Title

Blinded by inequality

Author

Price, Jennifer L

Publication Date

2005

Peer reviewed|Thesis/dissertation

BLINDED BY INEQUALITY:
POVERTY AND BLINDNESS IN MALAWI

by

JENNIFER L. PRICE

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

MEDICAL ANTHROPOLOGY

in the

GRADUATE DIVISIONS

of the

UNIVERSITY OF CALIFORNIA SAN FRANCISCO

and

UNIVERSITY OF CALIFORNIA BERKELEY

[redacted]

Date **University Librarian**

Degree Conferred: ....

This work is dedicated to

Anna, for sharing the journey

Jane, for taking care of Anna as if she were her own

and Chris, Mom, and Cheryl for giving of themselves
when I needed them the most.

ACKNOWLEDGMENTS

This work could not have been completed without the assistance, encouragement, and faith of a great many people and institutions.

I thank the National Institute on Aging, Fulbright-Hayes Doctoral Dissertation Research Abroad Training Grants, the Social Science Research Council, and the University of California, San Francisco for their generous financial support of my education and dissertation research.

I thank my dissertation committee: Gay Becker, Ph.D., Yewoubdar Beyene, Ph.D., and Gunilla Haegerstrom-Portnoy, O.D., Ph.D. for their guidance and support. Dr. Becker and Dr. Beyene never lost faith in me, prodding me along with their encouraging words. I am eternally grateful for their constant support.

I thank the Malawian people who generously participated in this research. Most remain anonymous to protect their privacy, but their kindness and generosity will always remain with me. I regret that I cannot name them. Dr. Moses Chirambo served as my Malawian sponsor and provided tremendous assistance in designing the research and gaining access to numerous people. Jane Ndau provided the greatest gift of all: caring for my daughter as if she were her own.

I thank my anonymous host family and the other expatriates who welcomed me. My host family became Anna's and my family. There can be no greater kindness.

I thank Mia Mosher, Esq. and Susan Erickson, Ph.D. They helped me through a very trying time.

I thank Mandy Mercier for formatting the dissertation.

I thank my family, all of whom provided assistance and encouragement along the way: Nancy B. Price, John Price, Chris Price, Nancy N. Price, Becky Hammond, Kris Hammond, Scott Emerson-Price, Carrie Emerson-Price, Craig Humphreys, Kerry Webster, Mark Welch, and Monica Welch. Becky and Scott were particularly kind with their words of encouragement. I thank my dear friend Kristin Garrity for always knowing what to say.

I thank my daughter, Anna Price Naim, whose pride and joy at seeing me finish was reward enough.

Finally, there are three people who had such faith and confidence in me that they made sacrifices in order to help me finish. I do not think I can ever adequately express my gratitude to them. They have given me a wonderful gift. They are Chris Price, Nancy B. Price, and Cheryl Mutschler. Thank you.

BLINDED BY INEQUALITY:
POVERTY AND BLINDNESS IN MALAWI

Jennifer L. Price

Malawi is plagued by a high rate of blindness. Despite efforts by government health services and aid agencies to lower blindness rates through a preventive and curative outreach program, most people do not accept free biomedical treatments or seek treatment too late to preserve vision. This research demonstrates that the social, political, and economic conditions present in Malawi have created an environment of inequality and diminished expectations, ultimately resulting in high rates of blindness. Current conditions in Malawi, the product of colonial and neo-colonial oppression and exploitation, have led to profoundly distorted perceptions of "healthy" and "normal," severe poverty, extreme vulnerability to disease, inadequate health care resources, and inequality in access to health care. Individuals, families, and communities do not have the necessary reserves to recognize and respond effectively and timely to debilitating and deadly disease.

Research was conducted from June 1996 to June 1997 using participant observation, one-on-one interviews, surveys, a life history, diaries, and examination of the popular press.

This research identifies several barriers preventing people from seeking timely biomedical care for blinding eye conditions and, once having sought treatment, preventing successful treatment: 1) distorted perceptions of "healthy," 2) insufficient patient capital, 3) limited access to biomedical resources, 3) low expectations of treatments, and 4) lack of knowledge of biomedical conditions and treatments.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1
INTRODUCTION

Malawi, a tiny land-locked nation in south central Africa, is plagued by a high rate of blindness. Despite efforts by government health services and aid agencies to lower blindness rates through a preventive and curative outreach program, most people do not accept free biomedical treatments or seek treatment too late to preserve vision. On one Wednesday in March 1997, Mr. Gondwe[1], the Ophthalmic Medical Assistant for the district of Salima, experienced a typical day in trying to gather the fifty-four people in their villages who had initially agreed to free cataract surgery: he was able to find and bring back to the hospital only six of them. I have sought to explain what Malawians do in response to eye disease and why they appear not to seek or use sight-saving biomedical therapies.

This research demonstrates that the social, political, and economic conditions present in Malawi have created an environment of inequality and diminished expectations, ultimately resulting in high rates of blindness. Macro-level forces, such as global economic relations, do influence the perceptions and behaviors of individuals. Current conditions in Malawi, the product of colonial and neo-colonial oppression and exploitation, have led to profoundly distorted perceptions of "healthy" and "normal," severe poverty, extreme vulnerability to disease, inadequate health care resources, and inequality in access to health care. Individuals, families, and communities do not have the necessary reserves to recognize and respond effectively and timely to debilitating and deadly disease.

---

[1] The names of research participants have been changed unless otherwise noted.

Research was designed with three main objectives: 1) to document Malawian beliefs, behaviors, and experiences regarding vision, blinding eye conditions, and blindness; 2) to explain Malawians' behaviors in seeking eye treatment; and 3) to contribute to the ethnography of Malawi and to a cross-cultural understanding of disability. While I did not enter the field intending to use a political economy approach in understanding Malawian attitudes and behavior, it became clear early in the research process that such an approach was necessary for understanding otherwise incomprehensible behavior.

This research is significant for three reasons. First, it contributes to the sparse ethnographic record on Malawi. Second, it contributes cross-cultural data on the notions of disability and how the disabled are defined and integrated into a non-Western society. Third, it links macro-level processes to individual beliefs and behaviors using a political economy approach.

ANTHROPOLOGICAL RESEARCH ON MALAWI

The anthropological literature on south central African societies in general and on Malawi specifically is limited and much of it is dated. When Read (1956) conducted her ethnographic research, there were no published ethnographies on Malawi. With the rise of the Manchester School studies on British Central Africa (see Gluckman 1956), more research was conducted in Malawi including Mitchell's (1956) and Van Velsen's (1964) studies on village politics, Barnes' (1954) study on political change, and Marwick's (1965) study on sorcery among the culturally related Cewa of neighboring Zambia.

More recent research by anthropologists and other social scientists has focused on political change and religious protest (Linden 1974; Fields 1985; Schoffeleers 1992), village history (White 1987), famine (Vaughan 1987), ethnomedicine (Peltzer 1983), colonial medicine (Vaughan 1991), and the role of animals in Malawian life (Morris 2000). Two physicians have recorded a history of disease and biomedicine from the colonial period to the present (King and King 1992). Steven Friedson's (1996) ethnography examines Tumbuka music and dance in healing. Wendroff's (1985) dissertation examines the role of written communication between healers and patients in healing practices of northern Malawi. Bruce Williams has recorded a narrative of his time in Malawi first as a Peace Corps volunteer in the mid 1960s and then as an anthropologist and the director of the Centre for Social Research at the University of Malawi from 1980 to 1982.

Vaughan's (1987, 1991), Peltzer's (1983), King and King's (1992), Morris' (2000), Wendroff's (1985), and Friedson's (1996) works are all extremely helpful in piecing together an understanding of the history of biomedicine in Malawi and indigenous medical practices. However, the ethnographic record is contradictory at times, is still lacking a deep understanding of indigenous medicine, does not include an examination of the interaction between biomedicine and indigenous medicine, does not examine the health status of the people, and does not examine health-seeking behaviors. My research adds to the ethnographic record on indigenous medicine, biomedicine, the interaction of biomedicine and indigenous medicine, health status, and health-seeking behavior.

It is particularly notable that these studies, with the exception of Vaughan's (1987, 1991) historical work, do not address the obviously atrocious health status of poor Malawians and the abhorrent inequities in access to most every necessity. In fact, when reading these works, I wondered, "Where are the malnourished children and horribly sick people I spoke with everyday? Is this the same country?"

It is clear that anthropological research on Malawi suffers from the same "visual-field defect" described by Paul Farmer (1999) for research on Haiti and by Orin Starn (1992) for research on Peru. Starn, commenting on ethnographies of Peru, which failed to see the coming revolution, writes:

> Ethnographers usually did little more than mention the terrible infant mortality, minuscule incomes, low life expectancy, inadequate diets, and abysmal health care that remained so routine. To be sure, peasant life was full of joys, expertise, and pleasures. But the figures that led other observers to label Ayacucho a region of "Fourth World" poverty would come as a surprise to someone who knew the area only through the ethnography of Isbell, Skar, or Zuidema. They gave us detailed pictures of ceremonial exchanges, Saint's Day rituals, weddings, baptisms, and work parties. Another kind of scene, just as common in the Andes, almost never appeared: a girl with an abscess and no doctor, the woman bleeding to death in childbirth, a couple in their dark adobe house crying over an infant's sudden death. (Starn 1992: 168 quoted in Farmer 1999: 7)

We are trained, as anthropologists, to focus on the explicit "cultural" trappings of a people–the everyday life, the rituals–without judgment. As Farmer (1999: 7) writes:

> Common indeed are the ethnographies in which poverty and inequality, the end result of a long process of impoverishment, are reduced to a form of cultural difference. We were sent to the field to look for different cultures. We saw oppression; it looked, well, *different* from our comfortable lives in the university; and so we called it "culture." We came, we saw, we misdiagnosed.

This blindness to oppression and inequality warps our understandings of people's actions and contributes to misguided programs to improve health. A person who *chooses* not to seek health care in a timely fashion is a completely different creature from the person whose perceptions and actions are constrained by oppression and inequality.

MALAWI AND BLINDNESS

More than 1% of Malawi's population suffers from preventable or curable blindness, a prevalence rate significantly higher than WHO's criterion for a public health problem and far higher than rates in North America and Europe (Chirambo et al. 1986). The epidemiology and prevalence of blindness in Malawi reflect a devastating burden of disease and disability with untold consequences to Malawian individuals, families, and society.

In an effort to reduce blindness, the Malawi government, in conjunction with several non-profit organizations, established an innovative program to train Ophthalmic Medical Assistants (OMAs) to supplement the work of the four ophthalmologists working in Malawi. They staff rural static and mobile eye units performing, free of charge, the majority of out-patient eye care including extra-ocular surgery. Some also perform cataract surgery (Chirambo and Schwab 1989).

These services, however, are under-utilized (e.g., see Eloff and Foster 2000). Extensive public health studies have been excellent in identifying numerous barriers to accepting services such as hidden costs of surgery, distance from services, "cultural and social barriers," lack of knowledge of services, and lack of trust in the outcome of services (see Courtright et al. 1994; Courtright et al. 1995; Lewallen and Courtright 2000, 2001). My research certainly confirms the existence of many of these barriers. However, the eye care program was designed to address barriers such as distance from the hospital, a lack of knowledge of services, and a lack of trust in the outcome of services, yet the services are still under-utilized. More significantly, concepts such as "cultural and social barriers" are too vague, to an anthropologist, for meaningful analysis. Indeed, it is the factors consigned to this general category that prove most intriguing. This research suggests that there are much deeper structural and perceptual barriers, born ultimately of oppressive and exploitive relations, leading to these barriers and, thus, inhibiting Malawians from utilizing free biomedical services. What I am suggesting, thus, is that analysis needs to be taken a step further in explaining why such barriers exist.

There are no publications on Malawian beliefs regarding the cause and treatment of eye disease or vision loss. Nor do we know the personal or social impact of blindness in Malawi. Studies in other regions of Africa point to the tremendous social consequences of becoming blind including lowered life expectancy, reduced economic activity, and increased dependence upon health services (WHO 1987). The importance of understanding the context of blindness in order to understand people's motivations for seeking eye care is well recognized by health workers designing prevention programs (Lewallen and Courtright 2001; Lane et al. 1992; Marx 1988; WHO 1987).

ANTHROPOLOGICAL RESEARCH ON EYE DISEASE AND BLINDESS

There are a few significant studies of vision, eye disease, and blindness within anthropology. The late John Gwaltney's (1970) study of the onchocercous blind in Oaxaca, Mexico is the first anthropological study devoted to blindness and is of particular significance to this research. Gwaltney, himself blind, concluded that Yoleno resistance to the Mexican government's onchocerciasis control and eradication program was due to pervasive negative expectations born from a litany of everyday traumas in the context of pervasive poverty. He writes:

> The prevailing belief that filarially induced blindness is the consequence of omnipotent, arbitrary, divine intervention tends toward the emergence of an essentially accommodative cultural response. The transgenerational link between the elderly onchocercous blind and child guides, the role of mendicancy in the maintenance of a sense of participation on the part of the blind, the ascription of ritual efficacy and public merit to deferential behavior toward blind persons, the obverse ascription of strong supernatural and social opprobrium to undeferential behavior toward them, and the absence of curative traits from indigenous technology and sorcery are indicative of an essentially accommodative adjustment to blindness.
>
> Control and eradication, the response of the greater Mexican medical technology to onchocerciasis, exceeds the prevailing indigenous concept of the possible. The standard course of treatment superimposed by the dominant state currently necessitates the addition of negative elements, therapeutic shock and minor surgery, to an already extensive accretion of environmental trauma.
>
> The indigenous subculture's accommodative response emerges from the transgenerational conditioning of a formidable roster of negative expectations in a traditional context of pervasive poverty. This fundamental disparity between the respective cultural definitions of the realm of possibility and the negative aspects associated with the standard course of treatment are instrumental factors in the massive resistance encountered by the Mexican government's National Campaign against Onchocerciasis. [Gwaltney 1970:v-vi]

My findings mirror Gwaltney's, indicating that such a response is not unique to a particular culture, but rather a not unexpected result of deprivation. Gwaltney's study was not political economic; he did not extend his analysis to the larger social, political, and economic forces generating such an accommodative response, nor explain why Yolenos accommodated rather than resisted their daily traumas. My research, I believe, builds upon Gwaltney's findings to explain such responses.

There have been few anthropologists since Gwaltney to focus research on the blind. Shlomo Deshen (1987) has examined blind Israeli's within a disability framework. Also of particular interest is the work of Nayinda Sentumbwe (1995) on blind people in Uganda. In his examination of the marital opportunities of blind Ugandan women, he also explores Ugandan perceptions of blindness. Like Gwaltney, Sentumbwe is blind, being able to draw upon his own personal experience in relating the perceptions and experiences of blindness. While Sentumbwe does not place his understanding of the experiences of blindness in Uganda within the larger political economy, his data is nonetheless quite informative when trying to understand Malawian perceptions and experiences of blindness and indicates numerous similarities.

POLITICAL ECONOMY IN MEDICAL ANTHROPOLOGY

This research is grounded in a political economy perspective of health and ill health. Political economy in medical anthropology places issues of health in the context of the larger social, political, and economic forces that shape health and well-being. Its theoretical roots lie in Marxism and materialism, with concepts such as power, hegemony, exploitation, and class being critical to analyses. The capitalist world system and the social iniquities it has generated are indicted as the ultimate sources of ill health. Thus, a political economy approach seeks to illuminate the social origins of illness.

