed have an easier time finding a common language than would most foreigners, language barriers were not altogether uncommon. Chichewa is the most widely spoken language throughout the country, and it is nearly ubiquitous in Blantyre and Lilongwe (the two largest cities in the country); however, as one travels farther from cities, especially in the Southern and Northern Regions, other languages begin to predominate, leading to a situation whereby even Malawian clinicians often need translators, which were *not* provided by the institutions. Thankfully, patient guardians were often able to assist. In those facilities where I spent time, if a guardian was not available, a bystander was asked to sit in on the consult and assist with translation. I never observed a situation where *someone* was not available to translate, but I heard stories about situations where clinicians had to proceed without the use of a common spoken language, dependent upon nonverbal communication and a series of 'best guess' translations. On the other hand, I also observed language barriers leveraged as an opportunity for friendly banter and closing the social gap, as clinicians stumbled through phrases that they knew in a local language (ChiLomwe or ChiYao, in those cases that I observed), which elicited laughter from the patient (at the clinicians' broken pronunciation or improper grammar, as Bantu languages are known for being tonally-dependent and having a series of prefixes infixes and suffixes—which proved to be tricky for me!).

Unfortunately, even those clinicians who were fluent in the patients' language(s) told me that clinical communication was often belabored by Bantu languages' lack of words for many biomedical concepts and items; e.g. Kohler, et al. (2017) found that less than half of the

Malawian women whom they interviewed were aware of breast cancer. Instances of discordant understandings led to confrontations at each of the hospitals where I spent time, as guardians expressed a reluctance to accept oxygen treatment for patients whom clinicians felt it was necessary. Stevenson and colleagues have examined this topic in Southern Malawi, and they discovered that patients' and guardians' fear of oxygen therapy is based upon fear of the equipment, distrust of medical staff, and fear of oxygen, itself (Stevenson, et al. 2015). Interestingly, some guardians in their study noted that clinicians' asking for consent to deliver oxygen therapy made them less likely to accept the treatment, as they reasoned that because clinicians asked permission, the therapy must be risky.

Another common point of disconnect between clinicians and patients/guardians involved patients accessing "traditional healers" (THs). In each of the facilities where I spent time, I frequently saw indices that patients had already visited THs for their current complaints (signs included a series of tattoos—roughly 1cm long, running in parallel near the site of symptoms, although not necessarily correlating with where a biomedical understanding would locate the etiology—amulets or jewelry), so I began to ask clinicians and administrators about how they felt about it. One administrator nonchalantly told me in our interview that it "becomes a part of the equation in whatever you're calculating. It's just expected—it's like you carry the one all the time; you don't forget about it…[laughter] Just carry the one." Basic arithmetic. All of the clinicians whom I interviewed grew up in Malawi, and they expressed that THs are a default option for many patients (and possibly most common for patients with neurologic or psychiatric conditions). While none of the clinicians with whom I spoke characterized traditional healers as direct competition, they expressed frustrations about patients' prioritizing THs above biomedical care, as interviewees felt that THs make their job more difficult because of delays in care or harming patients. In our interviews, clinicians readily shared their thoughts that traditional medicines can be powerful, but they were concerned about therapies' inconsistent concentrations, dosages or durations, which put patients in danger of unnecessary suffering (as in a case that a clinical officer told me about a TH cutting the frenulum of a tongue-tied baby without anesthetic or antiseptics). Or, as one physician told me in our interview, "people come here in already critical states because they were at home doing traditional medicine… and then we end up using more of our resources."

Patients were often forthcoming about having already seen a TH, as in the case of a woman with a history of epilepsy who visited a Mobile Clinic that I was observing. Just before the woman departed, she told the clinician that she had recently visited a traditional healer who gave her some herbs as a 'cure' for her epilepsy. She said that she took the herbs and that they caused her to go 'crazy' and run through the bush. Both the patient and clinician doubled-over in laughter and continued to laugh until the woman left the building. The most extreme case that I observed regarding THs involved a patient whose guardians removed him from the District Hospital in order to seek the services of a TH. To my surprise, the clinician on duty was not bothered, stating instead that 'that's where he should be,' as dealing with protesting patients and guardians is no cup of tea for clinicians, there may be little benefit to keeping a patient if she or her guardians will not follow treatment plans, and there is no shortage of patients to fill beds.

Given the near-ubiquity of breakdowns from ideals, it may come as no surprise that a clinical officer expressed during our interview that she holds an ideal for how interactions will proceed once original ideals breakdown. She shared that she hopes for patients who "are able to recognize our capabilities, and they are able to accept our failure." Empathy can be a two-way street, at least as idealized by some clinicians whom I interviewed. The analysis of Blau (1963) regarding obedience and compliance is helpful for thinking about this process. In his account, Blau draws from an the famous work of Mauss (1954) on gift economies to suggest that persons in authority come to expect both obedience and voluntary compliance because of recipients' sense of reciprocal debt. Another interpretation of these bonds—one based upon affirmation rather than gifts—comes from Arthur Kleinman's insights that "patient and caregiver reciprocated affirmation, acknowledgment, emotion, and presence (i.e., lives animated by meaning) as much as they exchanged information" (Kleinman 2013). In this vein, Damasio (2018) suggests that the affiliative *feelings* involved in these interchanges provide motivation for persons to engage further.

Unfortunately, this distinction between 'ideals' and 'actual practices' is only useful as a starting point. As it turns out (in line with discussions of reassessing ideals, as discussed last chapter), many clinicians adapt their ideals to the conditions in which they practice. For instance, a physician at the district hospital shared during our interview that what qualifies as good rapport:

> "depends on how fast you go through your own round. It depends on where or how critical the patients are and also how much records you have to finish. For example, if you know that you have 10 patients and you have one hour, you wouldn't sit down and discuss other things… you just have to do fast, see them quickly, mention what you've done, what's basic."

In these settings, the needs of the patient must be balanced against what is best for society, and because the clinician has no control over her schedule, both of these sets of demands must also be balanced against the demands of the throngs outside—I heard stories from clinicians about groups of patients shouting at them to 'hurry up!' if the clinician was thought to be taking too long with a patient. In this way, establishing a strong clinical relationship may not be deemed as valuable-per-unit-time as getting the patient medications. Likewise, acting buddy-buddy with patients may not be desired, as I rarely saw clinicians joke with patients who were in acute distress.

Notions of “continuity of care”—a factor that is thought to buttress clinician-patient relationships—was also recalibrated to align with practices in those facilities where I spent time. Within Western settings, “continuity of care” typically refers to an arrangement whereby the same clinician repeatedly sees the same patient over the course of months and years, so that a personal relationship is established and the clinician can customize care; however, such an arrangement was uncommon in the facilities where I spent time. During our interviews, clinicians and administrators broadened their definition of continuity of care to include continuity of workflow and information—i.e. patient data being available to clinicians in multiple settings (e.g. in health passports and ledgers for NCDs, ART and palliative care clinics)—as well as continuity in the sense of patients reliably navigating the referral system. If information from a previous clinical interaction could be retrieved, there exists continuity, so the reasoning went. After getting a sense that “continuity of care” had a different meaning in these facilities, I asked a physician whether “Western” continuity even mattered to patients. She responded:

> “It does to me, and it does to the patient as well, because if I start treating someone, I would want to see whether they improved, whether I was right or not. If I wasn't right, I would want to check what I did… If you keep moving from one place to another, I would start, and then the next person also starts again, and at the end they don't get treatment. They give up.”

Such insights inform us that just because an ideal or a definition may change, it does not make others irrelevant—and how close attention to the thoughts of Malawian clinicians breaks down notions of a homogenous, worldwide “biomedical culture.”

The lack of “Western” continuity at the facilities where I spent time shaped clinical practices in important ways, perhaps most notably in the manner that prescriptions were written, as patients who lived farther from facilities were prescribed differently than those who live nearby—a practice aimed at improving patients' and clinicians' convenience and peace of mind. This mode of prescribing often involved providing both *more* medications, to cover a greater duration, and *different* medications, to decrease chances of exacerbation. Such adjustments were also made by Chifundo in the hypertension clinic, as she asked patients where they lived, and then she provided a prescription covering a longer duration if the patient had come from far away. A more nuanced example involved a child with asthma who presented to a Mobile Clinic complaining of an extraordinary cough, but she did not have an elevated temperature, nor was she producing green sputum (i.e. she lacked signs of a bacterial infection); yet, she was still treated with antibiotics, as the clinician felt that her risk of bacterial superinfection outweighed risks associated with over-prescribing. I was told that it would be unnecessarily burdensome to ask the patient (and guardian) to head to the nearest clinic in case her symptoms worsened, as such a request would entail walking many additional kilometers. Additionally, during a discussion with this clinician, I was told that if this child's cough persisted, the clinician may assume (without a confirmatory test) that she has aspergillosis, as aflatoxin is endemic to the region (commonly associated with ground nuts). Recognizing that environmental conditions, such as geographic proximity (in addition to identity-based features, which will be discussed next chapter), guided the treatment of *actual* patients underscores our need to distinguish studies of 'biomedical theory' from studies of biomedical practices, lest we hypocritically transform shortcomings of 'essentializing biomedicine' *by essentializing the practice of biomedicine.* Lock and Nguyen exemplify this pitfall in their statement that "the assumption of a universal body (*which every biomedical practitioner well knows is a very crude gloss of reality*) should be revised, and the normalized, routinized practice of biomedicine as it is currently implemented modified appropriately" (emphasis mine) (Lock and Nguyen 2018). Contrary to Lock and Nguyen, my findings suggest that close attention to the practices of biomedicine display a host of ways in which the care of *actual patients* is customized, and essentializing characterizations of biomedical practice may recreate the problem that they critique.

Heuristic Adaptations

Having now discussed that clinicians have ideals, and that ideals often breakdown (and may be transformed) for reasons that revolve around high numbers of patients per clinician and difficulties with communication, I would like to take a closer look at how clinicians manage high patient volume with limited information. Elsewhere, biomedical practices have been described as reductionistic, authoritative, technophilic, individualizing, sympathetic and loving (Wendland 2010). While such accounts provide insights into possible conceptualizations and sentiments involved in clinical practices, they provide us with limited insight into how clinicians adapt to solve both 'mundane' and 'complex' problems while immersed in compromised conditions. For instance, if we suggest that clinicians collect information on a patient and then 'reduce' it to a cellular understanding, we have effectively passed the buck, as we must then explain how they go about 'reducing' all of that information (e.g. do they run through a checklist, utilize an algorithm, guess-and-check, etc). My observations and interview findings suggest that clinicians manage these situations via multiple adaptations.

Starting at the largest scale, when patient numbers are huge, clinicians' adaptive *strategy* is often simple: speed up and work longer. "We adjust," a clinician told me in our interview, "quickness might not necessarily mean that you won't do the right thing, but because you are quick, it is very easy to miss out on important areas that you might need to tackle." In our interview, a clinical officer leveraged a biological explanation for her experience with this mode of practice: “it’s quite challenging because the way the human brain works is [that] once it’s tired, it’s tired, and it needs to rest, but because as of now we are few, you push yourself just to make sure that neither of these patients suffer.”

Speaking more specifically about what they key into, clinicians suggested in our interviews that as patient numbers increase, clinicians put greater emphasis on a general inspection (i.e. does the patient simply ‘look sick’ or is there anything obviously wrong?) and vital signs (including temperature and blood pressure, which can be problematic on account of missing equipment and batteries). Additional challenges arose in the setting of mobile clinics, where entire families presented at once, and the clinician was left to guess to whom attention should be paid as she watched them enter and take their seats (a time when snap judgements about ‘looking sick’ were often made). For instance, I witnessed dozens of consults in Mobile Clinics where mothers brought in their small children, and then, after the clinician had dealt with each child, as the group got ready to leave, the mother pulled out her health passport and complained about her sore back or legs. The clinician had paid her no particular attention before that point—beyond common niceties and asking about her child—and then, after a couple questions and a quick scribble of the pen, the situations were resolved. Diagnosis: musculoskeletal pain. Prescription: Panadol. No physical exam or further questions. Such practices aggravated an administrator, who asked rhetorically during our interview, “what kind of diagnosis is musculoskeletal pain? That sounds like a symptom!” When I asked clinicians about such practices, they suggested that the mother’s complaints were probably afterthoughts and that she might not even have had pain at that moment, but she would prefer to have medicines on-hand for when she did need them. Given that so many children had just been seen in lightning fashion, and clinicians suspected that mothers’ complaints were not immediately pressing, I looked at the time spent with each person within the consult; however, I noticed no disparity between time spent on mothers or their children (perhaps because each person was seen so quickly and my measurements were not precise enough, as I rounded to the nearest whole minute).

I also observed the converse scenario: when a child’s complaint was a guise to stave-off any stigma that might accompany the parents’ new diagnosis (of syphilis, in this case). In this case, the nurse who had been checking vitals at a Mobile Clinic came back with the family and proudly told me that the clinic encourages fathers to get involved in the care of their babies, so this father was simply following their advice (hence why both parents came into the clinic). I congratulated her on her success. First, the baby was examined for a reported cough, which the parents said did not cause the child any difficulties, and no cough was observed in the clinic. Only after the child had been seen did the parents open up about their need for syphilis treatment—again, in what appeared to be an afterthought but turned out to be the only ‘medical’ problem in the visit. Again, the clinician quickly transitioned without missing a beat, such that even within tightly-constrained settings, clinicians were able to interact in such a way that the majority of patients who left appeared to be satisfied with the care that they have received. Perhaps they simply exemplified the findings of O'Donnell (2007), that the expectations of poor people for medical care in ‘developing countries’ remains low; however, either way, it sufficed.

In the midst of a seemingly-non-stop flow of patents, the clinicians with whom I spent time in the hospitals expressed a drive to “clear the ward”—that is, to discharge patients and lessen the burden for the next day’s shift (and to create space for new patients), an aim that supports Lorna Rhodes’s observations that empty beds can serve as a metric for success in swamped hospitals (Rhodes 1991). Ideally, Rhodes tells us, an empty bed would mean that the patient improved enough to be discharged; however, in high-demand settings, beds were also cleared for patients who were simply in worse condition. Alternatively, Rhodes tells us, if nothing can be done for a patient in a bad condition, attempts may be made to clear the bed for someone who can be better managed at the facility (ibid). I observed each of these strategies in the District Hospital, although the converse also occurred, whereby clinicians opted to keep patients for an extra day, as they reasoned that if nurses see “discharge” written on the cover sheet, the patient will be ignored and will not get her final doses of medication.

Perhaps the most common way that biomedical clinicians deal with large patient volumes throughout the world is triaging (i.e. sorting patients by their apparent needs). Across all three settings where I spent time, I observed two methods of triaging patients, to make better use of time while still (hopefully) meeting patients’ needs: 1) acutely ill patients were dealt with right upon arrival, or 2) ‘complicated’ patients were asked to step aside so that the clinician could deal with them last. After seeing one particularly cordial clinician employ each of these tactics, I asked her about the latter tactic in our interview, and she told me that she has a script for such situations, whereby she says “I think you can just wait somewhere for a few minutes. I will attend to you, and I will make sure everything is done rather than doing things in a haste… I don’t want to be seeing you here on the same problem.” This tactic put a premium on responding to the queue of patients, yet it came at the cost of the ‘complicated patient’s’ personal time, as the patient had to wait longer at the facility.

Choosing which patients got ‘sorted’ often involved some large, intuitive leaps. Within the settings that I observed, clinicians quickly made sense of a tremendous range of human behaviors that extended well beyond what would be expected in non-medical daily life, as patients and their loved ones faced (or so they thought) imminent mortality or permanent loss of function (Cassell 2004) and acted accordingly. For instance, I observed patients weeping and screaming, thrashing and yelling, and attempting to run out of the room—behaviors that, I assume, would strike any of us as unusual or alarming if they were carried out by someone older than a toddler. The interpretability of these behaviors may make them seem trivial, but their underlying complexity is striking—a change in the pitch and cadence of a patient's voice informed a clinician that a patient was responding to therapy (removing fluid from around the patient's lungs); the patient's position in the room relative to other objects (e.g. at the far edge of the chair) were interpreted as fear, for which a clinician extended 'peace offerings' of a pen and a chance to preview objects that would later become relevant (e.g. bell of stethoscope); and subtle facial expressions and gestures from patients were readily interpreted as acute discomfort (Darwin and Ekman 2009), for which sympathetic words and medications were offered. Missing a cue in this "silent language"—as Edward Hall (1959) refers to these complex interactions—meant potentially harming the patient or spoiling the clinician-patient relationship.

At some level, all clinicians that I observed who dealt with children were able to quickly distinguish between a "sick kid" from one who is "healthy"[16]—a label that was not meant to imply any particular diagnosis, but rather to key the team into how the child was behaving relative to expectations for 'normal' children with similar development/background, or what would be expected for a particular child, if a guardian were around to provide information on the child's typical behavior. The behavior of "sick kids" deviated from the norm in predictable ways (they were clingier to caregivers, played or ate less, their eyes may have been glassed-over, they were weaker, they cried or whined in response to events that they would not normally cry or whine about, or they took in stride events that would normally have precipitated resistance). Importantly, notions of 'universal' expectations were colored by individual and local tendencies.

---

[16] As will be discussed next chapter, adults were thought to be more tricky for making such binary determinations.

For example, anemic children (by Western standards) frequently behaved as if nothing was wrong with them, exemplifying a situation that Margaret Lock refers to as situated biology, whereby environments create different expectations for behavioral norms (Lock and Nguyen 2018).