Medical anthropology was rather slow in embracing a political economy perspective. The adoption of political economy in medical anthropology owes much to the pioneering work of political economy of health researchers such as Vicente Navarro and those published in the journal he helped found, the *International Journal of Health Services* (see Navarro 2002 for a history of political economy of health research). A political economy approach to the analysis of health and ill health within anthropology was first addressed at the symposium "Topias and Utopias in Health" at the 1973 Ninth International Congress for Anthropological and Ethnological Sciences (Baer et al. 1997:26; see Ingman and Thomas 1975). Onoge (1975), for example, called for an explicit analysis of capitalism and illness in the medical anthropology of Africa. However, it was not until 1979 that the glaring neglect of political economy within medical anthropology received greater attention with Soheir Morsy's article *The Missing Link in Medical Anthropology: The Political Economy of Health* (Baer et al. 1997:26; see Morsy 1979). Morsy's seminal article prompted closer examination of the utility of political economy of health perspectives in medical anthropological studies (Baer et al. 1997:26; see Baer 1982).

The approach that developed from this examination of political economy was coined Critical Medical Anthropology (CMA). CMA has sought to distinguish itself from political economy of health studies:

> While a perspective on capitalism is an important starting point for a critical medical anthropology (CMA), it is insufficient for a fully developed

> approach. CMA attempts to address the nature of health-related issues in indigenous societies as well as in precapitalist and socialist-oriented state societies. It understands health issues within the context of encompassing political and economic forcesBincluding forces of institutional, national, and global scaleBthat pattern human relationships, shape social behaviors, condition collective experiences, reorder local ecologies, and situate cultural meanings. The emergence of CMA reflects both the turn toward political-economic approaches in anthropology in general and an effort to engage and extend the political economy of health approach (Baer, Singer, and Johnson 1986; Singer, Baer, and Lazarus 1990; Morsy 1990). [Baer 1997:27]

CMA studies, as well as political economy of health studies in general, have been criticized for being "mechanistic" and neglecting the experience of illness. Lock and Scheper-Hughes (1987), in an attempt to unite macro-level and micro-level analyses, extended CMA to include the notion of "embodiment" and labeled their approach "critical-interpretive." They see the human body as being both naturally and culturally produced and only contextually understood. They proposed that an anthropology of the body, in which a tripartite conception of "body" is formulated, would be an important heuristic device for understanding cultural sources and meanings of health and illness. These three bodies are the individual body (the self as understood apart from others), the social body (the individual body as metaphor for nature, society, and culture) and the body politic (the surveillance and control of the individual and social bodies).

Whether one calls such research political economy, critical medical anthropology, or some variant thereof, this research recognizes the social origins of disease. And study after study demonstrates that diseases afflicting the poor are the result of the conditions of poverty (see, for example, Taussig 1978; Leatherman et al. 1986; Stillwaggon 1998; Turshen 1984, 1986; Scheper-Hughes 1992; Farmer 1999). As Stillwaggon (1998: 8) writes,

> For the most part, the diseases that affect the poor are the result of the poverty of their environment. The rich generally do not contract cholera, summer diarrhea, tuberculosis, lice, worms or leprosy. They do not suffer from burns caused by inadequate home heating or cooking facilities or electrocution from do-it-yourself wiring. Poverty also determines the availability and effectiveness of the medical response, which also plays an important role in health. Poor people do not get medical care for their poverty-induced conditions either because the country is poor or they are poor in a country in which the market rations medical care only to the rich.

While Malawi is a poor nation both lacking in health care resources and rationing what is available to those with power and wealth, the fact that diseases of poverty are borne of that poverty does not explain the apparent Malawian reluctance to utilize free health care resources.

Malawi's eye care program provides free biomedical therapy, such as antibiotic ointments and cataract surgery, to patients. Yet, the majority of people either seek help too late to preserve vision or decline therapy, particularly cataract surgery. Although there are not enough resources to provide therapy for all people in need of eye treatments, medical personnel are frustrated in their attempts to get people to use the resources that are available. This research explains this conundrum within a political economy perspective.

CHAPTER 2
METHODOLOGY

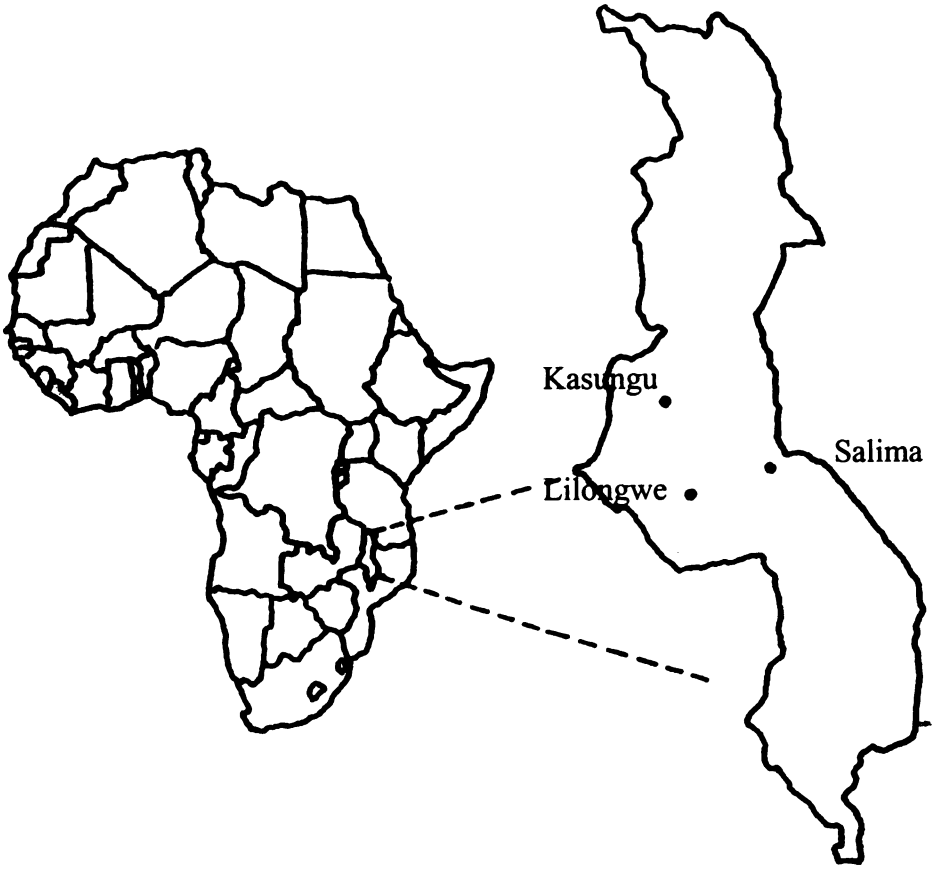
STUDY SITE AND TIME FRAME

Research for this study was conducted from June 1996 to June 1997 in three primary districts of Malawi: Lilongwe, Kasungu, and Salima. However, observations and interviews were conducted in other districts including Dowa and Dedza. These districts were chosen because of their rates of blindness, the lack of previous research in the region, and the proximity of these districts to the training program for Ophthalmic Medical Assistants in Lilongwe (see Figure 1 for a map of Africa and Malawi).

I lived in the capital, Lilongwe, and traveled by four-wheel drive truck to the other districts. The nature of the research required extensive travel to reach blind informants throughout the districts, which meant I could potentially live in any of the three districts. I chose Lilongwe because of the greater assistance I found there in caring for my infant daughter, Anna.

Funding for research was provided by the Social Science Research Council, which provided a pre-dissertation fellowship in 1994 to enable me to set up research and establish contacts in Malawi, and by a Fulbright Hayes Doctoral Dissertation Research Abroad grant for the 12 months of research. Additionally, the University of California, San Francisco provided two grants to enable me to write the dissertation, a University Grant and a President's Scholarship. The research protocol received approval from the University of California, San Francisco Committee on Human Research.

Figure 1
Africa and Malawi



RESEARCH METHODS

I conducted this research using a variety of methods: participant observation, one-on-one interviews, surveys, a life history, diaries, and examination of the popular press.

Research Staff

I hired three research assistants to help in conducting the research. The first, 35 year old Yusuf Mataka, served as the primary research assistant. He played a vital role in helping me gain entrée into the rural communities with his unabashed charm and confidence. Had I attempted visits to villages alone, I would have had tremendous difficulty gaining trust among people. The other two research assistants were 18 year old women awaiting their entrance into the University of Malawi. The University was on strike and these two women found themselves waiting for a year before they could begin their studies. They were employed to transcribe and translate interviews from Chichewa to English. One, Rose, had a particular interest in rural communities and also participated in traveling to the villages and helping interview informants. However, Mr. Mataka's presence was necessary still because Rose was too young to command respect among the villagers. Anita, the third assistant, had no interest in going to the rural areas and so exclusively transcribed interviews.

In addition to my three research assistants, I hired a nanny, Jane Ndau[1], to help care for my six month old daughter, Anna. For half the time, we lived with a white, Zimbabwean family who employed a maid, Isabel; a gardener, Richard; and a guard, Samson. For the other half of the year, we sublet a young tobacco buyer's bachelor pad, which included the services of an elderly cook, James. All of these individuals became vital key informants in

---

[1] I have retained Ms. Ndau's real name.

helping me to understand Malawian life, ethnic and class relations, socio-economic stratification, and health-seeking behavior. I consistently asked them to help me understand what I was observing or being told.

Participant Observation

Observations were made, of course, throughout the research by living and Ahanging out@ in the various communities in which research was conducted. In addition to living and performing everyday activities within the communities, observations were made in hospitals, clinics, schools, homes of the blind, on the streets where the blind and other disabled beg, and at the Malawi Council for the Handicapped's (MACOHA) weaving factory.

I observed Ophthalmic Medical Assistants (OMAs) in their clinics and accompanied them on field trips to clinics and schools to treat patients. I observed eye surgeries performed at Lilongwe Central Hospital. I also observed classroom instruction of future OMAs. For interview subjects who became key informants, I revisited them several times, observing their everyday routines.

Interviews

A total of 99 one-on-one interviews were conducted. Four groups were interviewed: blind people, sighted people, medical staff, and blind support services staff. Among interviews with blind and sighted people, participants were recruited in Kasungu, Salima, Lilongwe, and Dowa Districts, with the majority coming from Kasungu and Salima Districts. Among medical and blind support services staff, interviews were conducted throughout the country where these providers were located.

Blind Informants: A total of 54 blind people were interviewed. Potential blind participants in each district were initially identified with the assistance of the OMA for that district. Mr. Mataka, the OMA, and I would drive to the potential participant's home, where the OMA would introduce us and explain the research. Among blind recruits, no one refused to participate.[2] After being introduced to two or three individuals in each district by the OMAs, Mr. Mataka and I then approached potential recruits on our own. By this time, our reputation preceded us, for word spread quickly across the district of the research. In addition to those identified by OMAs, potential recruits were also identified by asking blind participants if they knew of any other blind individuals who would be interested in being interviewed. This snowball recruiting yielded many blind individuals unknown to the OMAs.

---

[2] Given the hierarchical structure of Malawian society and a blind person's low status, it would have been difficult for a blind person to refuse to be interviewed, particularly after being asked to participate by the OMA or a foreigner. Despite this, there was only one person whom I felt was uncomfortable participating. It became clear that her discomfort was from relatives who were nearby during the initial interview. On a subsequent interview, we were able to speak privately and she revealed the reasons for her discomfort. All other participants seemed quite eager to participate.

Before the interview, informants were given a visual acuity test[3] using the illiterate "E" chart,[4] unless the informant reported only hand movement, light perception, or no light perception. All interviews were tape recorded with permission of the informant. No one refused to be tape recorded, though tape malfunctions or anthropologist incompetence occasionally occurred. Notes were also taken during the interviews. After the interview, informants usually asked numerous questions, gave us a tour of their home and fields, and asked us to take their photographs. Each informant was compensated with a 1 kg bag of sugar[5], a precious gift to a villager because of the expense of sugar and its frequent shortage in the country.

A total of 22 women (40.7%) and 32 men (59.3%) were interviewed ranging in age from 15 to approximately 95 years old. Many informants, particularly elderly men and women, did not know their exact age. I estimated age by asking their marriage status, the number of children they had, or their estimated height during particularly significant historical events such as the famine of 1949 or when the former president Hastings Kamuzu

---

[3] Central visual acuity is tested by using a chart with progressively smaller rows of letters. Each row corresponds to the distance a person with normal vision can be from the chart and still read all of the characters in that row. Each eye is tested separately. The person is placed six meters (20 feet) from the chart and asked to read the letters of each row from the largest to the smallest row. Acuity for each eye is represented by two numbers separated by a /. The first number represents the distance from the chart the vision was tested. The second number represents the smallest row of characters the person could read. Thus, an acuity of 6/80 means a person was tested at six meters and was only able to read characters that a person without any vision loss could read at 80 meters. An acuity of 6/6 is considered normal.

[4] The illiterate "E" chart consists of the letter E rotated randomly right, left, up, or down in each row of the chart. The person is asked to point in the same direction of the three bars.

[5] I usually gave white sugar. However, for approximately two weeks, white sugar was not available from the stores, so I had to give the less desirable brown sugar. Informants were still very appreciative, however.

Banda first returned to the country in 1958. This gave me a general estimate of their decade of life.[6]

The majority of informants, 28 (51.9%), came from Salima District, with 23 (42.6%) from Kasungu District and 3 (5.5%) from Lilongwe District. The vast majority of informants, 45 (83%), were of Chewa ethnicity. Other ethnic identities included Tumbuka, Ngoni, Lomwe, and Nyanja (Chapter 3 provides a brief description of ethnicity in Malawi). Forty-four (81.5%) identified with a Protestant Christian denomination, nine (16.7%) were Roman Catholic, and one maintained indigenous religious beliefs.

For this study, blindness was defined as a visual acuity of 3/60 or less in the better eye. The visual acuity of blind informants ranged from no light perception to 3/60 in the better eye. The majority, 25 (46.3%), reported no light perception. The age at which informants became blind was difficult to determine. Becoming blind is a process and

---

[6] A typical exchange between respondent (R) and me (I) to determine age was as follows:

I: Can you tell me how old you are? R: I can't know because our parents don't know when their children were born. All they can tell you is, for example, if you were born around 12 p.m., they would tell you that you were born when the sun was overhead. So they didn't tell me the year. I: How old were you when Dr. Kamuzu Banda was coming to Malawi? How old were you, do you think? R: That time I was grown up. I had about four children at that time. I: So you are younger than Dr. Banda? R: I am younger than Kamuzu Banda.

informants typically had a progressive loss of vision, which differed with each eye. There often was significant time between the onset of an eye disease and blindness. Twenty-six (48.2%) were blinded by the age of 10 and six (11.1%) were blinded after the age of 50.

Sighted Informants: A total of 31 sighted people were interviewed. Potential participants were recruited by visiting villages and simply asking individuals if they would be willing to be interviewed. Although most people agreed to participate and were welcoming, occasionally people would decline to be interviewed either because of suspicion about our intentions or because they were too busy with work. Five of these 31 interviews were with family members of blind individuals. Their interviews provided additional information on the experiences of seeking help to treat the blinding condition and on the family's and individual's adjustment to the disability.