Aside from intuitive notions of "sick persons", or other obvious signs that a patient could not function (e.g. severe malformations), we may ask how these clinicians determined who was a complicated patient (i.e. who needs more or less attention) when each patient may get less than one minute of direct attention, and the remainder of the visit was split between the patient and documenting/prescribing. After all, determining whether someone is "really sick" or "pretty much OK", from a medical standpoint, can require considerable time, experience and diagnostic tests. This phenomenon of clinicians making rapid judgements based on limited information is commonly referred to as *clinical acumen*. Recent studies into clinical acumen have focused on topics like whether computers can use images and associated patient information with 'deep learning' algorithms to surpass human clinicians (Fazal, et al. 2018), or to discuss the current state of artificial intelligence in echocardiography (Gandhi, et al. 2018)—interesting topics, but scarcely related to clinical practices in Malawi (at this point, at least). Other explorations into clinical acumen have been more prescriptive, as in the push by Gawande (2010) to extend checklists for error-prone tasks, or the push by Bosk, et al. (2009) *against* universalized checklists because of the importance of local contexts. Even low-tech interventions, such as checklists, were rarely referenced in the high-pace clinical situations that I observed; nor did I frequently see clinicians develop a list of differential diagnoses and systematically exclude those that did not fit; nor did I see clinicians adhere exclusively to cellular or 'physiologic' explanations of disease.

To make better sense of how the clinicians with whom I spent time quickly navigate tricky situations, I suggest that we turn to Gary Klein's description of naturalistic decision making (NDM), which moves beyond assumptions of 'optimal' decisions whereby people make choices between well-defined alternatives in carefully-controlled settings, to discuss real-world situations that involve "limited time, uncertainty, high stakes, vague goals, and unstable conditions" (Klein 2008). In such situations, Klein argues, people rely on heuristics (i.e. mental shortcuts) to make decisions, "even when these strategies generated systematic deviations from optimal judgments as defined by the laws of probability, the axioms of expected utility theory, and Bayesian statistics" (ibid). Heuristics appear to be especially pronounced in the settings where I spent time, where the conditions of practice deviate from those of training—a mismatch which Robin Hogarth calls "wicked" because it hampers the development of accurate intuition (Hogarth, et al. 2015). Looking at 'wicked' environments, Klein suggests that formal training and decision-making tools were not adopted because "people found these tools and methods cumbersome and irrelevant to the work they needed to do" (Klein 2008). Similarly, borrowing from Klein, I suggest that we avoid these additional assumptions about practices, which did not hold for my observations or interviews with Malawian personnel:

> "That expertise is based on learning rules and procedures (it primarily depends on tacit knowledge]... that people make sense of events by building up from data to information to knowledge to understanding (experienced personnel use their mental models to define what counts as data in the first place]... that insights arise by overcoming mental sets (they also arise by detecting contradictions and anomalies and by noticing connections]... that we can reduce uncertainty by gathering more information (performance seems to go down when too much information is gathered – Uncertainty can stem from inadequate framing of data, not just from the absence of data]... that we can improve performance by teaching critical thinking precepts such as listing assumptions (too often the flawed assumptions are ones we are not even aware of and would never list]" (Klein 2015).

Taking these insights into account, along with what has already been discussed regarding situated knoweldge, patient-driven pruning of ideas, and rapid consults, I suggest that heuristics allow clinicians to proceed with "the first workable option rather than trying to find the best possible option" (Klein 2008). While heuristics have their advantages, they also come at a cost, in that efficient pruning must be balanced against the risk of premature closure (i.e. jumping to a diagnosis without adequate information, and then going no further in attempts to clarify or rule out the diagnosis (Graber, et al. 2005)—an error that resembles Kahneman and Taversky's descriptions of 'intuitive' misconceptions regarding basic statistical puzzles, as clinicians employ shortcuts to navigate challenging cases (Kahneman 2011).

Similarly, as one would predict from the definition of 'technologies' provided by Heidegger (1977) (i.e. a tool that reveals and canalizes thoughts in a specific direction), the presence of select diagnostic tests also guides clinicians' thoughts and confidence, creating dichotomies between what clinicians told me in interviews are 'easiest' and 'most challenging' diagnoses. For instance, I was told by multiple clinicians at the Mobile Clinics that if a patient presents with any combination of fever, diarrhea, vomiting and chills, and then she tests *positive* for malaria, the case is often closed, and the entire interaction may last under a minute. If, however, the patient tests *negative* for malaria, it becomes a 'fever of unknown origin', which clinicians typically sub-categorize as "sepsis", and the patient is given an antibiotic, despite clinicians' awareness that they have a very imprecise idea of what is happening, and that the situation likely does *not* qualify for the technical definition of sepsis (involving the body's response to an infectious agent and/or toxin in the bloodstream). Nevertheless, "sepsis" is often written in the ledger, and, in this way, "common conditions" *become* common because they are commonly diagnosed, *not* because they are necessarily what predominates in the population. In these instances, heuristics and technologies buttress conceptions of reality that may not accord with what would appear if more time and resources were available. Clinicians then get caught in a mobius loop of diagnosing and prescribing, and reporting figures, and program and research dollars may be allocated accordingly.

Operating under these conditions, missing "rare" and "complicated" diagnoses or treatment regimens becomes somewhat of a self-fulfilling prophecy. A DHO shared during our interview that "conditions which are not common…will spend years without being diagnosed. We have cases of cervical cancer, a lot of them which are being treated as hepatitis, being treated as STIs over and over again. By the time somebody thinks of doing a simple thing as a VIA[17], it's too late." The same can be said of lung cancer or congenital heart defects, which I was told (and observed) are often treated as pneumonia or bronchitis. Reflecting on rushed practices, a clinical officer working in the Mobile Clinics told me in our interview that "when the day has gone, I do go home and say, 'I have assisted patients, [but] how have I assisted them?' You tend now to remember, you say 'but that chap! I think I was supposed to do or to add ABCD,' developing the situation or whatever. I rushed…so you tend now to get worried."

While heuristics no doubt functioned by matching clusters of 'medical' signs and symptoms[18] with clinicians' understandings of pathophysiology, the heuristics of those clinicians I observed also depended upon clinicians' observations of specific behaviors in and around clinical settings, and clinicians' conceptions of which behaviors correspond to medical and non-medical problems—possibly fitting together in a process described in (Klein 2008), whereby situations are checked for familiarity, fulfillment or violation of expectation, and then either more information is sought or a potential solution is examined and either implemented or modified for better fit to the situation. I have already mentioned many of the more

---

[17] Visual inspection with Acetic Acid, a low-cost form of cervical examination.

[18] In biomedical parlance, symptoms are patient reports, whereas signs are directly observed by the provider.

pathognomonic behaviors that facilitate heuristics (e.g. change in voice pitch, wincing), but the heuristics employed by clinicians went much further, as clinicians paid attention to the consistency of such behaviors within and around that consult. By consistent behaviors, I do not mean flat-line, no variance. Rather, clinicians expected some degree of variability in a patient's affect and behavior throughout a visit. For example, unusual consistency in patient affect (e.g. mania or flat affect) led clinicians to suspect a psychosocial or psychiatric issue, as when I observed and heard of instances of inconsolable patients arriving with complaints of "seizures" or "heart attacks", but upon further questioning, the clinician determined that each patient was having a panic attack. In the case that I observed, the clinician probed further and discovered that the inconsolable patient had been suffering from domestic violence and the recent death of a loved one.

Perceptions of consistency also went the other way, as when clinicians perceived behaviors to be inconsistent throughout a visit or across multiple visits. For example, a clinician told me in our interview about patients who repeatedly presented with the same complaint (body pain) and displayed gregarious behaviors outside of the clinic. This clinician began to suspect poor adherence (e.g. maybe the patient does not understand the instructions) or ulterior motives (e.g. maybe the patient is selling her medications). Regarding this latter group of patients, the clinician shared, "if I'm using my own language, I do call them the drug seekers—the imitators." Markku Hokkanen tells us that such "imitators" were among the least favorite patients for early missionary clinicians, who referred to them as "old medicine eaters" (Hokkanen 2007). To identify such patients, the clinician told me in our interview, "in the morning, I do like cracking jokes when I'm doing the health talks[19], and you'll see them 'ha ha ha!' Now the time they reach

---

[19] A Mobile Clinics, the clinician gives a short lecture to all of the patients who came early. The lectures pertain cover a medical topic of the clinician's choosing.

the observation room, they change completely," such that they are solemn and wincing. This tactic, while useful insofar as a clinician wants to treat patients in ways that are consistent with her understanding of health and disease, comes with a risk of creating social distance between the clinician and the patient. For instance, if the patient does not reciprocate friendly banter (e.g. because of pain, lethargy or sorrow), the clinician faces a decision of whether to retreat to a more somber tone, or to push further in attempts to crack (what might be) a façade. If the clinician goes too far, she may be perceived as insensitive, thereby spoiling ideals of interactions. If the clinician does not run any of these social tests, she may be accused of being a pill-pusher who has neither the best interests of the patient nor society at heart. For the record, I never observed clinicians make the 'mistake' of overly-friendly or -joking behavior with a patient in a consult, as they generally began each consult with a fairly stern greeting (except with children), and then gauged the patient's demeanor before changing their own.

From a more theoretical perspective, such nuanced interpretations of behavior may suggest that not only do clinical practices extend beyond the realm of protocols or checklists, but they may not even be protocolizable, as clinicians key into aspects of behavior that appear to function at the level of habitus and hexis, which Bourdieu and Thompson (1991) define as stylized, generative dispositions that persons nonconsciously develop, and stylized ways of moving one's body, respectively, and for which technical understandings are still extremely limited.

Summary and Conclusion

In this chapter I discussed how, despite dramatic constraints on practices, the Malawian clinicians I interviewed held ideals for clinical interactions that included dialogical exchanges with patients and attention to the whole biopsychosocial spectrum. Clinicians shared that they have a variety of strategies to improve interactions and establish rapport. In practice, however, such ideals were often compromised by high patient numbers and short supplies. In response, clinicians reconceived of ideals and employed a series of adaptations that allowed them to quickly make sense of situations and serve all patients waiting in the queue. While these adaptations had their benefits, they also risked premature closure and creating illusory depictions of patient populations, which can drive programs and practices in directions other than what would have been the case if more personnel, time and resources had been available. Finally, I suggest that attention to clinical heuristics provides us with an opportunity to gain insights into clinicians' understandings of habitus and hexis, as well as the potential clinical consequences of these concepts. Taken together, these findings call into question descriptions of "homogenizing biomedicine" and force us to engage with daily practices of medicine before drawing conclusions about underlying priorities or ideologies. Once we dig into the intricate ways with which clinicians manage patients, I suggest, we see opportunities to address breakdowns or shortcomings of care without resorting to accusations of ideological simplicity or maliciousness. Instead, we may point to specific conditions of clinical interactions and shared ways in which persons make sense of complicated information in stressful situations. Much more work could be done to explore the details of these phenomena, as further understanding may provide clinicians and administrators with opportunities to improve their practices (and work satisfaction) without necessarily relying upon high-tech supplies or donor funds.

CHAPTER 7: Experiences with Patient Identity

“A man who falls sick at home or abroad is liable to get heroic treatment, or nominal treatment, random treatment, or no treatment at all, according to the hands into which he happens to fall”
--Jacob Bigelow (1835), speech to Massachusetts Medical Society

Mobile Clinic visits; Wednesday August 9, 2017

It is a cool afternoon in the Mobile Clinics, and Gabriel, a clinical officer in his mid-40s, sits in a stackable, blue, plastic lawn chair, which he has positioned under the end of a foldable, white plastic table. On the other side of the table he has placed two stackable, blue, plastic stools, which are situated just around the corner of the table, such that Gabriel could reach them if he twisted his body around the table. He placed this whole setup in the corner of a room whose beige-colored walls are covered in etchings by children in this village, which give me the impression that they had just been learning to write their names and got overzealous with displaying their new skills. This is a noteworthy day in clinic, not because of any extraordinary patient ailments, nor because of any lost or forgotten supplies, and not even because of any heroic medical interventions by Gabriel or the team. Rather, this day is noteworthy because of just how smoothly everything seems to be going. Gabriel has already seen over sixty patients, and he is showing no sign of fatigue.

The door on the far side of the room swings open, and the next patient walks in, a woman in her thirties who is wrapped from head-to-toe in zitenji (i.e. colorful fabric) to shield herself from today’s chill. As their consult progresses, Gabriel asks to check her temperature. He picks the thermometer from his bag on the table and leans over the folding table toward the patient, who raises her left arm. He inserts the thermometer into her axilla, taps her on the elbow, and she lowers her arm, securing the thermometer—a perfectly normal and expected activity for anyone who has had an axillary temperature taken. Once the thermometer beeps, the woman eases the tension in her arm, and Gabriel pulls it from her axilla. The visit continues, no fuss is made, and she goes on to get her medications.

The next patient to come through the door is a toddler, who is wearing a winter hat and is strapped to the back of his mother and secured with two layers of zitenji, which cradle the baby's back and bottom, and are tied across the mother's bosom. They take a seat, and the mother swings the baby around to her lap. Once again, Gabriel feels that it is necessary to take the patient's temperature, but this time, a much different social dance ensues. To begin, Gabriel repeats the baby's name in a high-pitch voice, "Kingston, Kingston, Kingston…" until both the mother and her baby express signs of amusement by smiling and rounding their shoulders, and then Gabriel offers a (closed) bottle of hand sanitizer to the baby, as a concessionary toy. Kingston points at Gabriel, and Gabriel points back. With his thermometer now in the pocket of his white lab coat, Gabriel gets up and walks around the table to stand over Kingston, who is still sitting in his mother's lap. Gabriel gently touches the top of Kingston's head and circles to Kingston's left, touches Kingston's left arm with his right hand as he simultaneously reaches around Kingston's other side to palpate his posterior thorax and lower back with his left hand. Gabriel then switched hands, and with his left hand now on Kingston's right arm, he palpates Kingston's abdomen with his right hand. Gabriel then mobilized Kingston's left arm and holds it stable as he slides the thermometer into Kingston's axilla, at which point he taps Kingston's elbow three times (Kingston does not drop his arm as hoped). Gabriel then rests his hand on Kingston's arm and keeps it there, to hold it down while the thermometer is in Kingston's axilla. Removing the thermometer involves both stabilizing and mobilizing Kingston's arm.

Through this well-orchestrated dance, Gabriel was able to keep Kingston calm, obedient and entertained, as he also accomplished his goal of taking Kingston's temperature.

Unfortunately, such interactions did not always go so smoothly, as just three patients later, a different toddler erupted in inconsolable crying and was whisked away for a rapid malaria test (which precipitated even more crying).

This level of detail may strike us as overkill for understanding something as ‘simple’ as taking a patient’s temperature, but such nuances can be found in every biomedical encounter, and it is through such details that clinicians experience and manage patients. Furthermore, depending upon the shape that these details take, the encounter may be deemed a “success” or an utter “failure,” and the line between the two is frequently quite thin. When considered in the context of mobile clinics, where clinicians must quickly see hundreds of patients in a day, or hospital settings, where clinicians make decisions about complex conditions, and all of these can contribute to the formation of national data and determine funding allocation, we see that such details can have tremendous impacts on individual care and health systems. Thought of in these terms, questions arise regarding if and how clinicians’ thoughts and behaviors vary between patients (i.e. if, how and why clinicians deal with different patients as individuals), and what sense we should make of such differences.

Recent work by Lock and Nguyen describes biomedical practices as operating under “the assumption of a universal, decontextualized body as the primary site for the production of medical knowledge and the management of disease” (Lock and Nguyen 2018). While such characterizations may hold for their topics of concern, I aim to further our understanding of biomedical practices by taking a closer look at how Malawian clinicians manage patients of various identities. During my interviews with clinicians, I asked each person about her preferences for patients: who were her favorite or least favorite patients to deal with and why, which types of cases were most enjoyable, which were least enjoyable, offensive or annoying.

Given reports of decontextualized, objectified patients representing the biomedical norm, I expected responses to stratify across different ailments (e.g. something along the lines of 'patients with malaria are best/worst!'); however, I found that the groups most commonly described in a positive light were children (not specified by any particular age demarcations) and "the poor" (not defined by any particular quantity of wealth). Conversely, most interviewees were hesitant to voice negative impressions about any patient groups; however, after more discussion, interviewees shared that the groups most commonly viewed in a negative light were elderly (not defined by any particular age demarcation) and affluent persons (not defined by any particular quantity of wealth). In addition to clinicians distinguishing between patients of different age and economic statuses, they also distinguished between patients of different genders. While patient gender was not associated with overt preferences, it was described in ways that inform our understanding how care varies across patients. To begin, I discuss clinicians' and administrators' thoughts and practices regarding each of these groups. Next, I move into a discussion of the historic and intersectional nature of these trends, and finally, I propose that these findings can best be understood through a biocultural lens that takes clinicians' preferences and behaviors into account.

A Dance that Varies Across Ages

The most recent Malawi Demographic and Health Survey reports that 48% of the general population is below 15-years-old, whereas only 4% of the population is above 65-years-old—a trend which has held constant since 2010 (National Statistical and Icf 2017)—and these extremes of the age spectrum made up a disproportionately-high number of visits at the Mobile Clinic (as mentioned above). Also, youth and elders bookended daily practice in the Mobile Clinics, with babies being the first patients who are typically seen, and elders being the last, and Pediatrics was the busiest department at the Central Hospital. As mentioned, each of these groups also garnered special attention from interviewees. Starting with interviewees' perspectives on elders, much of their distaste would best be described as mere annoyances, as they rarely described situations that escalated to the point of shouting matches or other sorts of confrontations. "The most challenging patients to deal with are the elderly ones," a clinician told me in our interview, "because they don't differentiate on when to go to the hospital… They go to seek the medication, even if they are not sick… so, they feel like it will be a loss if they don't come to the clinic because we're there in the village [laughter]." I heard similar sentiments across multiple interviews, and such ideas were casually expressed within each facility where I spent time, as clinicians portrayed elders as frequently treating clinics as social opportunities, such that they get dressed up to complain about "minor" ailments, like chronic body aches. Clinicians explained that such behaviors were seen as undesirable because they may unnecessarily increase clinicians' patient volumes (thereby potentially lengthening their work days), and communicating with these patients can be challenging. For instance, a clinician shared during our interview that she gets annoyed with elderly patients on account of having to "repeat thrice one word. *Thrice one word*! [laughs]," for which "sometimes other people cannot tolerate; they just move to the next." Thus, clinicians' annoyance may lead to elders' premature dismissal from clinics. While such opinions were frequently expressed, I suggest that it would be a mistake to attribute such sentiments to biomedical advances, as does Atul Gawande (2017) regarding opinions toward elders in the United States. Gawande writes that "the advances of modern medicine have given us two revolutions: we've undergone a biological transformation of the course of our lives and also a cultural transformation of how we think about that course" (Gawande 2017). For one reason, this perspective was not unanimously expressed, as a clinician in the Mobile Clinics shared during our interview that elderly patients have become some of her favorite ever since a visiting physician sparked in her a sense of curiosity about their complaints possibly reflecting more serious issues and risks (e.g. hypertension and stroke). This clinical officer told me that she had begun to advocate for elderly patients amongst her colleagues, such that clinicians should spend more time with them and at least check their blood pressure. Additionally, as will be elaborated below, this sentiment likely antedates biomedical advances in Malawi.