As with blind informants, sighted informants were given a visual acuity test using the illiterate "E" chart. All interviews were tape recorded with permission of the informant. No one refused to be tape recorded. Each informant was compensated with a 1 kg bag of sugar.

A total of 18 women (58.1%) and 13 men (41.9%), ranging in age from 20 to 63 years, were interviewed. At times, age had to be estimated as with the blind interviews. Informants came from Kasungu District (41.9%), Salima District (25.9%), Lilongwe District (16.1%), and Dowa District (16.1%). The majority were Chewa (80.6%), though some identified as Yao (6.5%), Ngoni (6.5%), Tumbuka (3.2%), and Tonga (3.2%). Twenty-three (74.2%) were Protestants, five (16.1%) were Roman Catholic, two (6.5%) were Muslim, and one (3.2%) maintained indigenous religious beliefs.

We also tested sighted informants' visual acuity. The majority, eleven (58.1%), had a visual acuity of 6/6 or better in the better eye. Eleven (35.5%) had a visual acuity of 6/9 to 6/18 in the better eye. One informant had a visual acuity of 6/36 and one had a visual acuity 3/18 in the better eye. Two informants wore corrective eyeglasses.

Medical Staff: A total of nine medical personnel were interviewed, which includes four OMAs, two medical assistants, one doctor, and two indigenous medical practitioners. In addition, one blind informant was a *sing'anga* (indigenous healer) and she provided wonderful insight into healing practices.

Blind Support Services Staff: I interviewed a total of 5 people who work in some capacity with the blind. This includes teachers of the blind, teacher educators for those learning to teach the blind, and staff working at MACOHA, the Malawi Council on the Handicapped, the umbrella organization for services to all disabled individuals in the country.

Life History

The life history of Mr. Johnson Kumbwenza, a man blinded by *retinitis pigmentosa*, was collected over the course of the research. Mr. Kumbwenza was one of the 54 blind individuals interviewed and, thereafter, became a key informant. He helped me find individuals to interview, came with me on many interviews, and helped me to untangle many moments of confusion.

Rather than interview him to gather his life history, I provided him with a typewriter and reams of paper, at his request. He typed his life story for me, giving me installments each time we met and, after I had returned to the United States, sending me installments. So his work is perhaps more appropriately considered an autobiography. Mr. Kumbwenza differed from the majority of blind informants I interviewed. He had a college education and a respectable office job as an accountant for a government agricultural research station, though this job was increasingly at risk because of his blindness. As a benefit of his job, he also had a masonry home with electricity and water (though both were rarely available) at the research station in Salima District. And his blindness was the result of a genetic condition rather than poverty and poor health care. In fact, he received relatively good health care including a trip to South Africa for diagnosis and specialty care.

Despite his higher class status, Mr. Kumbwenza was very aware of life for the most disadvantaged blind people and was an acute social critic. He was also devoting much of his energy to searching for other blind people and assisting them with donations of clothing and assistance in finding work and aid. He was attempting to start a non-profit organization under which he could organize his efforts.

Surveys

Two separate surveys were conducted in Kasungu, Salima, Dowa, and Lilongwe Districts. The surveys were conducted in public places such as bus stops, markets, and school grounds by two research assistants. Individuals were approached and asked to answer questions for a research study.

Survey of Attitudes on Disabilities: The first, a Survey of Attitudes on Disabilities, examined people's definitions of disability and sought to understand which conditions were considered more debilitating. One hundred and eighty one people were surveyed, 110 men and 71 women.

They ranged in age from 15 to approximately 67 years. As with the interview informants, some respondents did not know their exact age and thus estimates were given.

While the interviews were conducted in Salima, Kasungu, Dowa, and Lilongwe Districts, some participants were from other districts (Mzimba, Mchinji, Nkhotakota) and were traveling through or visiting one of the four districts. Participants represented Chewa, Yao, Ngoni, Lomwe, Tumbuka, Tonga, and Nkhonde ethnic affiliation, with 72% being Chewa.

Respondents' level of education ranged from 0 years to 12 years. Some interviews were conducted at schools, which skews the educational level of respondents when compared to the general population (Chapter 3 discusses education and overall educational attainment in Malawi).

Survey on Eye Diseases and Treatment Choices: The second survey sought to understand Malawian medical concepts of eye diseases and people's preferences for treating eye diseases. From my interviews, I made a list of eye diseases mentioned by informants. In the survey, we asked people if they knew of these diseases, as well as the most significant biomedical conditions, and their etiologies. If they did, we asked them to describe the associated symptoms. We then asked people to rank their preferred choice of treating each disease, either self treatment, treatment at a hospital, or treatment by a *sing'anga* (healer). We also asked people about their attitudes towards eye surgery.

A total of 177 people were interviewed in Lilongwe, Salima, Kasungu, and Dowa Districts by two research assistants. As with the first survey, people were approached in public places. Ninety-three men and 83 women were surveyed. They ranged in age from 15 to 67. Again, age sometimes had to be estimated.

Respondents came from Lilongwe, Salima, Kasungu, Dowa, and Mchinji Districts. The majority identified as Chewa, although people of Yao, Ngoni, Lomwe, and Tumbuka ethnicity also participated in the survey.

Respondents' level of education ranged from no formal education to 12 years. Again, educational attainment is skewed because of the location of some of the surveys.

Diaries

I asked some blind informants to write a diary for me about their experiences being blind. I provided them with braille paper and a stylus on which to record their experiences. A total of 14 people wrote a diary, 12 men and 2 women. These braille diaries were then translated from braille by a blind man.

Popular Press

I regularly purchased the six major newspapers and culled the pages for any articles related to blindness, disabilities, health care, magic, medicine, or anything in any way related to the research topic. While the papers, to a Westerner, would be more akin to the National Enquirer in writing style and subject matter, the papers were avidly read by Malawians and taken to be factual by at least my group of research assistants and key informants. The articles reflect a general Malawian ethos, especially regarding the place of magic (or *juju*), medicine, and disabilities in society. They proved quite helpful in corroborating and exemplifying some of the findings from the other research methods.

LIFE IN MALAWI

I neither anticipated nor planned to conduct research as a single mother of an infant. The birth of my daughter two weeks before I was to begin research had a tremendous impact upon both the research methodology and my experiences in the field.

Elizabeth Colson (1984) writes about how her transitions through the life course influenced her research interests, the data she gathered, and her informants' interactions with her. There is no question that my status as a mother and the presence of my infant daughter, Anna, affected the perceptions people had of me and I had of them. The fact that I was there without Anna's father only elicited comments and surprise from expatriates. Malawians are used to single mothers and absent fathers. They did not find it unusual that I was working and caring for my daughter. They do it all the time. On the other hand, had I not had a child at my age, they would have questioned why I had not achieved as an important a life stage as motherhood.

Fulbright-Hays granted me a six month deferment, enabling me to begin research when my daughter was six months old. With the help of her father, who accompanied us the first three months, we arrived in Malawi via a circuitous route involving flights from San Francisco to Houston to London to Rome to Johannesburg and, finally, to Durban, South Africa. In Durban, we picked up a four wheel drive vehicle we had shipped from Scotland and drove north to Harare, Zimbabwe, across Mozambique, and then up through southern Malawi to Lilongwe in the Central Region.

Initially, the plan for research was to live in a rural village of Kasungu or Salima Districts. This would afford me an understanding of village life, for my research was initially focused on rural experiences. However, the addition of my daughter complicated matters. No one endorsed my desire to live with my daughter alone in a remote village. I stubbornly held to the plan for a month, searching in vain for a community and a home in either district. I also searched for research assistants and a nanny to help me care for Anna. Because no one endorsed my plan, no one provided much serious assistance and I could find no one qualified to work as a research assistant willing to live in a rural village. As time was rapidly passing, I finally decided to live in Lilongwe. Housing was difficult to obtain anywhere, but in Lilongwe we had the generous offer of friends of family to stay with them. Our benefactors were a young husband and wife from Zimbabwe. This experience turned out to have a dramatic effect upon the research and upon my theoretical perspective.

The young couple we lived with are a white Zimbabwean family living in the country for work. The husband worked for one of the three foreign tobacco purchasing companies in Malawi. This experience exposed me to a side of Malawian life that I otherwise would have not clearly understood. By living and meeting this side of Malawian life, the *azungu* (white) world, I came to have a more critical understanding of ethnic and class tensions. The Malawian staff within the homes of these expatriates served as the link, helping me to understand historical and current relationships among the various ethnic groups and classes and how these effect Malawian perceptions of "healthy" and "normal" and attitudes towards power and control, which in turn influences their health seeking behavior.

We lived with this couple for 6 of the 12 months of research. For the other 6 months, my daughter and I sublet the flat of a young white Malawian tobacco buyer who was in the United States for training. The flat came with the services of an elderly cook and "house boy," James.

While we lived with the Zimbabwean couple, my research assistants worked from the home of a friend, a Peace Corps worker, living in the same neighborhood. The presence of several Malawians working in the home of a white tobacco buyer would have never been acceptable. While we lived alone, the research assistants worked out of our flat, all of us sitting at the dining table translating, writing, or clipping articles from papers. In addition, Jane, my daughter's nanny, was there with Anna. The research assistants and house staff worked the typical Malawian work week of 8 am to 6 pm from Monday to Friday. House staff also worked from 8 am to 12 pm Saturdays, except for James, the cook, who was a Seventh Day Adventist and, thus, chose to work all day Sunday rather than Saturday.

A typical work day would consist of one or two research assistants and I driving to a rural village early in the morning to conduct interviews and observations. We would conduct from three to four interviews per visit and make the return trip in time for me to get Anna so that Jane could go home to care for her own son. These journeys were exhausting, the drives long and often frightening because of the poor roads and, by my perceptions, insane drivers. One would frequently round a bend in the road to find a truck or car coming directly at you in your lane. Miraculously, we only experienced one mishap, getting stuck for four hours in the mud in Kasungu District. Occasionally, Anna and Jane would accompany us to the villages, but this practice ended when a measles outbreak occurred, my daughter grew tired of the drives, and I feared for all our lives on the road. I wanted to at least minimize her risk of being in a car accident or contracting measles, for which she had not yet been immunized. I continued, however, to worry that she would be left motherless every time I drove some place.

When we did not go to the villages, I worked at home writing notes and quizzing my research assistants and house staff on issues puzzling me. I visited various government ministries, schools, hospitals, clinics, and agencies. Or, I dealt with many of the issues I faced in being responsible for so many employees and my daughter. I quickly found that when I became an employer, my responsibility did not end with providing a paycheck. I also needed to provide assistance in helping my employees acquire health care or other necessities, for my wealth and white skin provided them status and entrée to resources not easily available to the average Malawian. For example, when James, the cook, became ill, I naively told him to take the day off and go to the doctor, providing him with money to pay the fees. Jane and Mr. Mataka quietly took me aside and told me this was not sufficient, for he would not be seen by a doctor or taken proper care of unless I accompanied him to the hospital. Initially, these responsibilities frustrated my drive to constantly work and I was stressed at the time it took away from research. It took me a while to realize that these trips to the hospital or journeys to deal with other problems were providing me with invaluable insight into Malawian life.

ETHICAL ISSUES AND RESEARCHER BIAS

This research was accompanied by the typical ethical issues faced by any researcher conducting research among people who possess few resources and little power. People were remarkably accommodating and generous in their assistance and willingness to talk with me. The prospect of receiving assistance in some form was, no doubt, an incentive, but the fact that someone wanted to learn from them and hear their story was also significant.

My presence in the lives of some informants did have an impact upon them. As this study will demonstrate, power and agency are rarely attainable except through association with others. The fact that I was a white, wealthy woman[7] coming specifically to see some of the most destitute of a community impressed other community members. Thus, a blind person's association to me sometimes raised his or her status within the community. For example, one couple, both of whom are blind, had been living in a partially built home and were frustrated in their efforts to obtain a loan to purchase tools and seed to enable the husband to work in his trained profession as a carpenter and to plant subsistence crops. After my visit, villagers took notice of them and helped to build their home and provided them with assistance to become self-sufficient.

Probably the most difficult conflict I faced was in straddling the world of the poor Malawian and the world of the *azungu*, or whites. Malawian society is deeply stratified. I lived part of the year with a white, expatriate couple who provided tremendous assistance

---

[7] My research was conducted on the typical tight budget of dissertation research. However, there is no denying that my material wealth and life chances were vast and incomprehensible to my informants.

caring for my daughter. They were friends of family and, indeed, have become close friends and extended family to Anna and me. But it was obvious that I did not fit into the white, expatriate world. The Malawians' quickly realized this and understood my difficult position. In the home of my white Zimbabwean family, I could not violate the code of stratification, for it was not my home. But when in my own flat, I could maintain a different type of relationship with my Malawian employees and informants, one that at first was deeply shocking to them.

They knew I was not like the white expatriates working with the tobacco companies, but they found me unpredictable. One day I had one of my key blind informants, a 20 year old secondary school student with ambitions of studying abroad, and his close friend, a sighted student, over to my flat for lunch. My research assistants and Mr. Kumbwenza, my key informant who provided his life history, also joined us. The beginning of the meal was awkward and quiet, with everyone giving me nervous looks. I was sure I had committed some horrendous *faux pas* and finally asked what was wrong. Jane stated in a shocked voice, "Madam[8], never in my life did I think I would see such a sight!" Everyone, including James, who came out from the kitchen, then spoke at once, telling me that none of them could have ever imagined sitting down to a meal with a white person in that person's home.

---

[8] Malawians called me or any person of higher status Madam or Master. This was very difficult for me, especially when the Malawian was far older than I such as James, the cook. Despite my repeated efforts to get my employees not to call me Madam, they never felt comfortable calling me anything other than Madam and I stopped trying. Informants were easier to convince, for we did not have an employer/employee relationship.

They were stunned. And I too was stunned for I realized that my experiences in Malawi were quite different from any other experience I have had. Malawi had a stratification that took me a long time to comprehend.

Straddling these two worlds was a constant source of conflict for me. I liked the people I knew in both worlds even though I did not always agree with their values. I owed both worlds so much for their help and assistance, but the effort to maintain appearances in both worlds was difficult. Had I lived in a village by myself, this conflict would not have existed. My experience would have been quite different I am sure. However, I believe fortuitously, by seeing both worlds, I gained a perspective that did much to explain Malawian attitudes about their own agency in this world. Even the most rural Malawian is influenced by the stratification in Malawian society, for this stratification directly affects every person's access to resources. I could not have seen this so directly had I not experienced both worlds and seen them intersect as I did.

CHAPTER 3
THE POLITICAL ECONOMY OF MALAWI

Malawi is an obscure nation in an obscure continent to the majority of Americans. Many people, in fact, thought I was going to do research on one of the Hawaiian islands, apparently mistaking Malawi for Maui. For the descendants of its colonial masters and Christian missionaries, though, it is known as the former colony of Nyasaland and the site of David Livingstone's explorations. This chapter provides the background on Malawi necessary for interpreting Malawian responses to eye disease and blindness.

ADMINISTRATIVE STRUCTURE

Malawi is divided into three administrative regions, Northern, Central, and Southern. There is a rough correspondence between region and ethnicity, region and political/economic power, and region and indicators of poverty. For example, the Central region, the location of this research, is dominated by the Chewa ethnic group. And under the administration of Malawi's first president, Hastings Kamuzu Banda, the Central Region, his ancestral home, was favored in gaining political and economic perks. On the other hand, the Northern Region, neglected in biomedical facilities, had the earliest and most dominant missionary presence and, therefore, the Northern region has higher rates of formal education and literacy. The Southern region has the greatest population density and is often the lowest in measures of health and well-being.

At the time of research, the country was further divided into 24 districts[1], representing the largest unit of local administration. Research was conducted primarily in Kasungu, Salima and Lilongwe Districts and to a lesser extent in Dowa and Dedza Districts, all in the Central Region. Districts are further divided into Traditional Authority (or chiefs') areas.

GEOGRAPHY AND CLIMATE

Malawi is a stunningly beautiful country. It encompasses everything from valleys barely above sea level to mountain ranges more than 9,000 feet high. Surrounded by Tanzania, Mozambique, and Zambia, it has no ocean access. More than one-fifth of its 45.7 thousand square miles is water, much of it the vast, elongated Lake Malawi running 360 miles along its eastern border.

More than three-quarters of Malawi's land mass are plateausBrolling hills and shallow valleys dotted with steep, rocky hills. Kasungu and Lilongwe Districts are within one of the largest plateaus, the Lilongwe Plain. This plain ranges in elevation from 2,500 to 4,000 feet (Nelson et al. 1987:48).

The littoral zone of Lake Malawi constitutes another major land feature. Lake Malawi, the third largest lake in Africa and one of the deepest lakes in the world with depths

---

[1] As of 2004, there are 27 districts. Likoma District, consisting of Likoma Island and surrounding islands, in Lake Malawi and Balaka and Phalombe Districts in the Southern Region were added.

of 2,300 feet, constitutes the southern portion of the eastern Rift Valley. Along some portions of the lake, rock cliffs rise from the lake bottom to nearly 2,000 feet above the water. In other portions, including Salima District in the southwestern portion of the lake, the shoreline is a sandy beach extending to flat plains marked by swamps and dambos (areas of impermeable substrata creating moist ground) (Nelson et al. 1987:51).

Malawi's climate is marked by a dry, cool season (from approximately March to August) and a wet, warm season (from approximately September to February). Along the lakeshore such as in Salima District, the weather turns miserably hot and humid in the wet season, conditions favoring the *Anopheles* mosquito. Thus, while malaria is a problem throughout the country, it is far more prevalent along the lakeshore. Weather is more temperate in the Lilongwe Plain and, in fact, evenings become quite cold in the dry season.

The wet season rains are relentless, closing off roads and paths for the entire season. The only traveling mishap I experienced was during the wet season in Kasungu District. My four-wheel drive truck was mired in mud for four hours when we decided to risk the dry season approach to a village. With the help of ten village men, including two blind informants, the truck was eventually freed, but from then on we took the much longer wet season route.

DEMOGRAPHY

In 1997, Malawi's total population was 10.3 million with an average annual population growth rate of 2.7% (World Bank 1999:25). Crude birth and death rates[2] were 46

---

[2] Crude birth and death rates are the number of births and deaths occurring per 1,000

and 20 per 1,000 people, respectively (World Bank 1998:47). Its total fertility rate[3] was 6.5 (World Bank 1999:97). Its population pyramid, thus, is typical of such high fertility rates, with nearly half (47%) of the population under 15 years old (World Bank 1996:5). And, as a result, its dependency ratio[4] is extremely high, 1.06 in 1992 (i.e., there are 106 dependents per 100 adults of working age) (World Bank 1996:5). The population density in 1994 was estimated to be 100 people per square kilometer (World Bank 1996:5).

What these demographic measures tell us is that Malawi is burdened by rapid population growth and high population density. The result is a high dependency ratio and increasing strain on scarce resources. Malawi is a country, under current political and economic conditions, unable to provide the resources all of its people need for the most basic standards of well-being.

---

people, measured at the midyear population (World Bank 1998:49).

[3] The total fertility rate is the number of children a woman would give birth to if she survived her childbearing years and bore children at the current age-specific fertility rates (World Bank 1999:99).

[4] The dependency ratio is the ratio of the population between 15 and 65 years old to the population under 15 and over 65 years old (World Bank 1996:21).

EDUCATION AND LITERACY

Western-style education was introduced into Malawi by Christian missionaries in the late 19th Century. Beginning in the early 1900s, the colonial government contributed financial support for education. What eventually emerged was an educational system consisting of religious institutions funded through tuition and sponsorship from the parent religious organization, religious institutions receiving some government funding, and government schools partly funded through tuition fees (Nelson et al. 1987:124). All three types of schools bear the reminder of Christian missionaries' early influence on education. Religious instruction and theory are common in educational curricula (see Wendroff 1985).

Today, the educational system has four levels: primary, junior secondary, secondary, and tertiary. Primary schooling is 8 years, denoted as standards 1 through 8. The Primary School Leaving Certificate is awarded upon completion. The junior secondary level is two years long, denoted as forms I and II. After completion of form II, students receive their Malawi Junior Certificate. Secondary school consists of forms III and IV with graduates receiving the Malawi School Certificate of Education. Higher education includes the arts, sciences, and humanities; business; teacher training; law; medicine and allied health fields; engineering; forestry; and agriculture. Additionally, there are technical training schools including schools for the blind (see Chapter 7).

Education in Malawi has always suffered from inequality, poor infrastructure, and inadequate resources. In 1994, when Malawi elected a new government, primary school fees were eliminated and government expenditure on education was increased in an attempt to improve education. The elimination of school fees resulted in a dramatic increase (62%) in enrollment. Unfortunately, the system did not have adequate resources and infrastructure to absorb and educate all of these students and attrition was high (World Bank 1996:10).

The lack of resources and infrastructure is clear from statistics. For the 1994/1995 school year, there were 77 students per teacher and 131 students per qualified teacher (not all teachers are considered adequately qualified to teach). There were 422 students per permanent classroom, 56 students per chair, 31 students per desk, and 7.1 students per textbook (World Bank 1996:17). The schools I visited bore out these statistics. Buildings were crumbling and students lacked basic supplies. Exacerbating these difficulties are the malnutrition and undernutrition of students. Educational conditions, thus, remain very poor.

Such an inadequate system results in many people never attending school, high attrition and repetition rates, and tremendous age/grade mismatch. One in two Malawians aged 35 and older has never attended school, while one in three Malawians aged 16 to 35 has never attended school (World Bank 1996:10). In the 1994/1995 school year, 12% of students dropped out and 21% repeated a grade level (World Bank 1996:17). Finally, it is common for students to begin school older than the expected age and to have schooling disrupted. Thus, 66% of students in standards 1 through 4 are older than 9 years, with the average age in standard 1 being 10 years (5 years is the expected age for standard 1) (World Bank 1996:12). Such students are likely never to complete primary school.

There are regional, gender, and income differences in education. The Northern region, because of its longer association with Christian missionaries and missionary schools has higher school attendance rates. Girls and women have less schooling and have higher illiteracy rates. In 1995, 58% of women aged 15 and over were illiterate compared to 28% of men (World Bank 1998:17). Finally, poor people are less likely to attend school, more likely to drop out, and less likely to complete primary school (World Bank 1996:11).

HEALTH OF THE PEOPLE

Mortality and morbidity rates are among the best evidence of a society's overall well-being. The health status of Malawians is abysmal by all standard measures, the country consistently ranking among the worst in the world. In 1996, life expectancy at birth was 43 years, equal to life expectancy in Uganda and better only to life expectancy in Rwanda (41 years). In 1995, adult mortality[5] was 487 per 1,000 people for women (the sixth highest in the world) and 553 per 1,000 people for men (the fifth highest in the world). In 1996 the infant mortality rate, at 133 per 1,000 live births, was the third highest in the world (better only to Guinea-Bissau and Sierra Leone) and under-five mortality, at 217 per 1,000 people, was the fourth highest in the world (World Bank 1998:104-106). Maternal mortality is also high, estimated to be 620 per 100,000 births (World Bank 1996:8).

One in seven children dies before his or her first birthday and one in four children dies before his or her fifth birthday. There is regional variation in these rates with rural children being at far greater risk of dying. And child mortality (death between ages 1 to 5) in the Central Region, where this research was conducted, is more than 50% higher than in the Northern and Southern Regions (National Statistical Office 2002). These figures are

---

[5] Adult mortality is the population of 15 year olds who will die before their 60th birthday (World Bank 1998:107).

supported by observations and experiences in the field. Of the 71 blind and sighted informants who had children, only 22 had not lost a child before the child's fifth birthday. Infant and child death are an expectation.

These rates reflect a society overwhelmed by disease and hunger. The greatest cause of morbidity and mortality in Malawi is malaria. In 2002, malaria accounted for 38% of visits to medical facilities, 26% of admissions to hospitals, and 23% of in-patient deaths. Acute respiratory infections (ARI) were the second leading cause of hospital and clinic visits (18%), hospital admissions (14%), and in-patient mortality (23%). Diarrhoea and dysentery were the third leading cause in all three categories. Malnutrition tied diarrhoea and dysentery as the third leading cause of in-patient deaths (9%) (Ministry of Health and Population 2003:21).

Malnutrition and undernutrition are serious, widespread problems in Malawi. In 1992, 27% of children under five were underweight and 49% were stunted.[6] As a mother of an infant, I was keenly aware of Malawian children. I consistently underestimated ages because of stunting. And Malawians consistently over-estimated my daughter's age because of her size and developmental achievements, despite the fact that my daughter was small by U.S. standards. Signs of marasmus and marasmic kwashiorkor, such as muscle wasting and edema, were common among village children. Informants'descriptions of their children's deaths were often descriptions of malnutrition and starvation. And when I inquired about the health of one sighted couple's young daughter, clearly suffering from protein-energy

---

[6] Stunting reflects chronic deprivation, whereas wasting reflects acute deprivation.

malnutrition, the father laughed and said she was merely jealous of her newborn brother; a common problem in Malawi, he assured me.

While HIV/AIDS accounted for only 1% of hospital admissions and 3% of in-patient deaths, this likely under-represents the toll of HIV infection. In 1996, 33% of women attending urban antenatal clinics were HIV-positive and 78% of the urban high-risk population was HIV-positive (World Bank 1998:101). The infection rate for adults 15 to 49 years old was estimated to be 15% (Joint United Nations Programme on HIV/AIDS 1998). In 1998 there were an estimated 88,000 orphans and 480,000 children with only one living parent partially as a result of AIDS mortality.[7]

Malawi is typical of peripheral nations. The vast majority of morbidity and mortality is caused by parasitic and infectious agents and malnutrition and undernutrition.[8] What these figures do not reflect is that most ill people are suffering from more than one condition. Malnutrition and undernutrition compromise immunity, leaving an individual extremely vulnerable to disease and ill-equipped to recover from disease. I occasionally helped informants by taking them to a hospital or clinic and paying for medicines. I was initially taken aback by the sheer number of conditions diagnosed. People never suffered from one condition alone. The primary complaint was always accompanied by several other serious problems such as malaria, pneumonia, intestinal parasites, anemia, and so on.

---

[7] These figures are based on people aged 20 or younger, of which there were 5.7 million people. Thus, 10% of children had lost at least one parent.

[8] In peripheral nations, 42% of deaths are caused by infectious agents, compared to 1.2% of deaths in core nations (Platt 1996:11).

I was also surprised by how well people masked their discomfort despite suffering from so many diseases. They often did not claim to be ill. Malawian standards for "healthy" were obviously very different from my own standards. "Normal" and "healthy" are concepts relative to one's circumstances and experiences. As Emmanuel Kant stated, ". . . well-being is not felt, for it is the simple awareness of living" (Kant, quoted in Canguilhem 1991:234).

Malawians in general and poor Malawians in particular have a rather forgiving definition of "healthy" by Western standards, one that I would describe as distorted. What would incapacitate most Westerners, is ignored by poor Malawians. People did not consider themselves sick or sick "enough" for treatment in the face of disabling or life-threatening conditions. This is reflected in an interesting finding from research conducted by Malawi's National Economic Council. In a 1997 to 1998 study of poverty, the Council found that the non-poor were more likely to report being ill than the poor:

> One would expect that the poor, given the level of deprivation under which they live, to be more subject to illness than would be the relatively better fed, better housed, and better clothed non-poor. In assessing this information, one should remember that whether one was ill or not in the previous two weeks was self-reported. As such, the poor may very likely have a higher threshold in regards to feeling out of sorts before they would classify themselves as "ill". Consequently, the *illness* of the poor may not be directly comparable to the *illness* of the non-poor. The fact that the ultra-poor have even lower levels of morbidity than the poor as a whole lends additional support to this point. (National Economic Council 2000:22)

This diminished expectation for health is distorted precisely because people are dying or becoming permanently debilitated from conditions that are not only treatable, but are rarely suffered by truly healthy people. One would be hard pressed to defend the definition of "healthy" among poor Malawians on the grounds of "cultural relativity." It can only be described as a distortion, one that the wealthy need not make.

Malawians, themselves, are aware of the relativity of their definitions of "healthy" and "normal." In an attempt to help the obviously sick and malnourished son of a blind woman, I asked if I could take them both to the Salima District Hospital. She did not consider her son sick enough to warrant medical care, but, since I was offering a ride to the hospital, she decided to take me up on my offer. The lone medical assistant still working during a staff strike diagnosed pneumonia and admitted the boy to the hospital for treatment. When I asked the medical assistant if he would also be speaking to the mother about ways to improve her son's nutritional status, an admittedly naive question at the time, he responded, "Why?" in genuine confusion. I pointed out the boy's obvious signs of malnutrition. He replied, "This is normal in Malawi. Besides she can do nothing. She is too poor. It's of no use to tell her."

DIET

The poor nutritional status of Malawians begs a description of the Malawian diet. While there is a traditional cuisine, it is economics, not cultural preferences and tradition, that determines what, how much, and when people eat.

Maize and, in some areas, cassava or rice are the staple foods and form the base of every meal. Maize flour is boiled into a thick porridge, *nsima*, and served with a relish of vegetables. Malawians do not feel they have eaten if their meal has not included *nsima*.

The base ingredient of the relish is a vegetable. Okra, carrots, tomatoes, cabbage, pumpkin, various greens, onions, peas, green beans, and various legumes are typical. Meat is very rarely added to the relish because of its expense. As one informant jokingly said to me, "We are vegetarians, but not by choice!" Among my poorer informants, they reported eating meat once a year. Among the more financially secure, meat might be consumed once every week or two. Fish, particularly along the lakeshore, is the most significant source of animal-based protein in the diet, accounting for 70% of all animal-based protein consumed in Malawi. Meat, when one is able to afford it, is usually beef, goat, or chicken, though pork, lamb, mice, and other wild meats are eaten. It is common to see boys and young men on the sides of the roads selling long sticks of whole dried mice.

Relish is seasoned with *chidulo*, a solution made from the ash of various plants. Groundnut plants and husks, banana leaves, maize stalks, and sedges, among other plants, are burned and the ash mixed with water. The solution is then drained and used to season or tenderize foods (C.C.A.M. 1992:60).

Fruits such as mangos, bananas, papaya, pineapple, limes, lemons, and guava are also important in the diet. Collecting and selling fruit is a source of income for some people. However, these fruits along with wild fruits are not as freely available to people as in the past. Wild fruits are becoming scarce because of deforestation. And, in the urban areas, fruits are expensive and, thus, beyond the means of many people.