Despite common negative opinions toward elderly patients, in each of the clinical encounters that I observed, clinicians adjusted their behaviors in an effort to better connect with and serve elderly patients. For instance, I observed clinicians noticeably slow the pace of their speech and increase the amplitude of their voice while communicating with elderly patients. This adjustment was most apparent in Mobile Clinics, where behaviors could be compared between patients who were seen back-to-back-to-back; however, as mentioned, elderly patients were often the final wave of patients to come into Mobile Clinics, and by then, clinicians were often drained (after having seen upwards of 100 other patients), so nonverbal communication, including interpersonal touches and hand gestures were kept to a minimum. I should also note that the age of those clinicians whom I spoke with fell between 22 and 55-years-old, with most below 40-years-old. It is also noteworthy that of all of the hundreds of clinical encounters I observed, I only observed elderly patients or children initiate a touch on a clinician without the clinician mirroring the initiative—that is, an elderly patient (or a child) seems to be at liberty to touch a clinician (typically on the forearm) outside of the context of a handshake or high-five. I never observed such behavior from a non-elderly adult, for whom the most ambitious touch was mutually initiated (i.e. a handshake or high-five). Such behaviors may suggest that elders and children are afforded special social norms.

On the other end of the spectrum from dismissed elderly patients, children often elicited the most positive responses from interviewees *and* the most energetic and engaging behavior in clinical interactions—and it is worth mentioning that at each of the hospitals where I spent time, extra resources were provided by donors (both national and international) for the care of children, whereas I saw nothing of the sort for elders. In the Central Hospital, for instance, entire wards were erected from donations earmarked for children, and in both the Central and District hospitals, research and training organizations dedicated efforts to Pediatrics.

Childhood has been an important research topic for anthropologists for decades, as Lancy (2015) suggests that children have been conceived as holding the keys to understanding enculturation, and Bernard (2011) discussed how what qualifies as 'childhood' varies between culture and time, with the presence or absence of lexical items for teenagers influencing societies' opinions toward that group. Indeed, David Lancy suggests that "a majority of the world's societies delay the conferral of personhood," as part of a process that "has enormous implications for the practice of infanticide, attachment theory, [and] the diagnosis of child illness" (Lancy 2015). In this vein, based on ethnographic research in Malawi and Mozambique, Nancy Kendall argues that popular international models of childhood are based upon "Western conceptions of childhood and wellbeing" that assume "children's need for protection from adults; their inability to participate in "public sphere" activities such as politics, economics, and marriage; and their need to gain rights through adults " (Kendall 2010). In light of this range of uncertainties regarding notions of childhood, and strong proclamations that "childhood" is functionally different in Malawi, I was especially curious about clinicians' thoughts regarding children.

Part of the appeal of children for those clinicians whom I interviewed was a sense of their trustworthiness, whereas adults were seen as potentially manipulative (e.g. drug seekers). As one clinician put it in our interview, “I really love the kids because an under-five kid cannot feign an illness… when the child is sick, he's really sick.” In this sense of “really sick” (as opposed to just complaining) we may assume that the clinician meant ‘medically interesting,’ in that an intervention would have some gravity. Adding to this impetus to intervene, clinicians shared during our interviews that dealing with children provided an added bonus in that children have a greater potential for quick recoveries, as they often acquire bacterial infections that can be easily treated and they may “turn the corner” toward recovery as rapidly as morning-to-afternoon.

As mentioned, pediatric departments often had more resources than adult wards, which, when combined with clinicians’ apparent preferences for children, led to practices that differed from other patient groups in important ways. For instance, as mentioned in Chapter 5, I was told in interviews that “floor beds” (i.e. when patients are stationed on a mattress or blankets on the floor when the number of patients in the ward exceed the number of beds) are commonly used in adult hospital wards throughout the country during busy periods. Administrators and clinicians shared with me that floor beds erode staff morale. However, a pediatrician at the Central Hospital noted during our interview that Pediatrics is “the only department where they don't have floor beds. Kids are never put on the floor… We didn't think it would be good for our patient care… but it will be challenging because you might have three or four kids that are all convulsing on the same bed. That can be hectic.” Similarly, I was told that the staff motto for Pediatrics at the District Hospital is “it’s never full,” as children are never turned away—staff just “make more space.” While it is physically easier to pack multiple children than adults in a single bed (they are simply smaller), it is noteworthy that clinicians expressed that they take on the increased workload without resentment.

Additionally, children of different ages were treated differently by clinicians I observed and interviewed. For instance, a pediatrician shared during our interview that based upon her recent stint in the neonatal unit, “you realize their needs are completely different from the patients I'm looking after now,” as her caseload at the time included children aged 3-12 years. Such differences between groups of children required different styles of interaction. As she shared in our interview:

> “With the neonates… I like to talk to them… In Malawian culture, you don’t really consider a neonate as a person… Until they pass a certain age, they're not really considered as part of the human world, culturally. They're still considered as somebody who's part of the ancestral world. In the past, there would actually be a Passover ceremony to now introduce them to the world… Right now, it's no longer done. Still, until they're out of the hospital, people don’t really count them [as full persons]… you never find the women talking to their babies. Never.”

As mentioned above, Lancy (2015) suggests that not talking to children or considering them ‘full humans’ until they have developed further is common in many parts of the world (and, for the record, those children develop “normally”), so we should not take non-biomedical Malawians’ behavior as anomalous. Those restricted conceptualizations of children, Lancy suggests, are thought to be adaptations to the precarity of life, as well as to infant’s inability to participate in much of adult communication (ibid). As noted, however, clinicians do not abide by that norm. Given such differences from social expectations, I asked this physician what happens when she enters the scene and starts sweet-talking newborns. She responded, “Everyone looks at you like you're crazy, ‘Here comes the crazy lady!’ but I like talking to them. It's fun. It's nice. Then I like the older [children] because then they talk back.” In this vein, another physician shared during our interview that children “speak their own language,” which is full of nonverbals, and “you just have to ‘listen’ to them, then you'll figure out what's wrong”—extra effort and increased attention to perceiving and conveying nonverbal signals, perhaps, but worth it in the eyes of these clinicians.

While all clinicians whom I observed spoke directly to children (and raised the pitch of their voices in the process), interviewees expressed disagreement on the precise order in which kids should be addressed, with some clinicians preferring to speak first to the child because, as I was told in an interview, “I find that they respond to me better when they feel they've been acknowledged as an individual not as an accessory to mom.” Other clinicians whom I observed spoke first to the mom because, as I was told by another clinician in our interview, “children will feel a bit safer if you engage mom and then they see that you're engaging mom and addressing mom before you touch them or before you do anything to them.” In practice, clinicians quickly read children’s nonverbal communication and altered their practices accordingly—sometimes conducting the entire exam without touching a child, and other times having children sit on their laps.

LeVine and New (2008) point out that anthropological studies related to childhood language performance and enculturation have argued that children reproduce notions from their wider culture thanks to stimuli and feedback that they get from interactions; in this sense, it may be the case that clinicians’ extra efforts are enculturation devices, so that future visits with children will be smoother. Indeed, clinicians suggested that those children whom they frequently saw came to quickly understand how things work and were more cooperative during complicated or invasive procedures. For instance, a physician told me in our interview that sick children “know who's dangerous and who's not. They know who's coming to do routine things and who is not coming to do routine things.”

From interview responses and my observations in the wards, it seems that clinicians alter their behavior toward children because they get better responses from children *and* because such behaviors are pleasing to clinicians. This is a point worth stressing: despite the increased energy/labor that must be put into "winning over" many children, many clinicians with whom I spoke prefer this work because it brings them greater fulfillment and joy. The affective bonds that clinicians developed for children could become so strong that children followed clinicians around the ward during rounds, and some of the clinicians with whom I spoke with did not want to see some kids go home. This reality of having to discharge kids was described as especially tough in the face of extreme poverty, as a clinician shard in our interview that "the ones with the social issues also are very challenging… You get to the bottom, the root of the problem [i.e. extreme poverty or a torn family], then what? Are you going to take this child and raise them in your home?" I did not hear of any cases of adoption from the ward, but that such a thought would even arise, is telling.

Gendered Dance Partners

Anthropologists have given a great deal of attention to sex- and gender-based health disparities throughout the world, exposing trends that are said to be inherent to biomedicine (Findlay 1992), science (Martin 1991), and more recently, Claire Wendland made a strong case that global health statistics cloak sexism in Malawi (Wendland 2018). Within Malawi, many gender norms are policed both litigiously and culturally. For instance, a transgender prostitute was arrested during my 2017 fieldwork, as she was turned-in to a local precinct by a man who solicited her for sex, both prostitution and soliciting prostitutes are illegal in Malawi. Charges were filed against the prostitute, her name and photo were printed on the front page of a national newspaper, and no mention was made of the solicitor, who was portrayed as the clear victim. I share this story to convey some of the context surrounding gender, and to note that public displays of transgender behavior were rare in those settings where I spent time, as I never observed a transgender patient in a medical facility throughout any of my trips to Malawi. In the words of one physician I interviewed, “The society doesn't really accept people to discuss issues to do with sexuality.” With that being the case, I do not mean to deny the existence of transgender or genderfluid Malawians, but this discussion of gender pertains to the binary way that interviewees discussed the topic.

Figure 8: Health talk in a Mobile Clinic

From what I gathered in observations and interviews, clinical preferences and interactions between the sexes may be more convoluted than were the patterns concerning patients’ ages, as clinicians’ behaviors toward adult men and women appeared comparable in terms of allocated time and non-verbal communication. Furthermore, both men and women often got the short end of the stick with medical care for institutionalized reasons that are related to their gender. For instance, during my time on the wards at the District Hospital, clinicians told me that inpatient men are often the sickest people around, as they present late in their course of chronic disease or with an emergency. Additionally, I observed a relative scarcity of male patients at Mobile Clinics, and administrators of the Mobile Clinics told me during our interviews that they must undertake special efforts to attract men to clinical visits, as men choose to tend to their crops or conduct business during weekly clinic hours, and there is a stigma surrounding men who attend clinics that primarily cater to women and children. In this way, men “self-regulate” their access to medical care—although it is hard to call it much of a choice, when they often work for subsistence income/crops. Adding to this, I was told by district administrators in our interviews that the referral network favors women in the sense that if a man must be sent to the Central Hospital by ambulance, they will wait until the ambulance is full with patients (so as to conserve fuel) *or* until a maternity case is referred, in which case the ambulance will leave right away. In the words of one of these administrators: “Let's say you want to analyze which conditions are referred more from health centers. You can't really come to a conclusion to say, ‘In terms of the conditions that are in [the district], it's women or children who need more secondary care than the men,’ because the men usually are not prioritized.” Suggesting that such practice skew data on referrals, the administrator continued,

> “If it's OPD [out patient department]—usually they actually call them that. They call them OPD cases. The outpatient cases—but really, there are people who need admission so they will wait for them to pile up, maybe six of them. Maybe an adult will have been sick in the morning. The decision for referral has been made, but they wait until they get more adults and then they'll send the ambulance. But if we get a maternity case, then immediately, this guy will benefit. That means even if you are ordering drugs, the way you are ordering drugs for a district hospital, maybe they'll stock more for perinatal conditions or pediatric conditions because a lot of emphasis in all the programs is being pulled into maternal and neonatal—in newborn care, pediatric care.”

Additionally, at the District Hospital, maternity cases take priority over ‘elective’ surgeries, such that scheduled surgeries are postponed if a maternal emergency arises. We may appreciate the calculus of attempting to save the life of a mother and her child over a non-emergency case (as there were not enough surgical theaters or equipment to meet all surgical needs), but the effects of this policy can be devastating. In the District Hospital, I watched a man’s scheduled toe amputation get delayed because of emergency maternity cases, which provided time for the infection to progress. The next time I saw the man, he needed multiple toes amputated.

Unfortunately, that surgery got pushed off once again, until his entire foot needed to be amputated. As if that wasn't bad enough, the last time I saw him, his foot/leg having smelled progressively worse each time I saw him, two weeks had gone by, his surgery still had not happened, and the surgeon informed me that he likely needed a mid-thigh amputation. It is difficult to call these priorities "wrong," given severe budget limitations and harrowing maternal mortality figures, but such outcomes are certainly troubling, and, as with heuristics described last chapter, such institutional protocols create a kind of self-fulfilling plan.

While the prioritization of these maternal health issues may seem to be a good thing for women's health, serious problems linger for women, as well, as undiagnosed and untreated males continue to spread infection and die at alarming rates (national reports suggest that 83% of women versus 70% of men report having been tested for HIV (National Statistical and Icf 2017)), often leaving behind ill widows to take care of multiple children, in rural settings that offer few chances for employment. Mobile Clinics, however, are seeking to tackle this problem head-on, with their deployment of "Men's Health Days." The clinics were initially called "Men's Testing Day," but the inclusion of non-infectious disease screening required a more expansive title, whereby they hold male-targeted clinics on Saturdays, so that working males can, in theory, attend clinic without missing work (or church, save for Adventists). Only a couple of these clinics had been carried out by the time of my departure in 2017, but they were well attended, with 208 persons (mostly men) coming for testing and treatment on the day that I observed.

On the other hand, despite institutional prioritization and a female predominance at mobile clinics, at each facility where I spent time clinicians shared during our interviews that access to care remains a challenge for women—which, by extension, leads to hardships for children. A physician working in the District Hospital suggested that women’s hardships are due to local kinship systems and religious cultures. She lamented that:

> “If the daddy is out, maybe he has gone somewhere else away for a day or two, [the women and children] will have to wait for the whole two days until he comes back. Maybe they can't even manage to give him a phone call. That means a lot because patients come into the hospital while it's too late… and then the child has died. If you ask them why, they say ‘the uncle is out, or the dad wasn't in, so I wouldn't have just taken the child to the hospital’.”

Similarly, another clinician shared in our interview that women, “don't have control of their health issues… Parents don't have control over the families. It's the uncles or the chiefs that are in control.” This relative disempowerment of women was highlighted in Malawi’s national survey, which found that only 68% of women reported being involved in healthcare decisions, and only 55% were involved in major household purchases (ICF 2017). The survey also points out that “marriage is nearly universal in Malawi,” and that of those currently married, 13% of women report that their husband has multiple wives (ICF 2017). During our interviews, clinicians mentioned disempowerment, neglect, abandonment and physical abuse from husbands as factors that harm women, and one clinician suggested that husbands are quicker to end a marriage, because they are more likely to be educated and have financial control. Regarding violence against women, two rape cases were reported during my time at the District Hospital: one involved a 15-year-old female who was reported to have been ambushed while walking home at night, was pulled into an abandoned house and raped by seven men. A couple hours after the rape, the woman came to the hospital, where she was seen by a junior clinician who performed a cursory examination and then told her that she could go home. A formal report was not filled out, nor did the clinician perform a complete examination—issues that sparked heated debate during morning rounds, resulting in the staff vowing to create a protocol and a “one-stop shop” for dealing with rape cases. Nearly a month later, a second woman came in reporting rape, an 18-year-old who had been walking home at night and was choked and dragged into a bush.

Once again, the case was botched and staff vowed to improve. Thus, medical hardships of women surrounding physical abuse clearly involves an institutional component.

I was also told about overtly abusive treatment of women that extended into hospitals. Interviewees suggested that female nurses and midwives have reputations as being harsher on mothers in the maternity ward, although they also suggested that women were better able to empathize with and advise adolescent females concerning manners of puberty and sexuality. Shining some light on this phenomenon, a WHO report suggests that harsh treatment of pregnant women "is proving to be as great a deterrent as cost of care and transport" (WHO 2014). I did not observe any such behavior, but, emblematic of the spirit of some wards, a physician at the Central Hospital shared: "I've heard a couple of examples here, where someone comes and says, 'I haven't had a baby since my operation,' and we tend to wonder. When you examine them, you find that they don't have a uterus, and they never knew—nobody bothered to explain to them what operation they had." For such reasons, a district administrator suggested in our interview that "maternity cases… end up wanting to deliver at home," because they "or a friend, or someone had a bad experience, lost a baby, [or] the father heard that the staff didn't treat them well. They say, 'I would rather deliver at home where at least there's some level of dignity.'"