Children are weaned with *phala*, a thin maize porridge. If financially possible, milk, *nsinjiro* (groundnut flour), powdered flying ants, eggs, bean flour, tomato pulp, papaya, banana, mango, or avocado, for example, may also be added.

Water is the most common drink. While Coca Cola and other foreign and domestic sodas are available, it is rare to see a villager drinking sodas. They are beyond the means of poor Malawians and a sporadic luxury for others. Beer brewed from millet (or other grains if millet is not available), is a very popular drink throughout Malawi. It is also a source of income for many women who brew and sell beer. Two types of Carlsberg beer and various spirits are sold in the country. Malawi produces some of its own spirits such as gin.

The Malawian traditional diet is, theoretically, quite nutritious. However, not everyone has access to affordable, consistent food supplies. Most people consume what they are able to grow. Maize flour and vegetables may be spent before the next crops are ready. Subsistence crops fail or are insufficient when a farmer is unable to obtain a loan for fertilizers, when rains do not come, when part of the land is diverted to cash crops such as tobacco, or when there is not enough land for crops.

When subsistence crops fail or are insufficient, most people do not have the money to purchase food. Thus, meals must sometimes be skipped, are often too small to satisfy caloric needs, and lack nutritional diversity. Among all my informants, blind and sighted, two meals a day was typicalBa morning and evening meal. Some ate three meals, adding a meal at noon. But for many, there are times when they must go without food, save for a bit of fruit or vegetable they may gather.

ECONOMY

Malawi has a very narrow economic base with a small industrial sector, small foreign and domestic investment, and negligible mineral resources. Malawi's economy is predominantly agricultural, employing nearly 90% of the population and accounting for 37% of Gross Domestic Product and nearly 85% of export earnings (see Kalinga and Crosby 2001:7). Agricultural production is from smallholder farms and estate farms.

Smallholder farms are responsible for 85% of agricultural production, growing both subsistence and cash crops. Maize is the main food crop, grown on 95% of cultivated land. Other staple food crops include beans, peas, rice, and cassava. Cash crops grown by smallholder farmers include groundnuts, cotton, tobacco, and coffee. The majority of smallholder farms are small, averaging three acres. Sixty-three percent of farmers cultivate on less than 4 acres. Nineteen percent of farmers cultivate on six or more acres.

Estates account for 12% of agricultural production and nearly 70% of agricultural exports. Tobacco is the largest export earner, representing 59% of export earnings in 1997. Tea, sugar, and groundnuts are also significant export earners.

Smallholder farms, while producing the majority of staple food crops, increasingly divert land to cash crops, a policy encouraged by the new Malawi government and the structural adjustment programs of the World Bank and International Monetary Fund. For example, tobacco production has increasingly shifted from estates to smallholder farms, where they are estimated to produce 70% of the tobacco crop (Carbone 2003:51).

A brief description of the role of tobacco production is illustrative of Malawi's role as a peripheral nation in an extractive global market. The smallholder tobacco farmer typically produces a very small quantity, one to four bales of tobacco. Because smallholder farmers do not have transport, they sell their tobacco to a middle man, who transports the tobacco to one of three tobacco auction floors in the country where tobacco is auctioned off to one of three large multi-national corporations. Alternatively, farmers may organize a cooperative to get their tobacco to auction floors.

The management within these tobacco buying companies are all white expatriates. They earn a wage in the local currency, the kwacha, which allows them to live a very lavish lifestyle: large, modern homes with generators that allow them to have electricity during the frequent power outages; numerous servants including a cook, maid, nanny, and gardener; luxury items such as expensive vehicles and swimming pools. In addition to this local kwacha salary, they are paid a much higher "secret" U.S. dollar salary, which is deposited directly into tax free accounts such as in the Channel Islands. While against the law in Malawi, this perk is either "over-looked" or not known about by the Malawi government. Expatriates take these jobs because they can work for 15 or 20 years, accumulating enough savings to retire at a young age. Such a secret pay structure, however, is exploitative to the Malawi economy. Income tax revenue and investment are lost. It is an essentially extractive system in which minimal investment is made in the country while as much tobacco as possible is extracted for processing and resale outside the country.

In this system, the smallholder farmer holds a precarious position. Smallholder farmers, while representing the backbone of the economy, are hampered by limited capital inputs. Farmers rely upon hand tools to cultivate the landBdraft animals and farm machinery are rare. In fact, in my year in Malawi, I never saw one draft animal or piece of mechanized farm equipment on smallholder farms. Fertilizers, pesticides, and select seeds are necessary for sufficient crop production, costly investments for farmers who must obtain these necessary inputs on loan from the Agricultural Development and Marketing Corporation (ADMARC). ADMARC, a statutory corporation owned by the government, once held a monopoly on purchasing smallholder production, setting purchase prices, and selling farm inputs such as seed and fertilizer. Since 1987, ADMARC's monopoly was ended, allowing entrepreneurs to purchase and sell crops from smallholder farmers, though most of the farmers I interviewed still relied upon ADMARC for loans of inputs.

These loans must be repaid after cultivation and sale of the crop. For blind farmers, though, such loans were rarely given because they were considered a poor risk. Thus, blind farmers routinely grew insufficient crops to support their families or earn cash. And for those farmers extended loans, crops may not be sufficient to repay the loans.

Farming is such a central identity in Malawi, that even people who are employed in other sectors grow a crop, hiring help if necessary. For example, Mr. Mataka, although employed by me, hired help to grow a maize crop.

LIVING CONDITIONS

The majority (66%) of Malawians live in homes constructed of thatched roofs, packed earth floors, and mud or mud and wattle walls, which the family builds itself (National Statistical Office 1998:xix). These homes typically last from five to ten years, eventually succumbing to ants, rain, and wind. It is common to see the remains of old homes next to newer homes in the rural areas. About 16% of Malawians live in permanent structures made from fired brick, concrete, or stone and roofs of iron sheeting, tiles or asbestos (National Statistical Office 1998:xix). The majority of housing in the rural areas is mud or mud and wattle, though wage laborers returning to their villages and the more successful farmers build permanent homes.

Rural homes are typically one or two rooms, a half wall dividing rooms. Cooking may be done outside the home or in a separate kitchen of similar construction. Pit latrines are the most common toilet facilities in the rural areas. However, 22% of the population has no access to any toilet facilities. Plumbing and electricity are essentially non-existent in rural homes. Only 2% of the entire population used electricity as their main source of cooking energy and only 5% used electricity for lighting (National Statistical Office 1998:xx). The majority use firewood (94%) and paraffin (90%) for cooking and lighting, respectively. More than a quarter (27%) of the people get their water from boreholes and a quarter (25%) get their water from unprotected wells. Twenty-one percent get their water from piped sources.

Rural dwellers have few material possessions. The poorest usually have only the bare essentials of cooking utensils, a water pail, sleeping mats, and one or two sets of clothing. The more well off have locally made furniture, such as chairs and a table, and additional amenities such as decorations for the home. Most possessions and amenities are handmade or found objects altered to suit one's needs. Sleeping mats are woven locally. People decorate their homes with newspaper or magazine advertisements. One man made storage units out of cereal boxes he salvaged from the garbage of a nearby town. And another man made a guitar from an old cooking oil tin, wood, and wire. In fact, one sign of Malawi's poverty is the lack of refuse along the roads, unlike in neighboring countries where littering is a problem. In Malawi, almost everything can be put to use.

In the urban areas, the wealthy live in Western-style homes with modern kitchens, toilet facilities, electricity, and piped water. Others live in shanties made of mud and wattle, fired brick, or concrete. These homes typically do not have electricity or plumbing, though in some areas people have rigged electricity to their homes. As in the rural areas, pit latrines are used. Housing in the urban areas is extremely expensive and difficult to find, resulting in over-crowded homes and squatter settlements. Mr. Mataka, for example, lived in a squatter settlement with the constant worry that the home he was slowly building would be demolished by the government. The least expensive housing I could find was $1,000 per month for a Western-style home and I could never find housing for my daughter's nanny.[9]

---

[9] This was the major reason my daughter and I lived with the young expatriate couple for

She had to live with relatives in a shanty town.

Electricity and water in Lilongwe functioned intermittently particularly during the rainy season, leaving those in modern equipped homes at a disadvantage. When electricity was gone, I could not cook food, but my staff went on with life as usual for they relied upon charcoal and paraffin. The wealthy circumvent this inconvenience by purchasing generators. The most difficult period was a stretch of four days in December when electricity and water were shut off. I cursed the useless modern appliances and plumbing.

The major form of transportation is walking. Approximately 41% of the people have access to a bicycle. Public bus services and private taxis are the major form of transportation for long distances. Railway service is minimal and is confined to southern Malawi.

Road conditions are abysmal. By the end of the rainy season, paved roads are pocked with deep holes which are temporarily filled during the dry season. Most roads are dirt or washboard gravel. Because of the road conditions, four wheel drive vehicles are a necessity unless one is limiting driving to the urban areas and even then, the suspension is quickly shot.

At the time of research, there were approximately 37,000 fixed telephone lines in the entire country. Service was frequently down for weeks at a time. Wealthier people had cellular phones, though service was expensive and limited to the two major urban areas. E-mail service was available through the University of Malawi in Zomba and from a recently opened private company in Lilongwe. E-mails were routed through South Africa.

---

six months and sublet an apartment for six months, for we could not afford our own housing.

Nearly half the population had access to at least one radio (National Statistical Office 1998:xx) making it the most accessible form of mass communication. The government-operated Malawi Broadcasting Corporation manages the radio stations. Programming includes music, news, plays, poetry, Malawi Correspondence College courses, and informational programs on topics such as health and agriculture. At the time of research, there was no television, so most Malawians were blissfully unaware of Western television programming. The wealthy, of course, could purchase satellite dishes and watch television programs from around the world. And some Malawians owned television sets on which they watched rented video tapes. There were two video stores in Lilongwe, all of their videos containing the constant imprint across the screen that the video is a promotional video not to be rented and listing a U.S. number to call to report illegal renting of the video.[10] There were six major newspapers, an increase since the switch to multi-party elections in 1994. Additionally, there are various magazines and book publishers, publishing books related to Malawi and Africa.

ETHNICITY

In simplistic terms, ethnicity is typically broken into three gross categories: Africans, Europeans, and Asians. These categories represent broad groupings of people who typically

---

[10] Before I hired Rose and Anita, who were waiting to enter University, their major activity during the day was watching rented videos. They frequently contrasted what they saw in the movies to what life was like in Malawi. For example, Rose commented one day that she watched an American movie in which an ambulance responded to a car accident. She noted that in Malawi there are no ambulances to respond to accidents, so one is likely to die if severely injured.

socialize and form close bonds within their own group. Thus, it is not common for a European to be seen socializing with an African unless for work related purposes.

Africans

There are eight major ethnic African groups in Malawi. The vast majority of participants in this research were of Chewa descent, though Yao, Ngoni, Lomwe, and Tumbuka, were also represented in the research.[11] The anthropological literature on Malawi stresses the cultural similarities among the various African ethnic groups as well as the apparent harmony in which they interact. Cultural heritage does appear to be quite similar, particularly for the matrilineal groups.[12] However, Malawians mark ethnic distinctions and the oft-noted harmony is somewhat of an exaggeration. During the rule of Hastings Kamuzu Banda, certain ethnic groups were targeted for suppression and were ignored in national development efforts. Today, Malawians exhibit ethnic pride, stereotypes abound among the various ethnic groups, and tensions still exist.

---

[11] The other African ethnic groups in Malawi include Ngonde (3% of the population), Sena (3%), and Tonga (2%). Individuals from these ethnic groups either did not participate in the research or were such a minor representation that their particular cultural features will not be discussed.

[12] Malawi lies within the "matrilineal belt" of central Africa with the majority of its ethnic groups practicing matrilineality and uxorilocality.

Chewa

The Chewa are the majority ethnic group comprising approximately 35% of the total population. They, along with the closely related Nyanja, are believed descendants of the Maravi State which existed in the region in the 16th century.

The Chewa live primarily in the Central Region where they farm, sell their labor, or run small businesses. They practice matrilineal kinship and uxorilocal residence. The majority of Chewa are Christians, with a small percentage maintaining exclusively indigenous religious beliefs. The Chewa language, chiChewa, is one of two official languages, the other being English. The former life president, H. K. Banda, was Chewa and did much to suppress other languages. Primary school is taught in chiChewa and, until recently, radio broadcasts were limited to chiChewa and English.

Yao

The Yao represent approximately 10% of the population. They immigrated into the Malawi region between 1850 and 1870 from northeastern Mozambique, where they were already established as slave and ivory traders with the coastal Arabs. From the Arabs, they adopted Islam. They too practice matrilineal descent and uxorilocal residence and are primarily peasant farmers, traders, or small business owners. Their primary language is chiYao. They are clustered in Mangoche, Ncheu, Salima, and Dedza Districts. The current president, Bakili Maluzi, is Yao which has resulted in a revival of ethnic pride (see Mitchell 1956 for more information on the Yao).

Ngoni

The Ngoni comprise about 8% of the population. The Ngoni originally entered the region in the 1830s while fleeing their southern homeland during the *Mfecane*[13]. Their migration to the region is more aptly described as a conquest, for they plundered and took captive those groups in their path. Captives were incorporated into the Ngoni social structure, though the Ngoni were also influenced culturally by the groups they conquered. With colonial rule, the Ngoni were forced to end their conquests and their former captives slowly began to assert their original ethnic identity.

Originally cattle herders, the Ngoni today continue to own cattle, farm, and do wage labor. They are patrilineal and practice patrilocal residence. They also pay *lobola*, a brideprice of cattle or money, and this custom has spread to some of their neighbors. Thus, for example, some of the Chewa I interviewed talked about the need to raise money for *lobola*. In their conquests, the Ngoni took on the languages of those they conquered and, thus, few people speak chiNgoni today, it being used only ceremonially and in songs. The Ngoni settled in two areas, one in the Northern Region and one in the Central Region (Ntcheu, Dedza, Lilongwe, and Dowa Districts), though today they live throughout Malawi in their search for employment.

---

[13] The *Mfecane* or "the crushing" refers to the wars among the southern African societies including the Zulu Kingdom of Shaka in the early 1800s.

Lomwe

The Lomwe represent about 18% of the Malawi population. They began migrating into the Southern Region of Malawi from Mozambique in the 19th century. When European plantations were opened in the early 20th century, Lomwe were recruited to work the plantations resulting in continued migration from Mozambique.

The Lomwe are matrilineal and practice uxorilocal residence. They are culturally similar to the Yao and Nyanja and have settled with them, sometimes intermarrying and taking on chiYao or chiNyanja as their first language. They are farmers and have represented one of the major ethnic groups working the tea and cotton plantations.

Tumbuka

The Tumbuka represent approximately 7% of the national population. Believed to have settled in northern Malawi from the Luba region (present day southern Zaire) in the 18th century, the Tumbuka were originally a conglomeration of different groups who gradually became a single ethnic and linguistic identity. Prior to the Ngoni conquests, the Tumbuka were matrilineal and practiced uxorilocal residence. Under Ngoni subjugation, many Tumbuka practices were suppressed, including descent and residence patterns, rituals, language, and housing patterns. When Ngoni subjugation was ended with British colonial subjugation, the Tumbuka revived many of their cultural traditions including their language.