Teen pregnancies were also a major concern for clinicians and administrators I interviewed and spoke with, as they complained that young mothers often present late, without having had antenatal care, and that their small pelvises can complicate labor. Septic abortions and subsequent rotten uteri were common in the hospitals where I spent time, and the clinicians I spoke with who dealt with these conditions described them as the harshest sensory and emotional experiences that they faced in their practices. Surgical emergencies for young mothers presented clinicians with a situation whereby, in the words of a clinician whom I interviewed, "you're supposed to act there and then, and if you don't make a decision, then you can lose the life of the baby or life of the mother." In a case that was recounted to me by the clinician on duty and discussed at length during morning report at the District Hospital, we can imagine being the clinician called in at night to deal with a pregnant teen who had stalled in childbirth. The mother had no antenatal care, so her baby's hydrocephalus was totally unexpected, which led to a prolonged, difficult labor. The nurse on staff called in a reserve clinician for assistance, and eventually the baby's enormous head was pulled through the birth canal. To the horror of everyone involved, five minutes later, the mother's blood pressure plummeted. The clinicians on duty performed a pelvic exam, noticed blood coming from her cervix and placed a couple stitches in the woman's cervix. Unfortunately, her blood pressure continued to drop, so she was given two units of blood and opened up for an exploratory laparotomy, to find and stop the source of bleeding. Upon incision, free blood poured out of her abdomen, and the clinician slopped through the blood to find a tear in her broad ligament, into which the clinician placed sutures and then closed the patient up. The patient's blood pressure stabilized for a moment and then plummet again, so she was reopened. With blood now covering the patient, the ground, and the medical staff, more stitches were placed. This time, her blood pressure did not stabilize, and she was subsequently pronounced dead. To make matters worse, discussions at morning report centered around what the clinicians should have done, and alternative proposals included puncturing and compressing the baby's head, or decapitating the baby in order to save the mother's life. Such situations represent tragic manifestations of systemic failures, and they place clinicians in horrific positions where no good options exist.

Female teen/childhood marriages were another issue brought up by personnel at each facility. In cases where girls said they got married because of poverty, I was told in interviews that clinicians at the Mobile Clinic took their name and worked with local chiefs to end the marriage and get the girls back in school. During our interview, one clinician explained her reasoning for taking such dramatic actions:

> “What I take into consideration is you're supposed to respect…their culture, if you are actually working, and if you are actually assisting them. At the same time, you're supposed to balance out and say, ‘this type of culture is it assisting them or maybe it's destroying their whatever?’ That's when you try to reason with them, ‘this culture, yes it might be good maybe for your fore-parents but now it's not good’… For example, like early marriages where a 13-year-old is getting pregnant. That' so harmful, isn't it?”

Clinicians with whom I spoke also expressed that cultural norms act against women being referred for other kinds of psychosocial support. As one clinician shared in our interview:

> “It's difficult because a Malawian lady or maybe an African woman… It's like they persevere, when they happen to have a problem. They will keep that problem to themselves. For them to share with somebody it's not easy sometimes. I don't know, but that's how we were just brought up… It's like lack of knowledge regarding rights.”

When More Isn’t More

As mentioned above, in response to my questions about preferences for patients, clinicians’ responses generally diverged regarding their preferences for what they perceived to be patients’ socioeconomic status (SES). Those clinicians and administrators with whom I spoke expressed strong desires to ‘serve the needy,’ which was often synonymous with rural, poor persons (although administrators wanted affluent persons to come to them in the future, to collect their money in private wards, as discussed in Chapter 4)—sentiments that are consistent with Claire Wendland’s findings regarding the desires of Malawian medical students (Wendland 2010). Thinking back to the intricate behaviors involved in taking Kingston’s temperature at the beginning of this chapter, I only saw such in-depth instructions for a routine physical examination involving one adult. In that case, near the end of the day in a Mobile Clinic, an adult man shuffled in whose pants were ripped at the knees and ankles, he had on a threadbare shirt, and his shoes were so large that the toes curled-up—he was obviously poor, even by local standards. The clinician took the man's temperature without issue, but he had to coach the man through how to breath in such a way that the clinician could hear into his lungs during auscultation (i.e. much deeper breaths). As was the case with children, this act conveyed a sense of compassion as the clinician patiently gave the man cues and praised him for his inhalations.

Even with such good intentions, however, clinicians' employment of heuristics (discussed in Chapter 6) may contribute to poor peoples' hardships, as clinicians in the wards told me that they may not even offer poor patients all available options, as they assume that expensive treatments are simply out of patients' reach, thereby saving themselves time in those consults. For instance, I observed a case of a middle-aged woman with dangerously high blood pressure (190/100mmHg) and a 30mmHg pressure discrepancy between her two arms, numbness in her legs and pain on one side of her body who was not referred for further workup because the clinician assumed that she would not be able to make it to the Central Hospital—the only place where a thorough workup could be done. For those poor patients to whom options were explained the relationship could still fail to meet ideals (as described in Chapter 6). For instance, a particularly empathetic physician shared during our interview that:

> "I do get the sense that they are dis-empowered. They are inclined to say 'yes' to everything I say. So, that also puts me in a fix because if I'm giving someone options, they should be in a capacity to choose, not me choosing for them… most of our patients you feel that they submit to whatever you tell them… They come to the hospital with a problem, they're expecting that the doctor is the one who knows… Maybe they're not well-informed… maybe we don't explain all the treatment options or anything, or they just are afraid."

On the other side of the SES spectrum, clinicians provided mixed opinions and stories. In a positive light, a physician at the District Hospital described during our interview a pleasant experience that she had treating a chief—someone of high social status, but not necessarily high economic status—as she was able to form a personal relationship with the chief, who presented in the middle of the slow night shift, therefore removing typical time constraints.

On the other hand, I more often heard stories of patients of high socioeconomic status being described as impairing clinical relations. Those patients were portrayed as "demanding" and attempting to undercut clinicians' autonomy and the "spirit of medicine." It was well known among those persons whom I interviewed that affluent Malawians often access private services to skip patient queues and increase the likelihood that they will get the medications that they need, although they did access public services on occasion. In the words of one physician I interviewed, "They feel like they own you [laughter]." "I'm sorry," continued this physician, as if speaking to one of these patients, "I cannot sit there dealing with your upper respiratory tract infection, I can't do it [laughter]… I want the serious things, things that will get my adrenaline pumping and then, no," she changes character once again, this time to represent the patient, "I have a headache. I stubbed my toe against their bed, so I'm here at the hospital." Shaking her head, she switched to her own commentary:

> "The thing with private practices is that it takes away from the beauty of medicine—that whole, you have a puzzle, then you decipher it, and then it forms a nice picture, and then you fix the patient—that is missing… I can't stand it. I'm sorry, so I don't want to be that enslaved by the system… On the record, I am rolling my eyes a lot [laughter]."

Unlike children, affluent adults were seen as often wanting treatment for trivial ailments. While clinicians I observed often suppressed their frustrations, such self-control was not always exercised. From what I witnessed around the wards, trainees often had the hardest time with these frustrating situations, as a senior clinician suggested to me that junior clinicians and students had not yet developed confidence in their skills, so they internalized the sense of inferiority that was cast upon them by patients who were professional urbanites and attempted to bully them into doing what they want. One such confrontation involved a 50-year-old male patient, a teacher (a high status and affluent profession by Malawian standards) from one of Malawi's main cities, who was suddenly stricken ill while visiting his home village. The man was brought into the District Hospital by his daughter with complaints of lightheadedness, chest pain that radiated down his arm and up his neck, and a feeling like he was dying. While sitting in the triage room, sweating profusely, the man oscillated between a decreased level of consciousness and agitation. The man's daughter was understandably worried, and she ordered the intern to admit her father. Reflecting upon the incident, a more senior clinician told me in our interview that "the guardian started attacking [the intern], shouting at her," and to make matters worse, the intern started yelling back at them. "It was quite challenging," the senior clinician continued, "because if the patient and guardian are in that state, then you have to come in with a low, calm [she puts her arms out to represent tranquility] so that you cool them up; then you explain to them. But if you do the opposite, that means there was total chaos," she told me, laughing. In this case, rather than follow orders, the intern did the opposite. As the only person staffing the emergency/triage room, she ordered a rapid malaria test (which makes sense in light of the heuristics described last chapter). Thankfully, a veteran clinician rescued the intern and admitted the patient to the ward. The rescuing clinician told me in our interview that "I used to [get mad like that] because there are other people who… irritate others. They see you, they feel they need to be reviewed by older clinicians, or they're well connected to some senior people there, so they will need a special treatment." After the patient was admitted, another veteran clinician went to the patient's bedside and diffused the situation by collecting more history and getting to know more about the patient, personally. Thankfully, the patient survived the event (despite clinicians missing the likely diagnosis of myocardial infarction—a rare diagnosis in each of the facilities that I visited—and not providing him with any of the recommended treatment), and the next day, when he was discharged, the patient expressed gratitude for the care that he received in his home district. As mentioned, I ended up discussing this case with multiple clinicians (in interviews and on the wards), and each of them got to laughing so hard that we could barely speak—laughing not at the patient or clinician, but at the obscene screaming match in an exam room and the fact that both the patient and the clinician narrowly dodged what could have been a tragic situation.

Historicity and Intersectionality

Thus far, I have spoken of patient identities as though they exist in isolation and outside of a sociohistorical context. However, social scientists, philosophers and historians have shown that these features overlap and interact in important ways (Davis 2008; Hokkanen 2007; Vaughan 1992). Scholars often refer to this overlap and interaction by the term "intersectionality," which MacKinnon (2013) (the author credited with coining the term) describes as a method of inquiry—a way of thinking about the world. In addition to providing us with deeper insights into perspectives and practices in Malawian biomedicine, intersectionality provides us with an opportunity to better situate these phenomena within their sociohistorical context. Megan Vaughan's work on the 1949 Malawi famine is particularly useful for this endeavor, as she shows that hardships were not evenly dispersed among the population. Instead, individuals' hardships depended upon one's place within a kinship network:

> "Both oral and written sources confirm that it was the very old and the very young who suffered most notably, and oral accounts also mention pregnant women as being vulnerable. Many old people were abandoned and either died in their homes or collapsed on the way to the distribution centers. The oral accounts of both men and women indicated that it was men who lost most body weight and who died most often of starvation" (Vaughan 1992).

I would like to call attention to continuities in these trends of suffering: elderly and infants appear to have been most vulnerable, women were in the most precarious position, men often fared the worst, and Vaughan identified that affluent Malawians were most likely to acquire necessary food and supplies throughout the famine (ibid). In other words, the social stratification of the 1949 famine matches up nearly perfectly with the sentiments expressed by those personnel I interviewed. I propose that such continuities indicate that *there is something much deeper happening here than individual clinicians' preferences for patients*. Indeed, Kenneth Ludmerer convincingly argues that:

> "Much of the behavior of physicians reflects influences from outside the medical school, such as the character and values of those who choose to enter medicine, the cultural climate of the time, and the particular rewards and incentives offered by medical practices… Our physicians reflect the type of people and society we are, not just the efforts of academic health centers" (Ludmerer 1999).

In 1949, blaming and neglecting the elderly made them the canaries in the coalmine for biocultural struggles ("bio" in the sense that the famine had clear biological implications, and "cultural" in the sense that the effects of the famine were distributed according to one's position within kinship networks). Similarly, neglected elders made up a special demographic at early mission settlements, as they readily risked their wellbeing by accessing missionary services (Hokkanen 2007).

That said, attention to the historicity and intersectionality of these issues also shows important differences. For instance, Freidus (2011) argues that childhood within Malawi has historically *not* been seen as a period of life into which adults should invest a great deal of emotional labor, and Kerr, et al. (2008) have shown that Malawians protect their customs for childcare, such that violating norms (as in the case of introducing non-milk foods) can lead to ostracization. In contrast to what these historic trends might lead us to expect, the thoughts and behaviors of clinicians whom I spent time with show a great deal of emotional investment and deviation from norms—to the extent that emotionally-distant behavior even represents the current norm, as everywhere that I have traveled in Malawi, it is customary for women to carry their children on their backs throughout the day and be responsive to their cries. Further, in general, there is remarkably little crying out of Malawian children who are strapped to their mother's backs. By discussing this history, I do not mean to argue for a strict cultural determinism, as individuals whom I observed clearly acted within the moment, according to their insights and personal preferences, and variation existed across and within each facility. Nevertheless, continuities are striking, and a question remains of what sense we can make of these trends of historic vulnerability of poor persons, children and elderly, with different hardships for women and men, and affluent persons generally finding a way to make ends meet.

Didier Fassin suggests that conceptions of *African* childhood took a turn in the early 2000s, when three "discoveries" came to light: 1) "preventable risk of mother-to-child transmission" of HIV; 2) global headlines involving child abuse and infant rape cases; 3) "the worrisome increase in the number of orphans resulting from the deaths of young [HIV-] afflicted parents," which he suggests created a new moral economy around childhood (Fassin 2013). Unfortunately, Fassin notes, this intense focus on children came at the cost of sympathy to adults, especially mothers (ibid)—a point which Claire Wendland shows has been institutionalized by national and global health bookkeeping practices that involve much stricter monitoring and reporting standards for children than mothers (Wendland 2018).

In addition to these historic and more contemporary trends, I suggest that institutional investments and individual identities of those clinicians whom I observed and interviewed sculpted their preferences for patients, which could buttress or mitigate biocultural hardships for patient groups, depending on identities. For instance, interviewees at each site expressed that poverty in their own backgrounds contributed to their preference to treat poor people, and a female clinician—who seemed to possess the energy and determination of an entire village, herself an orphan who was responsible for paying the school fees of her younger siblings while she raised a child of her own, was pregnant with another, and pursued a Masters degree on weekends—described one of her favorite patients during our interview as a 27-year-old woman who presented with hypertension. In her words, “After assessing and asking why the [blood pressure] is rising, she was open enough to say, ‘I have psychological problems at home. I have three orphans who I take care of… so finding food to feed them, finding money to buy soap and all the necessary household items is very difficult.’” In another setting, with another clinician, this patient may have been seen as burdensome, as her problems cannot be managed within the clinic; however, this particular clinician clearly identified with the patient on a personal level, and since she worked within an organization that valued horizontal healthcare programs, she was able to put the patient in contact with a village support program.

Stereotypes and Biases to Placebos and Nocebos

In this final section, I aim to further our understanding of how clinicians engage with patient identities by extending the work of anthropologists who showed that biomedical clinicians are, themselves, caught up in cultural processes, which shape clinical rituals and ways in which they approach patients (Katz 1981). Additionally, I aim to qualify the work of Lock and Nguyen, who describe biomedical practices as being carried out as though they pertain to ‘universalized bodies’, which, they suggest, homogenize patients of various identities (Lock and Nguyen 2018). Finally, I aim to connect my findings to broader literature to suggest that the nuanced behaviors of clinical interactions—particularly, the variability of nonverbal behaviors—can tell us a great deal about health systems and individual responses.

Outside of the field of anthropology, clinicians’ experience with patients whom they have positive or negative feelings about—feelings that do not necessarily rise to the level of sexism, racism or classism—have been described by Gelso, et al. (2002) by the terms countertransference (i.e. a clinician projecting her feelings onto a patient) and transference (i.e. a patient transferring her feelings onto a clinician), and psychologists have described a "therapeutic personality bias," which Cook (2010) defines as "an umbrella term for the unblended clinician's influence on the patient's perception of benefit"—in other words, when a clinician's behavior drives positive outcomes. While these concepts are valuable within their domains, I suggest that they fail to capture the social and historical nature of the thoughts and behaviors of those Malawians clinicians I observed and interviewed. Furthermore, physical manifestations of the preferences of clinicians I observed (e.g. eagerness to touch children) suggest that clinicians' "mental projections" and "personalities" do not account for the richness of these phenomena. The works of Hunt, et al. (2013), Boffi (2015) and Colas (2017) have each shown that wider social trends shape the ways that clinicians' think about and behave toward patients, depending on clinicians' perceptions of patients' identities, and that these differences in conception can lead to differences in behaviors that rise to the level of racism, sexism and classism. These studies suggest that the ways that clinicians manage patients of different identities depend upon local culture, institutional preferences, and biases implicit to biomedical knowledge and funding sources. With this combination of influences in mind, I suggest that the thoughts and practices of Malawian clinicians are shaped by the wider culture in which they are embedded, as evidenced by continuities between the 1949 famine and current ideas about patient outcomes, in combination with specific institutional designs, as evidenced by how adult male and female patients are treated differently within the facilities where I spent time. Furthermore, I have sought to show how personal preferences can be a deciding factor in determining the dynamic and outcomes from clinical interactions, as evidenced by interview responses and observations regarding clinicians' favorite and least favorite patients. These factors create layers of influences on the management of patients. For instance, while outcome trends remain impressively consistent with the 1949 famine, changes in cultural and institutional practices, as well as changing individual preferences, create important differences. Foremost among those differences that I observed were ways in which institutional and individual energies were so heavily invested into children. Importantly, as discussed above, Freidus (2011) and Fassin (2013) suggest that notions of childhood have changed dramatically within development and biomedical circles since the AIDS epidemic, and it appears as though Malawian clinicians, as integral members of biomedical development efforts, conceive of and behave toward children in ways that more closely align with notions that children as deserving special energy and protection. Additionally, clinicians' preferences for serving rural poor persons may mitigate historic and persistent hardships faced by this group of patients, even if clinical practices frequently fall short of ideals. I would also like to underscore that even though *trends* from 1949 have been reproduced to a large extent, general patient outcomes and available treatments have undergone dramatic changes in recent decades. As a rough index of such changes, the life expectancy at birth in Malawi was roughly 37 years in 1960, whereas it is now roughly 63 years (Bank 2016), and the numbers of healthcare providers has dramatically increased, in parallel with the development and implementation of dedicated programs for reducing maternal and neonatal mortality.

A question remains of how preferences shape the ways that clinicians engage with and respond to patients based upon patients' identities and the sociocultural context in which the interactions occur. In the settings where I spent time, clinicians do not sit back and contemplate the identity of each patient they saw. Rather, interactions took shape in a split second, and some interactions turned on a dime, depending upon the persons and behaviors involved (recall the babies in the introduction: Kingston was amenable to a physical exam, whereas the next baby became hysterical). Furthermore, in those cases that I observed, clinicians readily expended more energy to interact with favorite patients, even though they may have only achieved the same objective outcome (i.e. gaining a temperature reading from a toddler required greater energy expenditure than the same information gained from an adult). Perhaps my most remarkable finding regarding clinical preferences is that interacting with patients of certain identity groups can reverse *clinicians'* moods—a finding that differs in important ways from previous descriptions of clinicians' personalities influencing *patients'* wellbeing or individual patients' personalities influencing the way that clinicians treat them. For instance, during our interview, a pediatrician shared, "I can wake up some days where I'm having the worst day, but it's pretty difficult for you to stay mad or still feel down after you see a child who is getting better, who is smiling at you, who wants to play." Statements like this inform us that clinicians are aware of ways in which patient identities impact clinicians' mood and sense of wellbeing. My observations support such statements, as I often observed clinicians' moods transform from stern focus to upbeat playfulness once they began interacting with children. In this way, we see that patient identity has psychosocial impacts on clinicians. If we relate this to the previous discussion of how care differs across groups of patients, we see that these preferences and moods can influence patient outcomes if extra efforts are afforded to patients or they are prematurely dismissed—as was described for children and elders, respectively.