Asians

Asians comprise less than 1% of the Malawi population. The majority are of Indian and Pakistani descent. They first began immigrating to Malawi in the late nineteenth century at the encouragement of the British colonizers who felt they were more industrious and entrepreneurial than the local African population. They became the middlemen in commerce, shop owners, importers, and professionals and remain so today. In 1970, then President-for-Life Hastings Kamuzu Banda expelled Asians from all rural areas, limiting them to Lilongwe, Blantyre, Mzuzu, and Zomba. Lilongwe and Blantyre, the two urban centers of Malawi, are home today to vast stretches of Asian owned retail shops and restaurants, but the rural areas are devoid of Asian businesses despite the repeal of the ban. They have not returned to rural areas for fear of losing their businesses again.

Like the European community, the Asian community is insular with little socializing among other ethnic groups. They employ African Malawians in their homes as domestic labor and in their businesses and they serve as middlemen in business dealings with African Malawians. I knew of no cases of intermarriage with *azungu* or Africans and socializing with other ethnic groups is limited.

Within the Asian community, religious affiliation is the most important distinction. The population is nearly equally divided between Muslims and Hindus. The Muslim Asians do associate, for religious purposes, with the Yao, one of the African ethnic groups, because they too are Muslim. However, I knew of no intermarriage between Muslim Asians and Yao.

Asians in Malawi, as part of a great Asian diaspora, have kin and business relationships in their countries of origin as well as in numerous other countries. They draw upon these relationships in their business dealings, providing them with the capital and contacts to start and maintain businesses. As business owners and professionals, they tend to hold great wealth and status as exhibited by their material possessions, housing, and travels abroad.

In addition to Asians of Indian and Pakistani descent, there is a sizeable Korean population. The Malawi government contracted with a South Korean firm to build one of the country's major roads. Seventy-five Korean families decided to remain in Malawi, apparently perceiving opportunities to be better in Malawi than at home. They, too, are professionals, shop owners, hoteliers, and restauranteurs. They do not appear to be as exclusive in their relationships as other Asians. For example, American Peace Corps workers befriended Koreans. However, marriage is apparently endogamous within the ethnic group.

Europeans (Azungu)

People of European descent represent less than one-half of 1% of the Malawian population. They consist of expatriates living and working in the country for various private corporations or aid agencies and non-governmental organizations (NGOs), missionaries, the descendants of the original colonial settlers in Malawi and surrounding countries, researchers, academics, Peace Corps volunteers, diplomats, and so on. They are referred to as *azungu* (*mzungu*, sing.), meaning "white people" and, in fact, when a *mzungu* is walking through a rural village or even shopping in a city market, he or she will inevitably hear the chants of youth yelling, "*Mzungu, mzungu*!" However, even a black person from Europe or the United States is called *mzungu* if their nationality is known. This is because cultural heritage and behaviors are far more important than skin color in classifying people, though skin color is the easiest and most obvious sign for initial classification.

Azungu, as a group, represent the most economically wealthy ethnic group in the country by virtue of their employment and their control over resources. They typically have tremendous material wealth much of which is often brought into the country rather than purchased locally. They have contacts outside of the country, for example, family and employers, which enables them to bring scarce resources into the country. Because of their greater wealth, they hold quite a bit of power in negotiating needs and desires. For example, white skin is a ticket for immediate access to health care.

They form tight social circles which are described by the *azungu* residents themselves as "impenetrable." They socialize mostly among themselves based upon employment connections. For example, those working in the tobacco industry will mostly socialize among other tobacco workers. Social activities largely occur in their homes or at private country clubs. They employ Malawians as domestic labor in the home to work as cooks, nannies, maids, gardeners, and "houseboys." For some *azungu* these employee/employer relationships are often a topic of major discussion in their social gatherings.

I did not know personally of any case of intermarriage between an *azungu* and an African or Asian, though such marriages occur. And some *azungu* such as American Peace Corps volunteers were known to date Africans. *Azungu* who resided in the country for work in aid organizations or in the Peace Corps or as researchers and academics were less insular and would socialize with Africans.

The majority of *azungu* appear to be Christian and, indeed, there is a lively missionary presence in the country. They practice bilateral descent and maintain strong ties to their countries of origin, typically Great Britain, though Dutch, Canadians, Americans, Germans, Greeks, Portugese and other nationalities are represented. There are also a sizeable number of *azungu* from other African nations, especially Zimbabwe, South Africa, and Zambia. These *azungu* may hold British passports, if eligible, for security. A British passport allows them to leave Africa for residence in Great Britain should the need arise. *Azungu* send their children to private schools or boarding schools locally or abroad.

CLASS

While ethnicity is the most clearly visible marker of status and well-being, class is far more significant. Lwanda (1997:20-21) delineates the class structure as classified by Malawians and as spoken about in everyday language among Malawians. The first two broad class groupings are *anthu wamba* (ordinary people; non-elites) and *abwana ndi adona* (masters and madams, i.e. those able to employ others; elites).

Among the *anthu wamba* are those who are able to survive on their own labor, the *anthu wamba opeza bwino*, and the poor, the *anthu wamba osauka*. The *anthu wamba opeza bwino* "include lower scale civil servants, other salaried employees like teachers, small scale farmers, salaried industrial and agricultural workers, artisans and craftsmen and women, skilled tradesmen, some small enterprise business people and junior civil servants, and others of middle peasantry" (Lwanda 1997:21). Lwanda estimates that this class represents approximately 20% of the Malawian population.

The *anthu wamba osauka*, or poor, comprise the vast majority of Malawian society; Lwanda (1997:21) estimates 74.5%. They are the subsistence farmers and fishermen, unskilled laborers, urban squatters, beggars, under- and unemployed.

The elites owe their status to their education, business ties, or political standing. They may also be divided into two sub-classes. The *abwana ndi adona achikulire* "are the big landowners, big businessmen and women, professionals with business interests, senior police or army figures with business interests, some traditional figures with business interests, estate owners, politicians, parastatal bosses, big Non-Governmental Organisations' (NGOs) and multinational company representatives, and other agrarian or industrial based bourgeoisie" (Lwanda 1997:20). This obviously is the ruling political and economic class, comprising approximately 0.5% of the population (Lwanda 1997:21).

The second elite sub-class, *abwana ndi adona opeza bwino,* is comprised of the professionals who may or may not have business interests, mid to higher level civil servants, executives and higher clerical officers of companies, salaried employees with NGOs, small estate owners, and medium-sized farm owners. In Lwanda's (1997:21) estimate, they represent 5% of the population. Nearly all *azungu* and Asians belong to one of these two elite sub-classes.

Class mobility is limited, except downward, where the *anthu wamba opeza bwino* are always at risk of becoming *anthu wamba osauka*. Illness, disability, loss of employment, or some other disaster can easily destroy a person's ability to be self-supporting. More difficult is to achieve upward mobility particularly from a non-elite to elite status. A good education might, for example, allow someone upward mobility by opening doors to well paid employment. Lwanda (1997:22) notes, though, that business and political connections, where patronage ties are formed, are far more important to class mobility. Indeed, it does not take long to realize that connections, patronage, are keys to accomplishing most anything in Malawi. Everyone, including *anthu wamba osauka*, is aware of this and, when given the opportunity, seek to establish such ties for future use. Thus, I frequently had people requesting "notes" from me to take to the hospital in the hopes that a connection to me would provide access to scarce health care.

It also needs to be mentioned here that, while *anthu wamba opeza bwino* may be classified as being self-supporting, they are not, of course, simply self-supporting. They must support a vast number of relatives so that their wages are spread across a large number of people, the wages diluted in their ability to purchase adequate food and housing. For example, Mr. Mataka, for the brief time under my employment an *anthu wamba opeza bwino*, was under constant stress to support his relatives. Despite his brief, high salary he could not save funds for the day he knew he would no longer be employed by me. He had too many relatives dependant upon him.

ETHNIC AND CLASS RELATIONS

At first glance, ethnic relations among Africans, *azungu*, and Asians appear much like the Kenyan world so controversially described by Shiva Naipaul (1979). The three broad ethnic groupings are highly segregated and myths and stereotypes about each are common. At a deeper level, tensions exist among Africans themselves and class is often the more salient cause of tension.

If one were to describe the hierarchy of ethnicity, *azungu* would be at the top of the pyramid, with Africans at the bottom and Asians in the middle. Regardless of actual wealth, *azungu* command respect. White skin brings one to the beginning of the line at a hospital. It brings quicker services at banks or restaurants. It brings polite treatment from passersby. Regardless of age, adult *azungu* are called "madam" or "master." And my infant daughter was being trained for such a life, playfully being called "madam" by Jane, her nanny.

I was under the impression that Malawians were extremely kind to everyone, for strangers would greet me and admire my daughter. But my research assistants and household help informed me that this was because I am white and had a baby. Rose stated, "We Malawians aren't nice to each other." While this seemed an exaggeration, *azungu* did receive more favorable treatment. In fact, an elderly African American Peace Corps worker said it was not uncommon for her to be treated rudely on the street unless and until passers-by would hear her speak and realize she was a foreigner.

This ethnic hierarchy was made clear to me during a visit to Lilongwe Central Hospital. Anna, my daughter, was experiencing stomach pains among other symptoms. We visited the paying section of the hospital and the doctor ordered an abdominal x-ray. When I went to the payment desk with the doctor's order, I was told an x-ray could not be done that day because they did not have the receipt booklet to note my payment. A doctor did not come to work and the receipt booklet was locked in his office. Incredulous with this situation, I argued with the clerk. She finally told me to go and have the x-ray without paying. While waiting in line for the x-ray, I chatted with the Asian woman in front of me.

After telling our stories of getting treatment, she said, "In this country, the whiter your skin, the better your treatment." She told of an elderly villager who walked for four hours to get an x-ray only to be told to return tomorrow because they could not give him a receipt. Not having sufficient status to argue, he left the hospital without his x-ray.

For most Malawians, it is enough to know that one is *azungu* or Asian to be accorded respect and privilege. And the worlds of the *azungu* or Asian and the poor African shall never mingle, as described in Chapter 2 when I inadvertently violated this social apartheid[14] by inviting some of my informants for dinner.

While there are moments of understanding and empathy, the ethnic groups hold fast to stereotypes and myths about each other. White expatriates repeatedly chastised me for allowing my daughter's nanny to take her to the "servant's quarters" because it was dirty. When it was my turn to purchase the household stock of beer, I came home with "brown" rather than "green" Carlsberg beer[15] (the only two beers, other than traditional beer, available in Malawi), because the "green" beer tasted weak to me. My adopted *azungu* family was clearly uncomfortable with my purchase and refused to drink it, but denied anything was wrong. I finally got the husband to confess. Africans drink "brown" Carlsberg and *azungu* drink "green" Carlsberg. When I asked if he honestly liked the "green" better than the "brown," he admitted that he preferred the "brown" but could not be seen drinking "brown" in front of their friends. I had to consume the entire case myself.

---

[14] I borrow this term from Bourgois (2002) who uses it to describe segregation in the United States.

[15] Brown and green, the nicknames of the two beers, referred to the color of the bottles.

African Malawians had their expectations of Asians and *azungu*, too. When I came home from the market with a bag of okra for dinner, Jane and Isabel were confused and one finally asked, "Did you buy this for us?" I said they were for me, but I was happy to share. They told me that *azungu* do not eat okra and were surprised to learn that there was an entire region in the United States where white people happily consumed okra. Jane and Isabel also would tease my daughter for having an Indian father. They would say to her, "Ah, your daddy is an Indian man! You are an Indian!" and then laugh hysterically. Anna did not understand what they were saying, but enjoyed the laughter. When I asked why they found this so amusing they explained that Indians were harsh employers and so they found it ironic that they were now caring for a child of an Indian. The irony was in the fact that they considered me a kind employer.

And, ethnic tension among Africans also existed. My research assistants would tell me stereotypes of the different ethnic groups. Mr. Mataka, a Yao, took great delight in reminding the others that the country's current president was a Yao. It was commonly known that one would receive quicker treatment at the hospital, in fact any treatment at all, if one happened to get a medical assistant from the same ethnic group. And I suspect that the tension that existed between Jane, a Tumbuka, and James (the cook), an Ngoni, was at least partly due to the Ngoni's subjugation of the Tumbuka. This ethnic tension was fostered under the rule of Banda, as is described below.

Living and working in the world of the African and *azungu* took an emotional toll. It became difficult to remain loyal to both sides, for their interests were so diametrically opposed to each other. It may seem obvious to place all blame and direct all anger towards white expatriates. Yet I came to love the couple with whom we lived. They became our family and second parents to my daughter. They are good people as are most of the *azungu* living and working in Malawi.

Reconciling these feelings with the blinders many had for the suffering and inequities abundant in the country was difficult. Social relations and economic disparities were so distorted and unfair that, I suspect, the only way one could survive emotionally would be either to distort one's own perceptions of conditions, as they did, or to leave. Thus, the poor African Malawian did not "feel" things the way whites do. They do not "grieve" the way whites do. They are somehow "different," even less, than whites. To think otherwise, to know the truth of the matter, that the woman you employ and who knows more about you than your own husband may ever know, suffers terribly when her child dies, would be unbearable, I imagine. Even more unbearable to know that your collective actions perpetuate the exploitation that led to that death.

Just as difficult for me to comprehend were the inequities and exploitation wrought by Africans themselves. Exploitation was not simply along ethnic boundaries. The working-class and poor African understands that class is an even more incisive factor in determining privilege and status. As so often happens, ethnicity was a proxy for what was really ultimately a matter of tragic class inequities. A small segment of African Malawians have perpetuated the inequities established during colonialism, consigning the majority to struggle for their basic needs. This will be apparent in the following discussion of colonialism, neo-colonialism and tyranny.

COLONIALISM

How did Malawi come to be in such a state of poverty and ethnic and class tension? The seeds of Malawi's present state may be found in colonialism, neo-colonialism, and dictatorial rule.

Colonialism is, fundamentally, domination and exploitation. European powers dominated and exploited nearly all of Africa, extracting its resources including the labor of its people. Malawi was no exception. Colonial rule began with the establishment of the Nyasaland Protectorate by the British in 1891. The objective of colonial administration in the Protectorate was the creation of commercially successful British settler plantations, the procurement of sufficient labor to achieve that success, and the collection of revenue to administer the colony (Kaunda 1992:51; Williams 1978:58-60). And, of course, the objective of the Christian missionary colonists was the collection of souls.

Colonial rulers forced the colonized into the cash economy through taxation, even though the colonized never received any services for their taxes. In order to pay taxes, people had to seek wage labor. Colonial rule in Africa was diverse, depending upon the exploitable resources of the particular region. Malawi had few mineral resources and, thus, became what Samir Amin describes as "Africa of the labor reserves" (Amin 1972). People either worked on the settler plantations in the south of the country or migrated to South Africa, Northern Rhodesia (now Zambia), or Southern Rhodesia (now Zimbabwe). By 1960, there were 400,000 Malawians working in South Africa and Zimbabwe, nearly 100,000 in Zambia, 20,000 in Tanzania, and 5,000 in Zaire (Mandaza 1992:xii). These massive migrations caused severe disruptions to traditional family life. For example, Malawi has a divorce rate of 40% to 65%, among the highest in Africa (Reniers 2003).