In his popular book *Medicine, Rationality and Experience,* Byron Good argues that:

> "entry into the world of medicine is accomplished not only be learning the language and knowledge base of medicine, but by learning quite fundamental practices through which medical practitioners engage and formulate reality in a specifically "medical" way… These include specialized ways of "seeing," "writing," and "speaking"" (Good 1994).

Good's suggestion that clinical students learn to ascribe new meanings based upon a variety of sensory modalities provides entry into a deeper understanding of my observations of clinical interactions, as I found that clinicians listened to and touched patients differently, depending upon patient identity and the context of the interaction. For instance, clinicians leaned in to speak with and hear elders, and the sounds that they heard from auscultating the lungs of infants were interpreted as having different meanings than the lungs of adults. Differences even extended to the ways that clinicians looked at patients, which may be an especially important variable, as Ong, et al. (1995) have shown that eye contact is one of the factors with the greatest correlation with clinician satisfaction. Differences in gaze can be readily appreciated by comparing the District Hospital's hypertension clinic, which dealt with all adult patients and clinicians told me that they loathed working in, to almost any other setting. In that hypertension clinic, there was almost no physical contact, so I tracked that ways that clinicians looked at patients and divided encounters into three groups: 1) those in which clinicians and patients made eye contact, 2) those where no eye contact was made but the clinician at least looked at the patient, and 3) those where the clinician did not even look at the patient. As it turned out, only 52% of consults involved shared eye contact, in 30% of visits Chifundo looked at the patient's body without making eye contact, and in 28% of visits Chifundo did not even look at the patient. In contrast, eye contact was a given within all encounters in Mobile Clinics and in most inpatient hospital encounters (although I observed many cases in which patients' eyes remained closed throughout inpatient interactions, as they were often too sick to open their eyes). Further, in each facility where I spent time, clinicians' gaze was especially animated when interacting with children as compared to adults (i.e. much more smiling and raised brows with children).

We cannot stop there, however, as Geertz (1973) reminds us that a goal of anthropology is to discern the meanings behind gestures, so that we may better understand how and why individuals and groups function as they do, lest we mistake an eye twitch for a wink. While I cannot definitively say what was the exact meaning of any particular touch, gesture or glance that I observed, it is worth noting that my observations of situations associated with a dearth of touches and eye contact corresponded to experiences that clinicians disliked; and, conversely, clinicians frequently invested a great deal more effort into touching and looking at children, about whom they often expressed warm sentiments. In this regard, the work of Sandy Pentland (2008) is theoretically useful. By measuring content-free, non-linguistic features of communication—including hand gestures, facial expressions, speech prosody, tone of voice, and orientation and proximity of bodies—Pentland shows that features of nonverbal communication are far from random, and he suggests that they form a protolanguage that provides robust insights into feelings and behaviors. By tracking these features, Pentland and his team suggest that mimicry conveys *and generates* trust and empathy between people, and that increased activity/energy level conveys *and generates* interest between people. Pentland suggests that patterns of nonverbal behaviors cluster according to social roles within a given context, and that clinicians' behaviors cluster in stereotypical ways that facilitate connecting with patients. Furthermore, Pentland shows how group decisions are often based more strongly on social signaling than on any kind of isolated, rational deduction—a point that is supported by neuroscientists who suggest that each of our senses are 'wired' to affect and meaning, such that what we "perceive", "think" and "feel" cannot be separated from one another (Damasio 2018; Rolls 2010; Sapolsky 2017). My observations suggest that Malawian clinicians displayed greater mimicry and activity levels with children, especially toddlers—so it may be no coincidence that clinicians expressed greater preferences for and trust in children than adults—and that the interplay of clinicians and patients played a central role in clinical decisions.

Given this phenomenon whereby clinicians prefer certain patients, with whom they interact differently, with whom they are willing to expend more or less energy to serve, and who differently affect clinicians' sense of wellbeing, I suggest that we expand our understanding of biomedical practice to include how patients affect clinicians. Thankfully, concepts already exist within the fields of anthropology and biomedicine for describing human tendencies to form different expectations about, and respond differently to, people and things within clinical interactions depending upon the contexts in which interactions occur. Unfortunately, thus far these concepts have only been applied to patients, as if patients are the only ones whose preferences and expectations shape interactions and outcomes—an assumption that a large group of medical anthropologists have shown does not reflect reality. In this way, I suggest that we think of clinicians thinking and acting differently toward patients within particular settings as placebo and nocebo responses *from clinicians* (depending on whether the response is positive or negative, respectively). By invoking the concepts of placebo and nocebo responses, I mean to call attention to those features of patients—most notably, their identities—that do not convey "objective" clinical data but nonetheless shape the way that clinicians conceive of the "success" or "failure" of a visit, and those features which are associated with greater or lesser energy expenditure on the part of clinicians, in order to obtain the same "objective" information—those aspects of clinical interaction that are thought to be "inert" when clinicians are portrayed as individualized, rational actors that treat patients homogeneously, according to notions of a "universal body." David Eknoyan and colleagues write, that "the primary mechanisms for a placebo (or nocebo) response are the individual's expectations… and conditioned learning from previous experiences," which are sculpted by "both explicit and implicit cues," and involve "many types of indirect experiences (social learning)" (Eknoyan, et al. 2013). They continue, “examples include speaking to someone who has had a good response to a similar treatment, observing someone who appears to be responding to the treatment, or viewing a commercial suggesting benefit. The converse also occurs" (ibid). Thus, placebo and nocebo responses are already thought of in sociocultural terms and are thought to be ‘passed’ from person to person via stories and observations. Anthropologists Andrea Wiley and John Allen add that placebo and nocebo are “broader than simply describing when inert substances have treatment effects,” as they involve “*meaning response”* from those persons involved (Wiley and Allen 2009).

At first glance, this application may seem quixotic, but I suggest that it helps facilitate (and balance or add symmetry to) our understanding of the practice of biomedicine, as to my knowledge, studies have thus far focused exclusively on how clinical interactions have biocultural effects on patients—for example, under terms like “biocitizenship,” which refers to the relationship between patients’ biological manifestations and the healthcare services that states are willing to provide (Petryna 2013), “biosociality,” which refers to how patients’ identify and group themselves according to their genetics and medical diagnoses (Rabinow and Rose 2006), and “biopower,” which refers to how states control patients’ bodies and behaviors (ibid). Without a counter-balance to these patient-specific biocultural notions, I suggest that we risk reifying artificial divides in our understanding of biomedicine. This expanded conceptualization, I suggest, aids in taking a step further toward understanding how biomedical culture ties together clinicians and patients within environments—or sociotechnical systems, as Lock and Nguyen (2018) prefer to think of it—that shape *both parties’* expectations, thoughts and behaviors. Rather than thinking of this as reducing biocultural processes to placebos or nocebos, I suggest that we think of this as elevating placebos and nocebos to legitimate processes that are inextricably part of patients’ and clinicians’ experiences. Furthermore, it may be the case that these phenomena influence and are influenced by aspects of clinical practice that range from the way in which a clinic is organized, to general opinions of patient groups, to the nuanced differences of physical examination techniques. I do not intend to make the argument that racism, sexism or other “isms” do not exist; rather, I aim to highlight how there are a host of other cultural and interactional factors that guide clinicians’ behaviors and that contribute to differential care without rising to the level of bigotry or malicious intent.

Summary and Conclusion

Those clinicians I observed and interviewed expressed clear preferences for certain groups of patients over others. The groups that were described in the most favorable light were children and the rural poor—groups that clinicians expressed greater fulfillment in treating and a greater willingness to extend extra efforts. Alternatively, clinicians described affluent and elderly patients as less desirable to interact with, as affluent patients were characterized as more demanding and elderly patients were described as presenting with trivial complaints and barriers to efficient communication. Clinicians’ preferences toward female and male patients was less straightforward, as a host of institutional arrangements and cultural practices presented challenges to caring for these patients. For women, clinicians noted a lack of autonomy in determining when to seek care, and for men, clinicians noted personal unwillingness to access clinics and institutional barriers that undermined timely care. These findings show us that medical hardships are not randomly distributed throughout populations, nor are group preferences or institutional policies indifferent to the identities of those persons who access biomedical services.

Taking an historical and intersectional look at these issues, we see that thoughts and feelings surrounding patient identities closely trace outcomes and sentiments from Malawi’s 1949 famine, as described by Megan Vaughan (Vaughan 1992). I suggest that these close alignments implicate broader cultural processes—in which both clinicians and patients are embedded—in shaping clinical outcomes for particular groups. However, we should not over-extend ideas of cultural determinism, as clinicians' preferences and patient outcomes showed important differences from the state of affairs described by Vaughan. Taken together, these findings suggest that changes in national healthcare policies, institutional protocols and targeted funding mechanisms *can* make a difference, as they have benefitted some groups more than others. A next step, I suggest, could be to construct targeted programs for elder care and addressing lingering barriers for women and men—programs that must be adequately funded and staffed. Designing and implementing such programs may benefit from recognizing and addressing clinicians' biases against managing certain groups or ailments, and they may benefit from providing clinicians and administrators with detailed information on the significance and proper management of the issues affecting elders. Additionally, historic continuities underscore the importance of coordinating biomedical development efforts with broader efforts aimed at education and community outreach.

Finally, within this chapter I draw links to the work of Geertz (1973), Pentland (2008) and Eknoyan, et al. (2013) to suggest that detailed attention to clinical behaviors and sentiments supports extending our understanding of placebo and nocebo responses to include clinicians' responses to patients. In this way, I suggest that clinicians' development within specific contexts influences the ways in which they experience patients—that is, for clinicians, many of their preferences for patients are experienced as perceptions rather than projections of their own feelings. Furthermore, my findings suggest that clinical behaviors and preferences are often self-reinforcing, as behaviors both reflect and generate affective sentiments, and these cycles may be desirable or not, depending on whether patients are viewed in a positive or negative light. Attention to such thoughts and behaviors is not meant to take away from the dedicated efforts of clinicians; rather, I suggest that it helps us to understand why, within particular settings and with access to particular resources, clinical interactions and outcomes tend to take certain forms and not others. These findings suggest that efforts aimed at mitigating clinical "biases" may need to do more than simply provide "objective" information, as clinicians perceptions of patients appears to change the ways that they access and apply such information. Training may need to highlight affective elements of care and encourage clinicians to find ways to be more involved and animated with all patients, especially elders.

While this chapter discusses long-term "cultural" continuities (i.e. with trend of the 1949 famine) and short-term "biological" reflexes (i.e. placebo and nocebo responses), I attempt to steer clear from any kind of cultural or biological determinism. I do *not* suggest that clinicians are hard-wired by "nurture" or "nature" to behave in certain ways toward certain patients. Rather, I suggest that clinicians develop (bioculturally) with particular contexts and are influenced by a variety of factors that include kinship relations and immediate perceptions of the person sitting in front of them. This argument is rooted in a logic described by Ingold (1998), who aimed to obviate the divide between biological and cultural understandings. It is my hope that conceiving of clinical interactions in this way helps narrow theoretical gaps between general anthropology and biomedicine in ways similar to how Byron Good showed that medical education guides students into a new way of perceiving and constructing meaning (Good 1993b), and how Pearl Katz showed that surgeons' technical behaviors are no less ritualistic (and maybe even *more* ritualistic) than most common laborers (Katz 1981).

CHAPTER 8: Conclusion

"The evidence presented is clear: there is no health coverage without a health workforce. The global community must act. A transnational, transformative contemporary agenda is required: one that rises to the grand challenge of human resources for health strengthening and makes possible the development and implementation of sustainable health systems, sustainable development and shared prosperity. No country is exempt or isolated from the challenges of universal health coverage and of the related human resources for health ones; we live in an interdependent world in which action and inaction have far-reaching implications for current and future generations"
–WHO and GHWA (2014), *A Universal Truth*

"It's not easy. Someone put it that being born in African countries is a huge risk… When I see many kids dying, sometimes I do think and sit down. I say, 'how did I survive? How is it real that I survived and then I am at the age I am?... It could have equally been me dying while I was a kid. Looking at where we were, I was raised in the village, and it's in a place where the health system was not that good, and things were even far much worse than now, but we were still able to grow. I look at our country as a place where it's so risky to be alive and it is so risky to be here and even to be born in the hospitals because there are many people who are dying… To me, it makes me feel that, as human beings, we can do something that can control these deaths. Though it is not easy, but I think we have a huge role in whether children should continue dying or should be saved as human beings. We can do something."
–Physician at District Hospital (2017), Interview

In this dissertation, I report on a study to better understand the experiences of Malawian healthcare personnel with development efforts, career prospects and patient care in Southern Malawi. Malawi is an important setting for this research because of the immensity of its healthcare challenges, which include crippling poverty, short-staffing, and high rates of morbidity and mortality from both infectious and noncommunicable diseases. Each chapter of this dissertation presents a case study about one aspect of healthcare and development efforts, with Chapters 2 and 4 representing the largest scale of analysis—that of global processes—and subsequent chapters descending in scale to institutional and interpersonal trends.

Throughout Malawi's long history, we find a mixture of innovations, set-backs, resistance and struggles that involve both local Malawians and international persons and organizations, which facilitate and restrict current efforts in healthcare. Some of the current healthcare challenges and opportunities discussed in this dissertation include national decentralization and coordination of domestic policies with international agreements, improved staffing, handling large patient numbers, and providing individualized care. Throughout my study of these topics, it became increasingly clear that the insights, experiences and preferences of Malawian healthcare workers were indispensable for understanding the ways in which these processes play out "on the ground." Unfortunately, large-scale efforts at national and international development have largely omitted the voices of Malawi's healthcare personnel, leaving them as unknowable or irrelevant black boxes. Those Malawians whom I spent time with voiced their disenchantment with many national and international interventions, as they expressed desires for improved alignment with local processes and personnel and strong hopes for decentralization of healthcare services and training programs. The details of this process—which will, in theory, will provide District and Central Hospitals with more control of their operations and finances—have yet to be worked out, and many serious questions linger surrounding staffing, finances and inequities.

Malawi's history of limited investments in and subordination of trained personnel throughout the colonial era and presidency of K Banda laid the groundwork for current challenges related to shortages and disempowerment of staff. Some large-scale impediments continue to be reproduced, as national planners deal with budgets that are frozen by international lenders, and individual facilities jerry-rig patches for inherited problems. Despite daily hardships, uncertain career prospects, and daunting personal and social obligations faced by those personnel whom I spoke with, they still aspired to provide quality care, to carry themselves with dignity, and to fulfill their social roles as charitable public intellectuals—tenets upon which they felt that their communities rely. I suggest that persistent struggles with these mismatches between expectations, aspirations and realities on the ground precipitate a host of adaptations among personnel, which include realigning expectations to better match realities on the ground (e.g. by distancing themselves from patients and investing less energy into their jobs), or by changing their environment to better match expectations (e.g. brain drain). While these adaptations may serve to mitigate the suffering of individual healthcare personnel, the adaptations can also hamper patient care and undermine both local and large-scale healthcare efforts. Throughout this process, we find examples of a nuanced interplay between macrosocial trends and activities of individuals and small group.

Despite hardships for their career paths, those personnel whom I interviewed held high ideals for clinician-patient interactions that included holistic and reciprocally-constructed care. Thanks in large part to sociohistorical conditions, ideals of care were often compromised, and clinicians adapted to achieve their goal of serving every patient with the resources and personnel that were available, and within a timespan that allowed them to uphold their personal responsibilities. In some instances, clinicians' adaptations seemed to anonymize patients, as neither names nor genders were gathered within clinical interactions. In other instances, clinicians used subtle behavioral cues and specific information about patients' lives to guide diagnostic and treatment decisions. In some instances, adaptations permitted efficient triaging and diagnoses of "common" ailments. In other instances, adaptations undermined both patient care and public planning. Even amidst conditions that contributed to quick encounters and anonymized practices, however, clinicians showed that patients' identities still influence patient care—for better or worse, depending on the clinician and patient—as clinicians distinguished between patients of different ages, genders and socioeconomic statuses, and these distinctions were accompanied by different preferences and clinical behaviors. Furthermore, my findings suggest that not only did clinicians treat some patients differently, but, by means of preconceptions, norms and different styles of communication, patients have different effects on clinicians. This finding highlights important ways in which clinicians and patients may be reciprocally bound within clinical interactions and draws our attention to the intricate connections between social norms, institutional designs, and interpersonal behaviors.

AIMS of Research

As stated in the introduction, the aims of this study were (AIM 1) to look into how Malawian healthcare personnel conceive of the ways in which large-scale trends of national and international organizations shape and influence current healthcare activities in Malawi; (AIM 2) to explore how healthcare personnel conceive of their roles and responsibilities within Malawi's healthcare network and their respective institutions; and (AIM 3) to investigate how Malawian personnel work within those 'larger' systems to provide care to a variety of patients. Within the introduction, I explained that to answer these questions, I would break observations into scalar dimensions and then connect those arguments in a way that obviates sociohistorical and biocultural divides. I will now revisit how this project addressed my research aims, and then I will describe some of the ways that these processes are interconnected across scales.

To answer the question of how Malawian healthcare personnel conceive of the ways in which large-scale trends involving national and international organizations shape and influence current healthcare activities in Malawi, I asked interviewees about what "development" meant to them and about their thoughts on national and international development efforts. In response, interviewees generally focused on two topics: 1) providing quality care, and 2) the plans and activities of national and international organizations (including the national government). Those persons whom I spoke with described QOC as consisting of adequate resources and facilities, staff with advanced training, an ability to treat a wide range of ailments, and close correspondence between expectations and ideals of staff and patients (with both staff and patients compromising to meet the capabilities of the other party). Within these descriptions, interviewees did not firmly divide notions of quality of care from the quantity of services provided, nor did they convey anything that could be taken as a unified, “national” or “Malawian” notion of what qualifies as *the* desirable metric for quality care. Rather, idiosyncrasies of work and personal experience appear to play a central role in determining what qualifies as quality care at different institutions and for different individuals. This finding seems to suggest, then, that governors, policy makers and academics will need to explore the hopes and opinions of local staff and work closely to buttress the goals of individual institutions, rather than assume that “national” or “African” goals apply to all Malawian institutions. Within such efforts, it seems imperative to key into the rank order of goals rather than assume that all goals hold the same weight or will be equally appreciated.

Regarding how national and international organizations shape efforts on the ground, personnel expressed a sense of being unimpressed by the Sustainable Development Goals (SDGs), as they suggested that the SDGs are “quite generic” and lack country-specificity. More generally, interviewees described international organizations as important for local success but often disjointed from local activities, as they were described as both unreliable and unaccountable. Opinions regarding the national government were no better, as the central government was portrayed as corrupt, inept and oblivious to the realities of daily practices in rural facilities. For these reasons, among many personal reasons, those personnel with whom I spoke held high hopes for the decentralization of healthcare and governance structures across Malawi. Idealizations and potential downfalls of decentralization raise questions about democracy, equality, distribution of personnel and the expansion of neoliberal priorities.

However, I suggest that it may be inaccurate to portray the proposals of these Malawian personnel as “neoliberal” or in some way “unMalawian,” as their support was based upon deeply personal struggles, rather than ideological extrapolations. Similarly, I suggest that it would be inaccurate to suggest that those persons whom I interviewed were calloused capitalists yearning to limit care and reap profits on the backs of poor villagers. Rather, my findings show that these are the people who live and work with their patients, and whose friends and families *are their patients.* Instead of relying on national or international funding and governance, those Malawian personnel with whom I spoke would prefer to take matters into their own hands. This finding suggests that we may need to develop a more robust understanding of the limitations of and divisions between ideologies and pragmatics, as conflating the two may contribute to inaccurate and counterproductive finger-pointing and fruitless policy recommendations in a setting that can scarcely afford to divert resources into marginal or counterproductive endeavors.

The second aim of this study was to explore how healthcare personnel conceive of their roles and responsibilities within their respective institutions and how this conception is influenced by their daily work. To explore this topic, I asked personnel about their personal goals, perspectives on the successes and failures of the institutions in which they work and about their conceptions of how their institutions fit into Malawi’s national agendas for development. Interviewees’ responses were highly contingent upon their senses of accomplishment and fairness within their respective facilities, and they expressed complementary notions of responsibility, which included seizing greater control of local healthcare efforts (as a result of feeling neglected and betrayed by the national government) and exploiting whatever opportunities were available for further education or augmenting their incomes. These findings show that interviewees’ perspectives on their roles and responsibilities within Malawi’s healthcare network cannot be cleanly separated from their personal and social roles and responsibilities; therefore, it may be the case that in order for national or institutional goals to be fully achieved, social and personal goals and responsibilities will need to be more fully explored and addressed by administrators and policy makers. As an example, when clinicians complained that the government did not fulfill its contract to provide them with housing, the problem was not perceived as a purely personal issue. Rather, the problem was interpreted as being intimately connected to national priorities and an ability to fulfill social roles as a physician.

The final aim of this study was to investigate how Malawian personnel work within the constraints imposed by on them by international, national, and facility-specific processes to provide care to individual patients. In line with Wendland (2010) who looked into ideals of medical students, my findings suggest that Malawian clinicians and administrators hold rich ideals that deviate from what have been described as biomedical ideals, which champion reductionistic rationality, authority over nature and the body, technological orientation and individualism. In contrast, those personnel whom I interviewed described wanting to deliver compassionate, biopsychosocial care to their patients, and ideal interactions were described as dialogical, with reliance upon patients to form relationships and a desire from clinicians to meet (what they understood to be) patients' expectations for attire, communication, clinical insights and treatment options. By my observations, clinicians deployed vast amounts of 'situated knowledge' to better understand, communicate with and treat patients. Additionally, my findings suggest that clinicians held different ideals for different patients—with ideals varying according to patient age, socioeconomic status and gender—and that such ideals contributed to differences in the ways in which clinicians experienced patients. This is to say, clinicians' previous thoughts and experiences seemed to prime them to interpret patient behaviors in different ways, and such experiences have impacts on clinicians' as well as patients' wellbeing.

Unfortunately, the conditions in which clinicians practiced were far from their ideals (e.g. short of staff, few resources, high patient numbers, poor outcomes), which led clinicians to make a host of adaptations that allowed them to see each patient while providing a level of care that would be at least temporarily tolerable. Clinicians' adaptations included: reduced time spent with each patient, reduced nonverbal communication, increased anonymity of care, altered prescribing behaviors, and leveraging heuristics that served to facilitate and/or undermine care. Split-second decisions were often carried out in accord with clinicians' "gut reactions" toward patients, which were based upon how they saw patients behaving in and around the clinic—thus, a main criterion for clinical decisions was often *not* a test result or a specific sign or symptom, but rather the clinician comparing a patient's behavior to what she expects within the cultural setting. This observation is not new, as numerous scholars have commented on the normative nature of medicine; however, this detailed attention to the ways in which normativity is leveraged to manage challenging clinical situations provides us with insight into why clinical interactions take certain forms in these Malawian facilities. Importantly, clinicians' adaptations were not applied uniformly across all patients. Rather, adaptations were influenced by what clinicians perceived to be patients' identities, which entailed more energy put into children than elders, and more patience with poor than affluent patients.

How Everything Fits

Throughout this dissertation, I have sought to add to work of other medical anthropologists in contributing to our understanding of connections between global and local processes. In the words of Steve Feierman and colleagues, I have attempted to "make local knowledge viable and salient in settings of policy and programme development, practice and evaluation" (Feierman, et al. 2010). Additionally, throughout the dissertation—but especially in Chapters 2, 4, 5 and 7—I attempted to show how the specific histories of biomedicine, economics, geopolitics and kinship systems in Malawi have given rise to current conditions, including the opportunities and restrictions facing Malawian healthcare personnel.

Links between international donors, Malawi's national government and workers 'on the ground' have been apparent throughout my fieldwork in Malawi—as when in my first trip to Malawi, in 2011, donors withdrew funding following President P Mutharika's expulsion of British officials, and the subsequent acute shortage of funds exacerbated anemic healthcare budgets. During my time in Malawi in 2013, donors returned to support President J Banda, but many left, once again, following Cashgate revelations, which undermined public trust through my 2015 trip. During my 2017 fieldwork, with public trust still low, the IMF-imposed a freeze on Malawi's national salary budget, which effectively cemented vacancy rates. The effects of these processes were felt by personnel at each facility where I spent time, as they contributed to staffing issues discussed in Chapter 5, as well as specific practices of hurrying through huge numbers of patients, as discussed in Chapters 6. While I did not track outcome measures in this study, interviewees suggested that their abilities to care for patients were compromised under these conditions, and they elaborated upon how the heuristics that they employ undermine patient care, as in missed diagnoses of cervical cancer or heart congenital heart defects, which smolder for years and are often only discovered once cure is no longer an option. In this way, as I explain in Chapter 6, "common conditions" *become* common because they are commonly diagnosed, *not* because they are necessarily what predominates in the population. This process contributes to the formation of facility-specific data, but it also feeds back to national and international plans, which may be sculpted to conform with misleadingly notions of what is needed “on the ground.” Similarly, while rapid deployment of heuristics may help in the management of time and stress, heuristics may also contribute to the dismissal of patients who are seen as annoying, and emotionally exhausted clinicians may be more likely to lash out at undesired patients.

While I have sought to highlight interconnections between local and international, personal and institutionalized aspects of care, I suggest that the abundance of inter-relations should not be taken as support for a “common-sense” conclusion that “everything is connected,” nor should it be taken as support for such statements as “what effects part, effects the whole.” As evidence against such sweeping generalizations, I observed numerous filtration and threshold effects that contributed to interpersonal, inter-department and interfacility-level variations—thus, gatekeeper effects seem to contribute to significant heterogeneity. For instance, clinicians at different facilities differed in their abilities to provide specific services to specific patients (e.g. patients who needed treatment for hypertension or diabetes could be treated at each of the public hospitals, whereas their care was extremely limited at the Mobile Clinics), and shortcomings of care at the Mobile Clinics did not necessarily effect the services at the District or Central Hospital (i.e. a patient who was insufficiently treated at one site might now necessarily go to another site for care). Threshold effects like these may play important roles in atomizing institutions, as failures at one facility were not necessarily perceived by employees at other facilities. It is also important to note that the “levels” of analysis that I chose for this study are not immutable. For instance, as Malawi pushes further in the direction of decentralization, it may be the case that issues that had previously been organized at the national level (e.g. staffing) will be organized within the District or Central Hospitals. Furthermore, as healthcare continues to change (e.g. with increased recognition of noncommunicable diseases), the relations between “scales” will necessarily change, as different “levels” will inevitably shoulder different aspects of care and those adaptations are (or are not) coordinated accordingly.

Individualizing with Anonymity

This dissertation contributes to anthropological works that highlight diversities of healing practices and it follows in the path of Wendland (2010), who argues that Malawian biomedical personnel challenge reductionistic notions of culture-free, universalized bodies, as despite tight time constraints, personnel still aim to provide individualized care, and their practices show nuanced differences, which seem to vary according to the individuals with whom they are dealing. In this vein, this dissertation extends the work of Vaughan (1992) by highlighting how kinship status and networks continue to have impacts on Malawian patients and providers, and this dissertation speaks to the work of Margaret Lock and Vinh-Kim Nguyen, who argue that:

> “findings derived from an anthropology of biomedicine… make clear that the assumption of a universal body (which every biomedical practitioner well knows is a very crude gloss of reality) should be revised, and the normalized, routinized practice of biomedicine as it is currently implemented modified appropriately” (Lock and Nguyen 2018).

Those Malawian personnel with whom I spent time showed that notions of a “universal body” have strict limitations *even within routinized practices of biomedicine*—that is, even is patients are thought of or described as a homogeneous unit, the actual care of patients differs markedly, depending on who is the patient and who is the clinician. Additionally, my findings suggest that appearances of “universalized” practice may be a function of the scale at which clinical behaviors are studied, rather than a trait of biomedicine *per se*. Those clinicians whom I spent time with did not metonymically conceive of their patients as mere sets of lab values. Rather, clinicians were intimately aware of the hardships that many of their patients faced outside of the clinic, and they often relied upon such knowledge to interpret nuanced behavioral cues and alter their practices accordingly. Such attention to the biopsychosocial wellbeing of patients is consistent with Lock and Nguyen's descriptions of embodiment, which they state "involves the internalization of social exchanges, lived experiences and events as emotional responses" (ibid); and consistent with Csordas (1990), who suggests that embodiment can be understood by studying perceptions and practices. This dissertation furthers these discussions by showing how embodiment is not a one-way street in which clinicians passively perceive and internalize experiences—even if that is how some clinicians think of their practices. Rather, it seems to be the case that clinicians contribute to the production of embodied experiences by drawing from preconceived notions and adhering to situational demands of clinical practice—trends which may prevent them from experiencing differential care as a projection of their own thoughts and preferences, even if that is an operative factor. This finding adds to the work of Good (1993b), who suggests that biomedical education contributes to medical students perceiving the world differently, and to ascribing different meanings to their percepts. Like Good (1993b), I suggest that these experiences and meanings span multiple sensory modalities and contribute to the construction of different meanings. Furthermore, such differences in care may not be visible in health service statistics, outcome measures or be conveyed through interviews. Instead, capturing these nascent patterns may require triangulated data collection that includes direct observation.

Development Policies

This dissertation informs discussions of specific development goals and policies—namely, progress and challenges regarding efforts at coordination and coherence of policies and plans, hopes and potential pitfalls of decentralization efforts within Malawi, SDG #3 (increasing the number of skilled healthcare providers) and SDG #17 (improving coordination of policies). Additionally, this dissertation provides an answer to a question posed by Keshavjee (2014) regarding how policies that appear to conform to neoliberal structures continue to be supported, despite what Keshavjee sees as clear evidence of their negative consequences. Rather than consider this an issue of choosing between "neoliberal" or "moral" interventions, as outlined by Keshavjee (2014) or Messac (2014), I suggest that those persons with whom I spoke consider additional dimensions of the situation and additional potential conclusions/political stances, and that accounting for their preferences (and, correspondingly, crafting better policies) requires a more robust model for evaluating development plans. Additionally, I suggest that we think of the divergence between "neoliberal and "moral" suggestions versus what I found on the ground as analogous to evolutionary spandrels—as results of our own incomplete and problematic theories, rather than as moral deficits of these providers. The implications of this suggestion are that we, as historically-concerned anthropologists, cannot assume that history grows in straight lines between policies (e.g. from Bretton Woods to Bamako to Malawi); rather, history is grown within the specific experiences and environments of those persons involved—with the operative word being persons. In other words, intentions of actors cannot simply be extrapolated from policies or historical records.

These findings call into question arguments based upon the premise that shortages of Malawian physicians—and brain drain, in particular—are a direct consequence of physicians' identification with a European culture and standard of living (e.g. Lwanda 2002), or a relative indifference to poor, rural Malawians. Rather, my findings align with Wendland (2010) and show that clinicians often prioritize the treatment of rural, poor persons—even if the physicians do not work in a rural setting, they still often express favoritism toward those patients—and these findings seem to suggest that clinicians' opinions and decisions related to employment and job satisfaction are heavily dependent upon their assessments of successes and hardships in their daily practices and personal lives, with frustrations in one domain seeping into the next. Therefore, potential avenues for improvements in job satisfaction and employee retention may be found in improving the working conditions of healthcare personnel as well as improving communication between government officials/planners and those persons "on the ground." This reorientation places lived experiences front and center rather than resorting to explanations that accuse healthcare personnel of harboring colonial ideologies.

Biocultural Understandings

Finally, this dissertation contributes to medical anthropology's goal of advancing biocultural understandings, as expressed by Lock and Nguyen (2018), Kleinman (2013), and Singer and Clair (2003). Biological implications of this (predominantly sociocultural) study may be most obvious for patients, as their care may be compromised by a variety of factors, which can contribute to greater suffering and disease. In Chapters 5 and 7, however, I highlighted how sociocultural processes implicate clinicians' biology in ways consistent the findings of DeChant and Shannon (2016), who show how burnout can have serious implications for the health and wellbeing of healthcare personnel. Furthermore, by considering healthcare personnel within their broader sociohistorical contexts, this study provides a more general theoretical framework for understanding the causes and effects of burnout, including how burnout contributes to brain drain and clinician shortages.

More subtly, I suggest that my findings concerning clinicians' employment of heuristics and placebo-nocebo responses to patients inform anthropological discussions of habitus and hexis—concepts that straddle divides between biology and sociality, as Bourdieu and Thompson (1991) nebulously describe these concepts as acquired and stylized ways of being and moving in the world. My findings suggest that clinicians' perceptions of and behaviors toward patients depend upon the context and patient(s) involved but do not necessarily rise to the level of conscious bias or favoritism. This mode of practice seems to subtly shape behaviors in specific ways that are consistent with wider cultural norms, although not rigidly prescribed in the sense of protocolization or declared rules. Furthermore, these behaviors are not simply the product of preferences, for it appears that they subsequently shape individual preferences and affective responses toward patients, thereby creating a feedback loop whereby clinicians engage in more enjoyable activities with patients whom they may already more greatly enjoy, and they may skip those same activities with patients who are thought of and experienced as less enjoyable. This process is a bit tautological, such that "enjoyable" patients are enjoyed because they are thought of as enjoyable (e.g. "cute" kids may pose insurmountable communication barriers, but they may be preferred over patients who are fully communicative and compliant with orders). The apparent bidirectionality of this process strengthens our understanding of inextricable connections between "nature" and "nurture," as both providers and patients may benefit or suffer from practices and norms. More general implications of these findings may be appreciated if we consider Ingold (1998), who comments on the profundity of Marcel Mauss's observations that people in different cultures carry themselves in different ways—such that differences can even be found in the ways that they walk—to suggest that such nuanced differences in styles of behavior are inevitable in human life, as persons are not simply (or primarily) biological creatures that subsequently have societies and environments thrusted upon them; rather, Ingold argues, persons necessarily grow within environments and societies, thereby *obviating* a divide between biological and social processes. However, my findings suggest an important divergence from Ingold's findings. Ingold argues that differences in perceptions across cultures occur:

> "not because they are processing the same sensory data in terms of alternative representational schemata, but because they have been trained, through previous experience

> of carrying out various kinds of practical tasks, involving particular bodily movements and sensibilities, to orient themselves to the environment and to attend to its features in different ways. Modes of perception, in short, are a function of specific ways of moving around - of walking, of sitting or squatting, of tilting the head, of using implements, and so on" (Ingold 1998).

My findings suggest that any distinction between the outputs of representational schemata and ways of moving around the world may be possible only in theory, as these processes and their effects seem to be two sides to the same coin. Conceiving of clinicians' behaviors in this way builds on the work of Good (1993b), who showed that medical education (i.e. "book learning" and sensory training) leads students into a new way of perceiving and constructing meaning. In this way, I suggest that different patients provide clinicians with genuinely different experiences of providing care, and that clinicians' development within specific contexts influences the ways in which they experience patients. That is, the way that clinicians experience patients is less as a projection of their own preferences and more as dyadic interactions leading to different perceptions for clinicians. As Ingold (1998) argues, this is not an issue of clinicians simply being enculturated into biomedicine—something along the lines of social forces inscribing their rules onto clinicians' biological senses—but rather that clinicians grow and perceive the world differently. As Ingold argues, "real humans… grow in an environment furnished by the presence and activities of others… Thus walking, for example, is embodied in the sense of being developmentally incorporated through practice and training in an environment. The same, indeed, goes for any practical skill" (Ingold 1998).