The Malawi economy today, thus, may be seen as the outcome of colonial policies:

> A settler-dominated and outward-oriented agricultural export economy was created. Local industrialisation was severely limited. The Nyasaland economy was therefore vertically integrated with that of the rest of Southern Africa as a labour pool for the mining industries, and with that of metropolitan Britain as a raw materials supplier. Internally, the economy was unintegrated. The settlers imported their manufactured consumer goods: there was no local manufacturing industry. The peasantry grew subsistence crops, and a little of the cash crops, which they sold either through colonial marketing boards or through European estate owners. Cash crop production was geared solely towards the export of raw commodities. Apart from their minor cash cropping role, the African peasants were seen as a little more than a source of labour for the settlers and for the mines elsewhere. A distorted and dislocated economy, with firm links with the international capitalist economy in which Britain was a major actor, was therefore in place. (Kaunda 1992:51)

The settler colonial government was overtly racist, inflicting indignities upon Africans under their rule. For example, the colonial government enforced the *thangata* system, a form of forced labor. Laborers were forced to work on settler plantations without compensation for two months or more per year in exchange for "rent" on the land the laborers occupiedBland stolen from the laborers by the settlers. Any opposition to coloninal policy was suppressed and colonial rule was maintained by detaining without trial opponents. People often imagine that colonialism in Africa was achieved primarily through violent domination. In actuality, colonial domination was achieved far more thoroughly and effectively by altering peoples' perceptions of themselves. European hegemony in Africa was the most pernicious and far reaching form of colonial oppression and exploitation. Hegemony goes beyond political and economic domination to include the ability of the ruling class to project its own perceptions and worldview upon the dominated.

The dominated come to internalize and even imitate the oppressor's views of what is "natural" and "true" (see Forgacs 2000, Ngugi 1981). Unlike ideology, hegemony is subtle, pernicious, and elusive, transforming people psychologically, morally, and culturally. The rule of Hastings Kamuzu Banda is a prime illustration of the ramifications of colonial hegemony to the post-colonial nation.

NEO-COLONIALISM AND TYRANNY

Malawi gained independence in 1964 and Hastings Kamuzu Banda became its first leader. Banda was born in the late 1890s and pursued an education through missionary schools, eventually being sponsored by the African Methodist Episcopal Church for schooling in the United States. He earned a bachelor's degree in 1931 from the University of Chicago and a medical degree in 1937 from Meharry Medical College. He moved to Great Britain where he established a medical practice first in Liverpool and then in London. In London he became active in the independence movement, establishing ties with other African expatriates such as Kwame Nkrumah.

In 1953, Banda moved to Ghana at the invitation of Nkrumah and practiced medicine until 1957. At the urging of political activists in Malawi, Banda returned to Malawi in 1958 to help lead the independence struggle. By 1964, Malawi achieved independence and Banda was appointed Prime Minister.

Almost immediately, the independent nation faced a cabinet crisis when several government ministers, concerned about Banda's leanings toward dictatorial rule, challenged his authority. Banda dismissed the ministers, who went into exile, and began the process of transforming the government and consolidating his personal rule. In 1966, he declared Malawi a one-party state and in 1971 he declared himself the Life President. He held this Life Presidency until 1994 (see Lwanda 1993 and 1997 for thorough analyses of Banda).

To achieve total control of the nation, Banda established the Malawi Young Pioneers, a paramilitary group which served as an intelligence network, intimidating and rooting out any possible opponents. He manipulated the legal system to further consolidate his control of the country, maintaining the colonial practice of detention without trial. Anyone deemed a threat to his power was imprisoned. Those imprisoned endured torture and atrocious conditions, many dying while imprisoned. And the death sentence was handed out liberally (see Mpasu 1995 for the account of one political prisoner). Other opponents died in mysterious car accidents and opponents in exile were hunted down and killed.

Banda's 30 year rule is a litany of brutality. He persecuted Jehovah's Witnesses because of their refusal to join his political party, a universal requirement. The religion was banned and its adherents murdered or forced into exile. He elevated the status of his own ethnic group, the Chewa, by banning other languages and establishing chiChewa as the official language. He purged particular ethnic groups from government employment and he banned Asians from owning land in all but the four urban areas. He established the Forfeiture Act which allowed the government to seize the property of anyone suspected of economic crimes, an executive act with no right of appeal, further consolidating his hold over the nation (Africa Watch 1990).

Particularly effective in maintaining power was Banda's control over the flow of information. Free discourse and expression were prohibited. The press and literature were censored. The expression of any view counter to Banda's was dealt with through imprisonment or murder (Africa Watch 1990). The result was a constant fear among the people. People were afraid even to express themselves openly within the family for fear of being reported to the police or the Malawi Young Pioneers. Zeleza's (1992) thinly disguised novel of oppression under Banda's rule portrays the extreme fear under which people lived.

Banda used his total power to amass a vast personal fortune. Africa Watch, in a report on Banda's human rights violations, wrote:

> The Malawian regime is deeply corrupt. Although the country is desperately poor, this is not the corruption of the junior official who cannot afford to feed his family. Indeed the civil service is remarkably clean and efficient. The corruption is at the very top and is so barefaced that it is never even called by its proper name. President Banda has used his position of political power to accumulate massive personal wealth. Thus the economic management of the country cannot be separated from issues of human rights. On the contrary, human rights abuses have occurred as a means of maintaining Banda in power in order to amass further wealth. (Africa Watch 1990:18)

Banda accumulated his wealth in much the same way his colonial predecessors did, through theft and the appropriation of his people's labor. He held power over two parastatal companies, Press Holdings and ADMARC, through which he acquired agricultural estates and controlled nearly every aspect of the economy (Africa Watch 1990). He secured loyalty and support through a system of patronage, in which he doled out favors and economic and political positions. For example, clients received absurdly low government loans to purchase confiscated estates.

Banda dictated even the most banal aspects of life, such as what people could wear. Men whose hair touched their shirt collar or who wore flared pants and women who wore pants or short dresses were imprisoned (or expelled from the country if they were not citizens).

Perhaps the most psychologically destructive aspect of Banda's rule was his maintenance of the illusion of African inferiority. At independence, to the dismay of his early cabinet, Banda refused to place Africans in positions of authority, claiming they were not yet ready for such responsibilities. He established Kamuzu Academy, an elite secondary school modeled on Eton, in which no African was allowed to teachBonly white expatriates were hired to teach. Additionally, the curriculum was decidedly Euro-centric; Latin and Greek were taught, but no African history or languages. During his 30 years in power, Banda never uttered a word in chiChewa in public, speaking only English while an official translated his speeches for the masses.[16] He had a penchant for wearing three piece suits and homburg hats.

---

[16] This fact, along with Banda's cruelty, was cited as sure evidence by many Malawians that President Banda was not the real Banda. A rumor circulating in Lilongwe was that Banda had a close friend in Ghana who killed Banda and took his identity. In their minds, there could be no other explanation for why a man did not speak his native language and treated his own people so horribly. A variation of this rumor was that Banda was really a *mzungu* from England. His light skin and his adoration of everything British supported this theory. Another rumor was that Banda gained total control of the country and amassed his wealth through the use of magic.

And, while Banda was clearly an Anglophile, he used traditional cultural features to bolster his image as the leader of his household, the nation. He organized women into the Women's League, whose function was to heap adulation upon Banda during public appearances and to enforce Banda's rules within the community (Mchombo 1998:24). He referred to women as *mbumba*, a kinship term meaning family, and to himself as *nkhoswe*, a kinship term meaning guarantor (Mchombo 1998:24), using language and kinship features to great psychological effect:

> In a matrilineal system, such as that of the Chewa, a man is responsible for the welfare of his mother(s), sisters, and their children, especially his nieces. These are collectively referred to as his *mbumba* (or family), and to them he is their *nkhoswe* (loosely translated as guarantor). *Mbumba* members are dutifully respectful of their *nkhoswe*, who is the most important person in the group. The choice of the label *mbumba* to refer to the women in Malawi, and Banda's self-appointment as their *Nkhoswe number one* underscores the neopatrimonialist nature of his regime. The subsequent incorporation of the women into the elaborate security apparatus, besides being expedient, exploited the psychology of kinship, especially in regard to the loyalty that a *nkhoswe* can expect to get from his *mbumba*. (Mchombo 1998:24)

The result was a personality cult, in which nearly every major public landmark was named after him, his picture was posted in every business, and he was always referred to by his full title: His Excellency, Life President, Ngwazi Dr. Hastings Kamuzu Banda. He was the only person in Malawi allowed to carry a fly whisk, a traditional African sign of power and authority. Those coming before him had to approach him on their knees. He demanded and received extreme obedience and respect.

In 1994, under pressure from the United States, Banda consented to multi-party elections and lost to Bakili Muluzi. This ended Banda's oppression, but not the consequences.

THE RAMIFICATIONS OF OPPRESSION AND EXPLOITATION

More than one hundred years of oppression and exploitation have surely exacted a toll upon Malawians. The writings of Fanon (1963, 1967) and Ngugi (1981) speak eloquently of the destructive nature of colonial oppression. But how did this colonial oppression followed by the autocratic brutality of Banda affect Malawians in their everyday lives?

Perhaps the most telling statement of Malawian behavior under repression is an interaction I had with a white woman who moved to Malawi when her home of Rhodesia switched to majority African rule and became Zimbabwe after a long, brutal war. Our conversation took place in 1994, a mere month after Malawi held multi-party elections and Banda was voted out of office:

> I: Are you originally from Malawi?
> R: No, I'm from Rhodesia.[17]
> I: Oh... I see, uh, why did you move to Malawi?
> R: Because it's the only place left where the African knows his proper place. But now that's changed and there's no place to go. I don't know what I'm going to do.

She sensed that Malawi's Africans would no longer be the subservient houseboys, maids, and gardeners to which she had become accustomed. The end of Banda's repression had opened up the possibility of Malawians asserting a different, less obsequious identity. For her, Malawi was the last of Africa's nations to keep the African where she felt he belonged.

---

[17] Her use of the country's old name, Rhodesia, a full 20 years after it had been changed to Zimbabwe, was a blatant political statement.

I suggest that one hundred years of oppression, exploitation, and brutality, have forced Malawians to adopt a range of accommodative behaviors and attitudes in order to survive. First, Malawians have limited expectations of their abilities to transform and direct the course of events, borne of experience. Having been groomed in a society in which their interests are subordinated to that of the elites, they have limited avenues through which they may influence the course of events. Second, the extreme poverty in which the vast majority live and the constricted opportunities found in such a repressive system generates low expectations of what life may offer.

At a superficial level, Malawians appear passive and fatalistic about their health. However, it quickly becomes apparent that they are anything but passive. As will be demonstrated in my analysis of their efforts to cure eye disease and blindness, Malawians expend a great deal of effort, within their constricted power, to effect a cure. Their efforts, however, are largely ineffectual because of the structure of the system in which they must operate. In order to be assured of achieving most anything in Malawi, one needs a connection, a "patron." And for the poor, such a "patron" is hard to find.

CHAPTER 4
MEDICINE IN MALAWI

The Malawi health care system is comprised of both indigenously-derived medicine and Western-derived biomedicine. In this chapter, I discuss the basic attributes of these two "medicines," particularly the features and interactions that most clearly influence an individual's, family's, and community's therapeutic practices.

INDIGENOUS MEDICINE

Practitioners

Morris (2000:214) describes the indigenously-derived medical system as pluralistic. He identifies two traditions: herbalism and spirit healing.[1] Each tradition emphasizes different etiologies and has distinct practitioners. Practitioners of both traditions are known generically as *asing'anga* (sing. *Sing'anga*).

The herbalist tradition is what Morris (2000:214) describes as the "classical" therapeutic system of Africa. In Malawi, the herbalist is the most common healer who uses

---

[1] Morris (2000: 214) notes a third tradition, stating only: "That there is a secular medical tradition with its own cultural logic, separate from both herbalism and spirit-healing, has also to be recognized. It revolves around what Richards described as 'blood, sex and fire' (1956:30, cf. Laguerre 1987:64-72) and is fundamentally concerned with 'balance'." Friedson (1996:67) writes, "The Tumbuka believe that health results, in part, from a balance in the body between hot and cold." More research needs to be conducted on this apparent humoral tradition.

his or her own herbal remedies for treatment. Their medicine (*mankhwala)* is used not only to heal illness, but also to effect other actions, as the following newspaper advertisement for *sing'anga* Bona demonstrates:

> The sing'anga Bona knows different types of medicine like: medicines to defend against harmful magic, medicine used for women, medicine to ensure successful business and increased profits, any type of disease found in people, medicine for cancer, medicine to attract or seduce the opposite sex, medicine used so that you will be loved, medicine to cure infertility, medicine to gain promotion at work, medicine to ensure that your tobacco crop is sold quickly and at higher prices at the tobacco market, medicine used so you can foretell dreams or through dreams, medicine to ensure passing examinations, medicine used to find stolen property, medicine to ensure your animals such as goats and cows breed prolifically, medicine to prevent all bodily diseases, a mirror used to screen if you have a disease or are bewitched or to discover who has done the magic (those who want to be screened with the mirror should come without eating any food), and medicine used to keep your money. DIRECTIONS. Board a Salima bus and get off at the transmitter at Mkwakwa Mbo. Ask where you can find Silcon Quarry road at Machilika. Ask for Chata school. This school is to the east so to the west of this school there are iron sheeted houses. So you can ask around these houses. For those who would like to be sent the medicines you can write enclosing a K50 note. ADDRESS. Tithane Gule wa Fiti, Chata F.P. School, P.O. Box 14, Chiwamba Kanengo, Lilongwe 4. The cost of medicines begins at K5. (Translated from Chichewa. The Democrat 1997:8)

Asing'anga provide medicine *(mankhwala)* for symptoms or needs described by patients, much as a biomedical physician does. They generally are not, however, concerned with etiology (Friedson 1996:50). They will, if necessary, diagnose a patient's problem using divinatory paraphernalia, as the above advertisement demonstrates (see Wendroff 1985:125-126n6).

The *sing'anga* may gain his or her knowledge either through training and apprenticeship or through a dream in which he or she learns of a medicinal concoction to cure a specific problem or set of problems. These dreams are brought to them by God or ancestral spirits (*mizimu*) and are considered a blessing. A person may not want to be called upon to heal, but if he or she has been called upon by spirits through a dream, there is little choice. For example, one blind informant was blessed by the spirits through a dream to heal. Her dream taught her of a medicine and she now heals with this medicine. However, she did not want to do so and it has affected her life. She was banned from her church, the Church of Central Africa Presbyterian, because it disallows members from practicing indigenous medicine and from communicating with spirits.

Sing'anga traditionally healed part-time, practicing agriculture or fishing, for example, as a source of livelihood. Today, though, an increasing number practice full-time. This was not the case in the 1970s when Wendroff (1985) conducted his research on indigenous medicine in Malawi. Today, it appears that the *asing'anga* have embraced capitalist medicine, making a living and profit from diagnosing and treating ill health. This transformation is understandable, considering the difficulties Malawians face in providing basic needs for self and family.