Appreciation of these biocultural interconnections is, in many ways, the underlying thread throughout this dissertation, as individual practices and large-scale development efforts are inextricably dependent upon one another—thus, dependent upon the persons involved. Technologies do not deliver themselves, and there is no singular, "natural" order by which institutions change. In each process described in this dissertation, whether it be checking a patient’s temperature or coordinating national efforts to reduce maternal mortality, the thoughts and experiences of those persons involved must be taken into account. My findings suggest that humans, not reductionistic accounts of diseases or technologies, nor abstracted notions of societies or histories, must remain at the center of global health and development, if efforts are to move closer to ideals. Thankfully, attention to the thoughts and behaviors of Malawian medical personnel provide ample opportunities for future study and attempts to further “development” and “quality care.”

REFERENCES

REFERENCES

Aantjes, C. J., L. Ramerman, and J. F. G. Bunders
2014 A systematic review of the literature on self-management interventions and discussion of their potential relevance for people living with HIV in sub-Saharan Africa. Patient Educ Couns 95.

Antón, Susan C., Richard Potts, and Leslie C. Aiello
2014 Evolution of early Homo: An integrated biological perspective. Science 345(6192).

Baer, Hans A., Merrill Singer, and John H. Johnsen
1986 Toward a critical medical anthropology. Social Science & Medicine 23(2):95-98.

Banda, Mabvuto
2015 Global Fund cancels $574 mln for fighting AIDS in Malawi. *In* Reuters. Reuters.com.

Bank, World
2012 Malawi - Second growth and development strategy for 2011-2016 : joint staff advisory note. Washington, DC.
2016 Malawi Country Report.
2018 The Changing Wealth of Nations 2018: Building a sustainable future. Washington, DC: International Bank for Reconstruction and Development/The World Bank.

Bell, Kirsten, and Judith Green
2016 On the perils of invoking neoliberalism in public health critique. Critical Public Health 26(3):239-243.

Belrhiti, Zakaria, et al.
2016 To what extent do site-based training, mentoring, and operational research improve district health system management and leadership in low- and middle-income countries: a systematic review protocol. Systematic Reviews 5(1):70.

Bernard, H. Russell
2011 Research methods in anthropology : qualitative and quantitative approaches. Lanham, Md.: AltaMira Press.

Berwick, Donald M., Thomas W. Nolan, and John Whittington
2008 The Triple Aim: Care, Health, And Cost. Health Affairs 27(3):759-769.

Berwick, Robert C., and Noam Chomsky
2016 Why only us : language and evolution. Cambridge, Massachusetts: The MIT Press.

Bianchi, Renzo, Irvin S. Schonfeld, and Eric Laurent
2017 Physician burnout is better conceptualised as depression. The Lancet 389(10077):1397-1398.

Blacklock, C., et al.
2014 Exploring the migration decisions of health workers and trainees from Africa: A meta-ethnographic synthesis. Social Science & Medicine 100:99-106.

Blau, Peter Michael
1963 The dynamics of bureaucracy; a study of interpersonal relations in two Government agencies. Chicago: University of Chicago Press.

Bodenheimer, Thomas, and Christine Sinsky
2014 From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. The Annals of Family Medicine 12(6):573-576.

Boffi, Emilia
2015 How Social Forces Don a White coat: The Social Context of Childbirth Management in Metro Detroit. *In* Dissertation. M.S. University, ed.

Bosk, Charles L., et al.
2009 Reality check for checklists. The Lancet 374(9688):444-445.

Boucher, Claude, et al.
2012 When animals sing and spirits dance : gule wamkulu, the great dance of the Chewa people of Malawi. Mtakataka, Malawi: Kungoni Centre of Culture and Art, Mua Parish.

Bourdieu, Pierre, and John B. Thompson
1991 Language and symbolic power. Cambridge, Mass.: Harvard University Press.

Bradley, Susan, et al.
2015 Too few staff, too many patients: a qualitative study of the impact on obstetric care providers and on quality of care in Malawi. BMC Pregnancy and Childbirth 15(1):65.

Broadhead, R. L., and A. S. Muula
2002 Creating a medical school for Malawi: problems and achievements. BMJ 325.

Brooks, Megan
2017 Leaders Move to Tackle Burnout in Neurology, Psychiatry. *In* Medscape. Medscape.com: Medscape.

Buse, Kent, and Sarah Hawkes
2015 Health in the sustainable development goals: ready for a paradigm shift? Globalization and Health 11(1):13.

Campbell, Benjamin C., Michael H. Crawford, and Dennis H. O'Rourke
2012 Perspectives on human migration: Introduction and Why do we migrate? A Retrospective. *In* Causes and consequences of human migration : an evolutionary perspective. M.H. Crawford and B.C. Campbell, eds. Pp. 1-8; 527-536. Cambridge: Cambridge University Press.

Cassell, Eric J.
2004 The nature of suffering and the goals of medicine. New York: Oxford University Press.

Cassirer, Ernst
1961 The logic of the humanities. New Haven: Yale University Press.

Cheney, Kristen
2010 Expanding Vulnerability, Dwindling Resources: Implications for Orphaned Futures in Uganda. Childhood in Africa 2(1):8-15.

Chirwa, Wiseman C.
1998 Democracy, Ethnicity and Regionalism: The Malawian Experience, 1992-1996. *In* Democratization in Malawi : a stocktaking. K.M. Phiri and K.R. Ross, eds. Pp. 52-69. Kachere book. Blantyre: Christian Literature Association in Malawi.

Coburn, David
2006 Medical dominance then and now: critical reflections. Health Sociology Review 15(5):432-443.

Cohen, David William
1988 The Cultural Topography of a 'Bantu Borderland': Busoga, 1500-1850. The Journal of African History 29(1):57-79.

Colas, Kelly
2017 Reproducing Inequality: An Examination of Physician Decision-Making during Childbirth in Merida, Mexico. M.S. University, ed.

Collins, Robert O., and James McDonald Burns
2014 A history of Sub-Saharan Africa. New York: Cambridge University Press.

Cometto, G., et al.
2013 Health workforce brain drain: from denouncing the challenge to solving the problem. PLoS Med 10.

Cook, Chad
2010 Mode of administration bias. The Journal of manual & manipulative therapy 18(2):61-63.

Csordas, Thomas J.
1990 Embodiment as a Paradigm for Anthropology. Ethos 18(1):5-47.

Csordas, Thomas J., and Elizabeth Lewton
1998 Practice, Performance, and Experience in Ritual Healing. Transcultural Psychiatry 35(4):435-512.

Cumes, David
2013 South African Indigenous Healing: How It Works. EXPLORE: The Journal of Science and Healing 9(1):58-65.

D’Alessandro, C., and L. C. Zulu
2017 From the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs): Africa in the post-2015 development Agenda. A geographical perspective. African Geographical Review 36(1):1-18.

Damasio, Antonio R.
2018 The strange order of things : life, feeling, and the making of the cultures. New York: Pantheon Books.

Dao, Amy, and Jessica Mulligan
2016 Toward an Anthropology of Insurance and Health Reform: An Introduction to the Special Issue. Medical Anthropology Quarterly 30(1):5-17.

Darwin, Charles, and Paul Ekman
2009 The expression of the emotions in man and animals. Oxford ; New York: Oxford University Press.

Davis, Kathy
2008 Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. Feminist Theory 9(1):67-85.

Deaton, Angus
2013 The great escape : health, wealth, and the origins of inequality.

DeChant, Paul, and Diane W. Shannon
2016 Preventing physician burnout : curing the chaos and returning joy to the practice of medicine. North Charleston, South Carolina: CreateSpace Indepedent Publishing Platform.

Dewa, C. S., et al.
2014 How does burnout affect physician productivity? A systematic literature review. BMC Health Serv Res 14:325.

Dionne, Kim Yi
2014 Donor dependence, donor withdrawal: Implications of Malawi’s Cashgate scandal. *In* AID DATA: A research lab at William & Mary. aiddata.org.

Dohlman, E.
2016 The importance of a policy coherence lens for implementing the Sustainable Development Goals. *In* Debate the Issues: New Approaches to Economic Challenges. Pp. 37-40. OECD Insights. Paris: OECD Publishing.

Donald, Kate, and Sally-Anne Way
2016 Accountability for the Sustainable Development Goals: A Lost Opportunity? Ethics & International Affairs 30(2):201-213.

Durand, M., and S. Scott

2016 Measuring multidimensional well-being and sustainable development. *In* Debate the Issues: New Approaches to Economic Challenges. P. Love, ed. Pp. 33-36. Paris: OECD Publishing.

Durkheim, Emile, and George Simpson

1997 Suicide : a study in sociology. New York: Free Press.

Easterly, William

2015 The SDGs should stand for senseless, dreamy, garbled. Foreign Policy 28.

Economist, The

2015 The 169 commandments: The proposed sustainable development goals would be worse than useless. *In* The Economist.

Eidhammer, Asbjorn

2017 Malawi: A place apart. Lilongwe, Malawi: Logos.

Eknoyan, Donald, Robin A. Hurley, and Katherine H. Taber

2013 The Neurobiology of Placebo and Nocebo: How Expectations Influence Treatment Outcomes. The Journal of Neuropsychiatry and Clinical Neurosciences 25(4):vi-254.

Ellis, Frank

2006 Agrarian change and rising vulnerability in rural sub-Saharan Africa. New Political Economy 11(3):387-397.

Englund, Harri

2006 Prisoners of freedom : human rights and the African poor. Berkeley: University of California Press.

Esser, Daniel E.

2014 Elusive accountabilities in the HIV scale-up: ‘Ownership’ as a functional tautology. Global Public Health 9(1-2):43-56.

Farley, John

1991 Bilharzia : a history of imperial tropical medicine. Cambridge ; New York: Cambridge University Press.

Fassin, Didier

2012 The Obscure Object of Global Health. *In* Medical anthropology at the intersections: Histories, activisms, and futures. M.C. Inhorn and E.A. Wentzell, eds. Pp. 95-115: Duke University Press.

2013 Children as Victims: Them moral economy of childhood in the times of AIDS. *In* When People Come First: Critical Studies in Global Health. J.P. Biehl, Adriana, ed. Pp. 109-129. Princeton, NJ: Princeton University Press.

Fazal, Mohammad Ihsan, et al.
2018 The past, present and future role of artificial intelligence in imaging. European Journal of Radiology 105:246-250.

Feierman, S., et al.
2010 Anthropology, knowledge-flows and global health. Glob Public Health 5(2):122-8.

Feierman, Steven
1985 Struggles for Control: The Social Roots of Health and Healing in Modern Africa. African Studies Review 28(2/3):73-147.

Ferguson, James
2013a Declarations of dependence: labour, personhood, and welfare in southern Africa. Journal of the Royal Anthropological Institute 19(2):223-242.
2013b How to Do Things with Land: A Distributive Perspective on Rural Livelihoods in Southern Africa. Journal of Agrarian Change 13(1):166-174.

Field, Tiffany
2014 Touch. Cambridge, Massachusetts: The MIT Press.

Findlay, Deborah
1992 The Medical Gaze: Medical Models, Power, and Women's Health. Atlantis: Critical Studies in Gender, Culture & Social Justice; Volume 18, Numbers 1 and 2 (1992-1993) 18(1&2):104-124.

Foucault, Michel
1977 Discipline and punish : the birth of the prison. New York: Pantheon Books.

Foucault, Michel, and James D. Faubion
2000 Power. New York: New Press.

Freidson, Eliot
1970 Profession of medicine; a study of the sociology of applied knowledge. New York,: Dodd, Mead.

Freidus, Andrea
2010 “SAVING” MALAWI: FAITHFUL RESPONSES TO ORPHANS AND VULNERABLE CHILDREN. NAPA Bulletin 33(1):50-67.
2011 Raising Malawi's children: AIDS orphans and a politics of compassion. M.S. University, ed.

Fuglestad, Finn
1992 The Trevor-Roper Trap or the Imperialism of History. An Essay. History in Africa 19:309-326.

Gandhi, Sumeet, et al.
2018 Automation, machine learning, and artificial intelligence in echocardiography: A brave new world. Echocardiography 35(9):1402-1418.

Ganti, Tejaswini
2014 Neoliberalism. Annual Review of Anthropology 43(1):89-104.

Gawande, Atul
2010 Checklist Manifesto: Penguin Books.
2017 Being Mortal. New York, NY: Picador.

Geertz, Clifford
1973 Thick Description: Toward an Interpretive Theory of Culture. *In* The interpretation of cultures ; selected essays. Pp. 3-30. New York: Basic Books.

Gelso, Charles J., et al.
2002 Countertransference management and therapy outcome: An initial evaluation. Journal of Clinical Psychology 58(7):861-867.

Good, Byron
1994 Medicine, rationality, and experience : an anthropological perspective. Cambridge ; New York: Cambridge University Press.

Good, Byron J.
1993a How medicine constructs its objects. *In* Medicine, Rationality and Experience: An Anthropological Perspective. Pp. 65-87. Cambridge: Cambridge University Press.

Good, Byron; DelVecchio Good, Mary-Jo
1993b "Learning Medicine": The constructing of medical knowledge at Harvard Medical School. *In* Knowledge, Power and Practice: the anthropology of medicine and everyday experience. S.L. Lindenbaum, Margaret, ed. Pp. 81-107.

Graber, M. L., N. Franklin, and R. Gordon
2005 Diagnostic error in internal medicine. Archives of Internal Medicine 165(13):1493-1499.

Grollemund, Rebecca, et al.
2015 Bantu expansion shows that habitat alters the route and pace of human dispersals. Proceedings of the National Academy of Sciences of the United States of America 112(43):13296-13301.

Hall, Edward T.
1959 The silent language. Garden City, N.Y.: Doubleday.

Heidegger, Martin
1977 Modern Science, Metaphysics, and Mathematics; and The Question Concerning Technology. *In* Basic writings from Being and time (1927) to The task of thinking (1964). Pp. 247-317. New York: Harper & Row.

Høg, Erling
2014 HIV scale-up in Mozambique: Exceptionalism, normalisation and global health. Global Public Health 9(1-2):210-223.

Hogarth, Robin M., Tomás Lejarraga, and Emre Soyer
2015 The Two Settings of Kind and Wicked Learning Environments. Current Directions in Psychological Science 24(5):379-385.

Hokkanen, Markku
2007 Medicine and Scottish missionaries in the Northern Malawi Region 1875-1930 : quests for health in a colonial society. Lewiston: Edwin Mellen Press.
2017 Medicine, mobility and the empire: Nyasaland networks, 1859-1960: Manchester University Press.

Hunt, Linda M., et al.
2017 Electronic Health Records and the Disappearing Patient. Medical Anthropology Quarterly 31(3):403-421.

Hunt, Linda M., Nicole D. Truesdell, and Meta J. Kreiner
2013 Genes, Race, and Culture in Clinical Care. Medical Anthropology Quarterly 27(2):253-271.

ICF, National Statistics Office (NSO) [Malawi] and
2017 Malawi Demographic and Health Survey 2015-16. Zomba, Malawi and Rockville, Maryland, USA. : NSO and ICF.

Iliffe, John
2002 East African doctors : a history of the modern profession. Cambridge, United Kingdom: Cambridge University Press

Ingold, Tim
1998 From complementarity to obviation: on dissolving the boundaries between social and biological anthropology, archaeology and psychology. Zeitschrift fur Ethnologie 123(1):21-52.

Inhorn, Marcia C, and Emily A Wentzell
2012 Medical anthropology at the intersections: Histories, activisms, and futures: Duke University Press.

International, Transparency
2018 Corruption Perception Index, Vol. 2018: Transparency International.

Iwelunmor, Juliet, et al.
2016 Toward the sustainability of health interventions implemented in sub-Saharan Africa: a systematic review and conceptual framework. Implementation Science 11(1):43.

Jourard, S. M.
1966 An exploratory study of body-accessibility. Br J Soc Clin Psychol 5(3):221-31.

Kahneman, Daniel
2011 Thinking, fast and slow. New York: Farrar, Straus and Giroux.

Kalipeni, E
1995 Malawi-US relations and political change in Malawi: The post-independence experience, 1964-1993. *In* The United States and Africa : from independence to the end of the Cold War. M. Munene, J.D.O. Nyunya, and K.G. Adar, eds. Pp. 139-169. Nairobi: East African Educational Publishers.

Kalofonos, Ippolytos
2014 'All they do is pray': Community labour and the narrowing of 'care' during Mozambique's HIV scale-up. Global Public Health 9(1-2):7-24.

Kannappan, S.
1968 The Brain Drain and Developing Countries: Labour Review.

Karan, Abraar, Daniel DeUgarte, and Michele Barry
2016 Medical "Brain Drain" and Health Care Worker Shortages: How Should International Training Programs Respond? AMA journal of ethics 18(7):665.

Kaspin, Deborah
1995 The Politics of Ethnicity in Malawi's Democratic Transition. The Journal of Modern African Studies 33(4):595-620.

Katz, Pearl
1981 Ritual in the Operating Room. Ethnology 20(4):335-350.

Kelly, Ann H., Hayley MacGregor, and Catherine M. Montgomery
2017 The publics of public health in Africa. Critical public health 27(1):1-5.

Kendall, Nancy
2010 Gendered Moral Dimensions of Childhood Vulnerability. Childhood in Africa 2(1):26-37.

Kenworthy, Nora J.
2014 Participation, decentralisation and déjà vu: Remaking democracy in response to AIDS? Global Public Health 9(1-2):25-42.

Kerr, Rachel Bezner, et al.
2008 "We Grandmothers Know Plenty": Breastfeeding, complementary feeding and the multifaceted role of grandmothers in Malawi. Social Science & Medicine 66(5):1095-1105.

Keshavjee, Salmaan
2014 Blind spot : how neoliberalism infiltrated global health. Oakland, California: University of California Press.

Kim, M. H., et al.
2018 Burnout and self-reported suboptimal patient care amongst health care workers providing HIV care in Malawi. PLoS One 13(2):e0192983.

King, Michael, and Elspeth King
1992 The story of medicine and disease in Malaŵi : the 130 years since Livingstone. Malawi: s.n.
2000 The great rift : Africa, surgery, AIDS, aid. Cambridge: Arco Books.

Klein, Gary
2008 Naturalistic Decision Making. Human Factors 50(3):456-460.
2015 Reflections on applications of naturalistic decision making. Journal of occupational and organizational psychology 88(2):382-386.

Kleinman, Arthur
2013 From Illness as Culture to Caregiving as Moral Experience. New England Journal of Medicine 368(15):1376-1377.

Kleinman, Arthur, and Lilias H. Sung
1979 Why do indigenous practitioners successfully heal? Social Science & Medicine. Part B: Medical Anthropology 13(1):7-26.

Kohler, Racquel E, et al.
2017 Breast Cancer Knowledge, Behaviors, and Preferences in Malawi: Implications for Early Detection Interventions From a Discrete Choice Experiment. Journal of Global Oncology:JGO. 2016.005371.

Kruk, Margaret E., Elysia Larson, and Nana A. Y. Twum-Danso
2016 Time for a quality revolution in global health. The Lancet global health 4(9):e594-e596.

Lancet, The
2017 Physician burnout: let's talk. The Lancet 389(10077):1370.

Lancy, David F.
2015 The anthropology of childhood : cherubs, chattel, changelings. Cambridge ; New York: Cambridge University Press.

Last, M.
1981 The importance of knowing about not knowing. Soc Sci Med B 15(3):387-92.

Leslie, Charles
1980 Medical pluralism in world perspective [1]. Social Science & Medicine. Part B: Medical Anthropology 14(4):191-195.

LeVine, Robert Alan, and Rebecca Staples New
2008 Anthropology and child development : a cross-cultural reader. Malden, MA: Blackwell Pub.

Livingston, Julie
2012 Improvising medicine : an African oncology ward in an emerging cancer epidemic. Durham: Duke University Press.

Livingstone, David
1857 Missionary travels and researches in South Africa. London: John Murray, Albemarle Street.

Livingstone, Frank B.
1958 Anthropological Implications of Sickle Cell Gene Distribution in West Africa. American Anthropologist 60(3):533-562.

Lock, Margaret M., and Vinh-Kim Nguyen
2018 An anthropology of biomedicine. Hoboken, New Jersey: Wiley.

Lofters, Aisha, et al.
2014 "Brain drain" and "brain waste": experiences of international medical graduates in Ontario. Risk Management and Healthcare Policy 7:81-89.

Lomazzi, Marta, Bettina Borisch, and Ulrich Laaser
2014 The Millennium Development Goals: experiences, achievements and what's next. Global Health Action 7(1):23695.

Lovejoy, Paul E.
1983 Preface and Chapters 1, 10, 11, 12. *In* Transformations in slavery : a history of slavery in Africa. Pp. xvi, 349 p. African studies series. Cambridge Cambridgeshire ; New York: Cambridge University Press.

Ludmerer, Kenneth M.
1999 Time to heal : American medical education from the turn of the century to the era of managed care. Oxford ; New York: Oxford University Press.

Lwanda, John
2002 Doctoring the Brain Drain: Medical Case of Malawi. African Issues 30(1):47-51.

MacKinnon, Catharine A.
2013 Intersectionality as Method: A Note. Signs 38(4):1019-1030.

Maes, Kenneth
2015 "Volunteers Are Not Paid Because They Are Priceless": Community Health Worker Capacities and Values in an AIDS Treatment Intervention in Urban Ethiopia. Medical Anthropology Quarterly 29(1):97-115.

Malawi, Government of
2002 Malawi Poverty Reduction Strategy Paper. Lilongwe, Malawi.
2006 Malawi Growth and Development Strategy. Lilongwe, Malawi.
2012 Malawi Growth and Development Strategy II. Lilongwe, Malawi: Government of Malawi.

Mamdani, Mahmood
1996 Citizen and subject : contemporary Africa and the legacy of late colonialism. Princeton, N.J.: Princeton University Press.

Mandeville, K. L., T. Bartley, and M. Mipando
2012 Future career plans of Malawian medical students: a cross-sectional survey. Hum Resour Health 10.

Mandeville, Kate L., et al.
2015 Early career retention of Malawian medical graduates: a retrospective cohort study. Tropical Medicine & International Health 20(1):106-114.

Mandeville, Kate L., et al.
2016 The use of specialty training to retain doctors in Malawi: A discrete choice experiment. Social Science & Medicine 169:109-118.

Mann, Catherine L.
2016 Policy coherence from new data, new research, new mindsets. *In* Debate the Issues: New Approaches to Economic Challenges. Pp. 27-31. Paris: OECD Publishing.

Marcus, George E.
1998 Ethnography through thick and thin. Princeton, N.J.: Princeton University Press.

Martin, Emily
1991 The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles. Signs 16(3):485-501.

Martinussen, John
1997 Society, state, and market : a guide to competing theories of development. London ; Atlantic Highlands, N.J., USA: Zed Books.

Mauss, Marcel
1954 The gift; forms and functions of exchange in archaic societies. Glencoe, Ill.,: Free press.

Mburu, F. M.
1989 Non-government organizations in the health field: collaboration, integration and contrasting aims in Africa. Soc Sci Med 29(5):591-7.

McCracken, John
2012 A history of Malawi, 1855-1966. Woodbridge, Suffolk England ; Rochester, N.Y.: James Currey.

Messac, Luke
2014 Moral hazards and Moral Economies: The Combustible Politics of Healthcare User Fees in Malawian History. South African Historical Journal 66(2):371-389.

Miceli, Maria, Cristiano Castelfranchi, and Andrew Ortony
2015 Expectancy and emotion. New York, NY: Oxford University Press.

Michalopoulos, Stelios, and Elias Papaioannou
2013 Pre-Colonial Ethnic Institutions and Contemporary African Development. Econometrica 81(1):113-152.

Miller, Joseph C.
1999 History and Africa/Africa and History. The American Historical Review 104(1):1-32.

Mills, Edward J., et al.
2011 The financial cost of doctors emigrating from sub-Saharan Africa: human capital analysis. BMJ 343.

Mkandawire, Paul, et al.
2015 "My House Is the Hospital": Housing and Health and Wellbeing among Persons Living with HIV/AIDS in Northern Malawi. Journal of health care for the poor and underserved 26(4):1246.

Moyer, Eileen
2015 The Anthropology of Life After AIDS: Epistemological Continuities in the Age of Antiretroviral Treatment. Annual Review of Anthropology 44(1):259-275.

Mullan, Fitzhugh, et al.
2011 Medical schools in sub-Saharan Africa. The Lancet 377(9771):1113-21.

Mulwafu, Wakisa, et al.
2014 Initiating and developing clinical services, training and research in a low resource setting: the Malawi ENT experience. Tropical Doctor 44(3):135-139.

Murray, Christopher J.L.
2015 Shifting to Sustainable Development Goals — Implications for Global Health. New England Journal of Medicine 373(15):1390-1393.

Muula, Adamson S.
2005 Five-year experience of Malawi college of medicine with "learning by living" program. Croat Med J 46(6):1010-4.
2009 Case for Clinical Officers and Medical Assistants in Malawi. Croatian Medical Journal 50(1):77-78.
2016 How IMF's loan freeze will affect health care in Malawi. Malawi Medical Journal 28(1):26-27.

National Economic Council, Malawi
1998 Vision 2020: National long-term development perspective for Malawi. Lilongwe, Malawi.

National Statistical, Office Malawi, and Icf
2017 Malawi Demographic and Health Survey 2015-16. Zomba, Malawi: National Statistical Office and ICF.

Ngalande Banda, Elias E; Simukonda, Henry P.M.
1994 Moving Towards a Mixed Health Care System in Malawi. Health policy and planning 9(1):63-71.

Ngubane, Harriet
1981 Special Issue: Causality and Classification in African Medicine and HealthAspects of clinical practice and traditional organization of indigenous healers in South Africa. Social Science & Medicine. Part B: Medical Anthropology 15(3):361-365.

Ngwira, Robert
2015 Govt Coy on 20 Malawian Doctors Employed in Lesotho. *In* Face of Malawi.

O'Donnell, Owen
2007 Access to health care in developing countries: breaking down demand side barriers. Cadernos de Saúde Pública 23:2820-2834.

O'Laughlin, Bridget
2016 Pragmatism, Structural Reform and the Politics of Inequality in Global Public Health. Development and Change 47(4):686-711.

O’Hare, Bernadette, et al.
2015 Task sharing within a managed clinical network to improve child health in Malawi. Human Resources for Health 13(1):60.

Omaswa, Francis
2014 Health Leadership in Africa. *In* African health leaders : making change and claiming the future. F. Omaswa and N. Crisp, eds. Pp. 9-33. Oxford: Oxford University Press.

Omaswa, Francis, and Jo Boufford
2010 Strong Ministries for Strong Health Systems: ACHEST, New York Academy of Medicine.

Omaswa, Francis, and Nigel Crisp
2014 Introduction to Part 2: The greatest challenges. *In* African health leaders : making change and claiming the future. F. Omaswa and N. Crisp, eds. Pp. 37-40. Oxford: Oxford University Press.

Ong, L. M. L., et al.
1995 Doctor-patient communication: A review of the literature. Social Science & Medicine 40(7):903-918.

Packard, Randall M.
2016 A history of global health : interventions into the lives of other peoples. Baltimore: Johns Hopkins University Press.

Pathera, Donasius
2014 Malawi can address brain drain. *In* The Nation.

Pentland, Alex
2008 Honest signals : how they shape our world. Cambridge, Mass.: MIT Press.

Petryna, Adriana
2013 Life exposed : biological citizens after chernobyl. Princeton, NJ: Princeton University Press.

Pfeiffer, James, and Rachel Chapman
2010 Anthropological Perspectives on Structural Adjustment and Public Health. Annual Review of Anthropology 39:149-165.

Phiri, D. D.
2004 History of Malawi. Blantyre Malawi: Christian Literature Association in Malawi.

Price, A. J., et al.
2018 Prevalence of obesity, hypertension, and diabetes, and cascade of care in sub-Saharan Africa: a cross-sectional, population-based study in rural and urban Malawi. Lancet Diabetes Endocrinol 6(3):208-222.

Prince, Ruth J.
2014 Situating health and the public in Africa: Historical and anthropological perspectives. *In* Making and unmaking public health in Africa : ethnographic and historical perspectives. R.J. Prince and R. Marsland, eds. Pp. 1-51. Cambridge Centre of African Studies series. Athens: Ohio University Press.

Provost, Lloyd; Lloyd, Robert; Murray, Sandy
2016 QI 102: How to Improve with the Model for Improvement. *In* Open School. J.F. Roessner, Laura, ed, Vol. 2016. Cambridge, MA: Institute for Health Improvement.

Rabinow, Paul, and Nikolas Rose
2006 Biopower Today. Biosocieties 1(2):195-217.

Reubi, David
2016 Of neoliberalism and global health: human capital, market failure and sin/social taxes. Critical Public Health 26(5):481-486.

Reynolds Whyte, Susan; Whyte, Michael; Meinert, Lotte; Twebaze, Jenipher
2013 Therapeutic Clientship. *In* When People Come First: Critical Studies in Global Health. J.B.a.A. Petryna, ed. Pp. 140-165. Princeton, NJ: Princeton University Press.

Rhodes, Lorna A.
1991 Emptying beds : the work of an emergency psychiatric unit. Berkeley: University of California Press.

Rolls, Edmund T.
2010 The affective and cognitive processing of touch, oral texture, and temperature in the brain. Neuroscience & Biobehavioral Reviews 34(2):237-245.

Ruckert, Arne, et al.
2017 Policy coherence, health and the sustainable development goals: a health impact assessment of the Trans-Pacific Partnership. Critical Public Health 27(1):86-96.

Sachs, Jeffrey
2008 Common wealth : economics for a crowded planet. New York: Penguin Press.

Sambo, Luis
2014 Epidemiology and health policy in Africa. *In* African health leaders : making change and claiming the future. F. Omaswa and N. Crisp, eds. Pp. 71-101. Oxford: Oxford University Press.

Sapolsky, Robert M.
2017 Behave : the biology of humans at our best and worst. New York, New York: Penguin Press.

Sen, Amartya
1999 Development as freedom. New York: Knopf.

Simmel, Geog
1971 [1908] Domination. *In* Georg Simmel on Individuality and Social Forms. D.N. Levine, ed. Pp. 69-120. Chicago, IL: University of Chicago Press.

Simmel, Georg
1896 Superiority and Subordination as Subject-Matter of Sociology. American Journal of Sociology 2(2):167-189.

Singer, Merill, and Scott Clair
2003 Syndemics and Public Health: Reconceptualizing Disease in Bio-Social Context. Medical Anthropology Quarterly 17(4):423-441.

Smith, Adam
2015 The wealth of nations. New York: Fall River Press.

Soko, Boston
2014 Vimbuza The Healing Dance of Northern Malawi. Luwinga, MW: Mzuni Press.

Spear, Thomas
2005 Bantu Migrations. *In* Problems in African History: The Precolonial Centuries. R.O. Collins, ed. Pp. 95-98. Princeton, NJ: Mark Wiener Publishers, Inc.

Stevenson, Anna Clare, et al.
2015 Fear of oxygen therapy for children in Malawi. Archives of Disease in Childhood 100(3):288.

Street, Richard L., and David B. Buller
1987 Nonverbal response patterns in physician-patient interactions: A functional analysis. Journal of Nonverbal Behavior 11(4):234-253.

Tattersall, Ian
2009 Human origins: Out of Africa. Proceedings of the National Academy of Sciences 106(38):16018-16021.

Taussig, Michael T.
1980 Reification and the consciousness of the patient. Social Science & Medicine. Part B: Medical Anthropology 14(1):3-13.

Thompson, Jack
2007 Ngoni, Xhosa and Scot : religious and cultural interaction in Malawi. Zomba, Malawi: Kachere Series.

Thorsen, Viva Combs, Andra L. Teten Tharp, and Tarek Meguid
2011 High rates of burnout among maternal health staff at a referral hospital in Malawi: A cross-sectional study. BMC Nursing 10(1):9.

Timmermans, Stefan
2005 Death brokering: constructing culturally appropriate deaths. Sociology of Health & Illness 27(7):993-1013.

UN
2016 Sustainable Development Goals Vol. 2017: United Nations.

UNDP
2016 From MDGs to Sustainable Development For All: Lessons from 15 Years of Practice. UNDP, ed. New York, NY: United Nations.

Vail, Leroy, and Landeg White
1991 Tribalism in the Political History of Malawi. *In* The Creation of tribalism in Southern Africa. L. Vail, ed. Pp. 151-184. Perspectives on Southern Africa. Berkeley: University of California Press.

Vansina, Jan
1990 Paths in the Rainforests: Toward a History of Political Tradition in Equatorial Africa: University of Wisconsin Press.

Vaughan, Megan
1991 Curing their ills: colonial power and African illness. Stanford, Calif.: Stanford University Press.
1992 Famine Analysis and Family Relations: Nyasaland in 1949. *In* The Social basis of health and healing in Africa. S. Feierman, J.M. Janzen, and Joint Committee on African Studies., eds. Pp. 90-104. Berkeley: University of California Press.
1994 Healing and Curing: Issues in the Social History and Anthropology of Medicine in Africa. Social History of Medicine 7(2):283-295.

Waite, Gloria
1992 Public Health in Precolonial East-Central Africa. *In* The Social basis of health and healing in Africa. S. Feierman, J.M. Janzen, and Joint Committee on African Studies., eds. Pp. 212-234. Berkeley: University of California Press.

Weber, Max
1958 The three types of legitimate rule. Berkeley Publications in Society and Institutions 4(1):1-11.

Wendland, Claire
2010 A heart for the work : journeys through an African medical school. Chicago ; London: The University of Chicago Press.
2012a Animating Biomedicine's Moral Order: The Crisis of Practice in Malawian Medical Training. Current Anthropology 53(6):755-788.
2012b Moral Maps and Medical Imaginaries: Clinical Tourism at Malawi's College of Medicine. American Anthropologist 114(1):108-122.
2016 Opening up the black box: looking for a more capacious version of capacity in global health partnerships. Canadian Journal of African Studies 50(3):415-435.
2018 Who Counts? What Counts? Place and the Limits of Perinatal Mortality Measures. AMA journal of ethics 20(3):276.

WHO
2008 The Kampala Declaration and Acgends for Global Action. Geneva, Switzerland: World Health Organization.
2018 Maternal, newborn, child and adolescent health: Quality of care, Vol. 2018: World Health Organization.

WHO, GHWA
2014 A Universal Truth: no health without a workforce. Geneva, Switzerland: World Health Organization.

WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division
2015 Trends in Maternal Mortality: 1990 to 2015. Geneva: WHO.

Wiley, Andrea S, and John Scott Allen
2009 Medical anthropology: A biocultural approach. New York, NY: Oxford University Press Oxford.

Wright, David, Nathan Flis, and Mona Gupta
2008 The 'Brain Drain' of physicians: historical antecedents to an ethical debate, c. 1960–79. Philosophy, Ethics, and Humanities in Medicine 3(1):24.

Wrigley, Christopher
1987 Early History, and Why It Matters. African Affairs 86(343):255-271.

Zijlstra, E. E., and R. L. Broadhead
2007 The college of medicine in the republic of Malawi: towards sustainable staff development. Hum Resour Health 5.