People now distinguish between those who have commercialized their healing practice and those who practice healing part-time:

> *Respondent:* Many of the healers of nowadays are not real because most of them are business minded and not helping people, but in those days when we were young there used to be real healers because we could see people getting healed, but not nowadays. There were some [healers] who had the spirits within them but they didn't come to rise as a group [and open clinics]. But they felt themselves being blessed with a gift of dreams. They can dream maybe of a certain medicine that can cure a certain disease but the spirit behind these dreams was not revealed [in order] to be performed in a public place as some healers are [doing now].
>
> *Research Assistant:* So it's like we can say that those that are silent, it's like they humble themselves in order not to be seen by all men..... [T]hose healers

> who treat people quietly, it's like they were possessed by the spirit but only that they didn't want to show off to people that they can heal like that. So maybe they just dream that the medicine for this disease is like this. So they just go there quietly and make the medicine and treat the people. While the other people who are common and are recognized as healers, they are the ones who want to show off that [they] should be recognized... as healers. And mostly it's like they take the healing thing as a business thing so that they should get money. So they make maybe tents, build houses, so that the people should be going there with money and be treated.

Sing'anga Bona, described above, represents a commercialized *sing'anga*. In another example, Dr. Zanga Phee, who bills himself as "Herbalist of the Century" has a large, well-maintained clinic with several buildings on the Lilongwe to Blantyre road. He holds a B.Sc. degree in engineering. In 1988, he dreamt of the ingredients to make a drug capable of curing several conditions and of providing luck and protection. He named his drug AMulti-Purpose Drug 1988" and opened a clinic where he produces and sells it. His business card describes, in English, the capabilities of his medicine:

> MULTI-PURPOSE DRUG 1988 A Threat to H.I.V. and AIDS, Asthma, Cancer, Diabetes, Gout, High Blood Pressure, Monthly Periods, Piles, T.B., Ulcers, Multi-Purpose Charm, (Luckies Charm ever existed) Business Promotion, General Lucky, Examination to University-Body and Home Securities, Name it.

The fact that his card is in English and that he maintains a rather extensive clinic demonstrates the higher socio-economic class of his patients. At the opposite extreme, the blind informant described earlier, who was unwillingly called upon by the spirits to heal, has not commercialized her healing practice. She provides her services for free, though patients will give her small gifts. She does not wish to profit from the blessing of the spirits, despite her extreme poverty even by Malawian standards.

Most *asing'anga* charge for their services. However, the commercialized *sing'anga's* fees can be quite steep, preventing poorer people from utilizing their services. In fact, many informants said they could not afford to go to a *sing'anga*. Traditional, part-time *asing'anga* charge a small fee and will often accept a "gift" such as food as payment. Also, informants state that some *asing'anga* adjust their fees according to the financial circumstances of the patient. Poorer patients will be charged less for the same service as wealthier patients:

> Like me, I can go to African medicine and you can go to African medicine but together we have got [the same] problem. [The *sing'anga*] can charge me half of the rate but [you she] can charge more money. So someone can come to us and say, "How much that *sing'anga* charge you?" and I say K75 and you say K700.

The second type of indigenous healer is the *nchimi* or spirit healer. The *nchimi* gains his or her healing expertise when he or she is possessed by spirits. The *nchimi* makes and prescribes *mankhwala* as does the *sing'anga*. The *nchimi*, though, is particularly adept in diagnosing and healing witchcraft related illnesses.

The *nchimi* diagnoses complaints in one of either two ways. The first is through a public "choir ritual" (Wendroff 1985: 102) where patients and their guardians assemble to sing Christian hymns and traditional songs. The singing transforms the healer into a state that allows him or her to divine etiologies. The second is through the *vimbuza*[2] dance, also a

---

[2] *Vimbuza* are spirits of "others" or outsiders. *Vimbuza* protect people who have been attacked with magic by possessing them and making apparent the magic. Though *vimbuza* are a cause of illness, it is a protective, beneficial illness. Friedson (1996:64-65) in his research on Tumbuka *nchimi* provides an interesting discussion of *vimbuza*: "These spirits who both help and afflict, are a kind of catch-all category that includes any spiritual entity not directly descended from the Tumbuka. It is the distinctive feature of foreignness, the status of being the "other," that groups the many different kinds of *vimbuza* spirits into one category.... By far the majority of

public divinatory ritual. Patients and guardians sing Christian hymns and traditional songs, which are accompanied by drumming and clapping. The healer dances vigorously and enters a trance state during which diagnoses are made. After these diagnostic rituals, the medicine is distributed to the patient or patients.

There are fewer *nchimi* than *asing'anga* and they tend to have facilities for inpatients. Patients may stay with the *nchimi* for a considerable time, sometimes up to a year. While they are experts at healing witchcraft related illness, they are sometimes suspected of also providing malevolent medicine.

A third type of indigenous practitioner is the *seketera*. *Seketera* specialize in finding witches (*wafiti*), punishing them with death or illness, preventing them from eating or exhuming dead bodies, and in diagnosis and prevention of magic (*juju*). Because their skills are a form of sorcery, they walk a fine line between good and evil. They know how to produce both malevolent *mankhwala* and preventive *mankhwala* and so are both respected and feared (Wendroff 1985: 110). *Seketera* may also practice as *asing'anga*.

---

vimbuza spirits are from foreign peoples who, for various reasons, have come into contact with the Tumbuka. With only a few exceptions, they are not the spirits of individual persons but rather the spiritual energy of entire peoples. These spirits are, in many respects, a living history of the Tumbuka-speaking peoples of northern Malawi. The coming of ivory traders across Lake Malawi in the eighteenth century, the invasion by the Ngoni in the mid-nineteenth century, and the arrival of Europeans in the latter part of that century have all been incorporated into the pantheon of *vimbuza* spirits."

Mankhwala

Mankhwala refers to any substance with a vital force or potency capable of effecting change. This includes homemade remedies; a healer's medicines, charms, and amulets; malevolent magic; Western pharmaceuticals; and even agricultural fertilizer (Morris 2000:215). As such, *mankhwala*, in some form, is accessible to everyone and an integral part of everyday life.

The primary ingredients of the vast majority of an indigenous practitioner's *mankhwala* are plant products: roots, bark, fruits, leaves, or seeds (Morris 2000:215). The plant substances may be prepared and administered in several ways. An infusion may be prepared by boiling the substance in water. This infusion is drunk or, in the case of eye infections, dropped into the eyes. The plant substance may be chewed or boiled and the resulting essence blown onto the patient. Or the plant substance may be consumed in a porridge (see Morris 2000:220).

Some conditions or situations require a stronger *mankhwala*. In such a case, an 'activating agent' or *chizimba* (pl. *vizimba*) is added to the medicine. The *chizimba* is only one ingredient among other plant ingredients and provides additional strength to the *mankhwala*. *Vizimba* are usually animal or human products. *Mankhwala* containing *chizimba* is used for more serious ailments or complex issues such as the desire for success in a particular endeavor, protection against witchcraft, or the desire to harm or kill others. Such *mankhwala* is usually administered differently, being placed on the body or on the boundaries of the house or garden rather than ingested. Infusions, thus, may be sprinkled on the body, oil-based preparations rubbed on the body, or the ingredients may be burned and the ashes placed in incisions in the body (Morris 2000:220-221). Morris (2000:221) quotes a *sing'anga* to explain the difference between *mankhwala* with and without *chizimba*:

> *Chizimba* is a kind of medicine (*gulula mankhwala*). Its work is to strengthen (*kulimbikiza*) the medicine, so that it has power (*ndimphamvu*). Medicine without *chizimba* lacks power, and with it the medicine works on many ailments (*ntchito kwa matenda onse*). For example, in the treatment of rheumatism (*nyamakazi*), we take several (*mitengo*) horns together with a scorpion (*nankalizi*) and burn them (*kuocha*) and the ashes are applied to incisions on the person (*kuntemera munthu*) to cure the ailment (*imatha*). If a person is sick with large head (*mutawaukulu*), we cut various herbs into small pieces, and these we cook (*tikaphika*), together with the blood (*magazi*) of a chicken (*nkhuku*), which is the *chizimba*. For other ailments like stomachache and *kanyera* (a wasting disease affecting men) we do not use activating substances. For epilepsy (*chifufu*) we take various (*mitengo*) woody plants, and as *chizemba* we use the teeth (*mano*) of the warthog (*njiri*). Thus there is a difference between some diseases where we use activating substances and other diseases where no *chizimba* is used to protect the body (*oteteza thupi*).

The production and use of *mankhwala* is not limited to *asing'anga*. Most rural people know various remedies and prepare *mankhwala* to treat themselves or family members. If they do not know a specific remedy, family or friends almost certainly know one and will provide a recipe. These home-made remedies are not limited to plant-based *mankhwala*. Western pharmaceuticals are also purchased and altered. For example, a common self-treatment for some eye conditions is an eye drop made of a penicillin tablet dissolved in water.

Sources of Illness

In general, Malawians place more emphasis on personal circumstances than on "chance" in explaining misfortunes such as illness. While people may know the immediate cause of misfortune, they delve deeper to find the ultimate cause, which often is not chance.

At the most basic level, Malawians identify the ultimate source of illness as being from either ancestor spirits, magic, or God.

The spirits of one's ancestors, *mizimu* (sing. *mzimu*), may cause or send illness. *Mizimu* are immortal, representing the eternal existence of life and one's place in the continuum of life (Morris 2000:141). They need to be fed, honored, and obeyed. If one fails to obey their demands, has been negligent in honoring them, or has violated a taboo, then *mizimu* may send illness or even death to the transgressor or a relative of the transgressor (Friedson 1996:59).[3]

The most significant explanatory model regarding life's conundrums is magic. Magic is a ubiquitous phenomenon in Malawian life. It may be classed in two broad categories: that to cause harm, *juju*,[4] and that to protect from harm or induce positive results,

---

[3] Friedson (1996:59) provides an interesting description of *mzimu*-induced illness: "An example of this kind of displaced punishment is the case of a divorced woman who came to see Nchimi Chikanje because her son was sick and was not responding to treatment given both by a local healer [*sing'anga*] and by doctors at the mission hospital in Mzuzu. Chikanje 'danced the question' and divined the cause to be an illness sent by the boy's dead paternal grandfather. This *mzimu* was upset because the boy had dreamed that his grandfather told him to leave his mother and go live with his father. The mother took him to his father's village, but the father refused to accept the child. Chikanje stated that if the father did not relent and take the boy, then the child would die and the death would be on the father's head. The *mzimu* was upholding the moral standards of the community, since in the patrilineal society of the Tumbuka, children from a divorce belong to the father's lineage."

[4] Researchers discussing malevolent magic in Malawi have used various terms to denote it including *mankhwala uheni* (lit. bad medicine), *mankhwala woipa* or *akupha* (lit. bad or deadly medicine), *nyanga* (lit. horn of an animal; charms or potions, perhaps so named because they are kept in animal horns), *nsupa* (lit. gourd; charms or potions kept in a gourd container), *ntcheso* (medicine for killing people). My research assistants, some informants, and newspaper articles often referred to generic malevolent magic as *juju*, a West African term for malevolent magic (as well as a style of Nigerian music). The use of this term, perhaps, is recent in Malawi. I have chosen to use *juju* because it is how we commonly spoke of malevolent magic and is less cumbersome than *mankhwala woipa*. Also, the various other terms used do not appear to be generic terms for malevolent magic. For example, *nyanga* is used by Friedson (2000) and Wendroff (1985) as a general term for malevolent potions among the Tumbuka, but according to

mankhwala[5,6]. Its validity in at least some of its purported actions is accepted by most everyone, from the rural villager with no formal education to the government minister with a university degree from abroad. Newspapers regularly report suspected incidents of witchcraft (*ufiti*) demonstrating the widespread belief in it as an explanatory model:

> Staff of Mphompha Rural Hospital in Rumphi have deserted the hospital due to alleged witchcraft practices. Mphompha Rural Hospital situated only 25 kilometres from the main Rumphi District Hospital has eight medical staff members. It is alleged that witches have been torturing the staff in various ways at night. Some of the alleged incidents was [sic] the blood stains in one officer's house and a lizard with a beard found tied up and thrown into the only borehole at the hospital. A source said several consultations with the health committee and traditional leaders around the hospital have failed to identify those practising this witchcraft. The hospital source added that the staff vowed not to resume duties until they were satisfied that life has returned to normal at the place. . . . [Daily Times 1997:2]
>
> An unidentified woman, believed to be a Zambian, on Wednesday night sent scares and shivers among the players and officials when she incited the Zambia national soccer squad not to put up at Ryall's Hotel [in Blantyre], claiming it was awash with juju. The woman, probably in her mid-twenties, plainly told the Zambians that Ryall's was not among the best hotels in the country and that if the team spent the night there, that would mark the end of its search for the continental championship since the premises had been spread with juju to weaken its fighting spirit.... Team leader, Milner, responded by pressuring Football Association of Malawi (Fam) officials to immediately transfer his "boys" to Mount Soche Hotel.... While this scuffle was going on, all the players were glued to their seats in the Malawi National Council of Sports mini bus which ferried them from Chileka Airport. The players refused to disembark from the bus apparently fearing that by doing so

---

King and King (1992:26) it is the horn for containing ingredients either to bewitch or protect from bewitchment.

[5] Magic used for protection or to induce positive results, such as ensuring success in school or business is referred to as "medicine for X" For example, medicine for friendship and love is *mankhwala achikonda*, the root *konda* meaning "love" (Morris 2000:217).

[6] It should be noted that *juju* in the various parts of Africa have different roles and meaning. The term, as used in other parts of Africa, may denote benevolent or malevolent magic.

> they would step on ground which had been planted with juju.... [Chimwaza 1997:1]

Juju is used by witches, *wafiti* (sing. *mfiti*), or what Evans-Pritchard (1937) termed sorcerers, for witchcraft *(ufiti)* in Malawi is a choice, not an innate characteristic.[7] Any person may become an *mfiti* and use *juju*. Those who do not know how to make *juju* may purchase it from others. In fact, *asing'anga* advertise their ability to make helpful *mankhwala*, such as to help one succeed in school, a form of magic differing only in the morality of its intended purpose.

Wafiti are said to have extraordinary powers. They may fly great distances, change themselves into animals or other people, raise the dead to work as slaves, or make themselves invisible (Friedson 1996:52). They are also believed to have the loathsome habit of eating human flesh, as illustrated in the following newspaper report of a Lilongwe man accused of being an *mfiti*:

> A church elder and his wife, a dedicated member of the Women's Guild from Msonkhamanja CCAP [Church of Central Africa Presbyterian] church, were on Sunday, April 13, caught with a half-eaten baby at their house at Biwi by a witchdoctor. The man, a Mr. Kadetsa, who is also a bus driver, confessed to the police at Kawale police station that indeed he was a witch. "But I eat only my blood, and this two months old baby is my grandchild," he commented. One of the neighbours, narrating on how everything came to be revealed, said that a watchman who works near the house of the alleged murderer, saw strange things happening near the house. He could see women coming out of a banana tree-trunk every morning at 4 o'clock. He then alerted the neighbours who consulted the witchdoctor. The witchdoctor arrived and touched the trunk. He then told the fascinated crowd that had gathered that the trunk was used as the dining room by the witches but

---

[7] I have chosen to use the terms witch and witchcraft, rather than sorcerer, because Malawians use these terms when speaking English. Also, researchers writing about witchcraft in Malawi use these terms for the same reason (see Friedson 1996, Wendroff 1985, Morris 2000).

> meanwhile there was nobody inside. Then by his magic he split the tree into two and extracted the half-eaten baby as the crowd suppressed an urge to boo and a deathly silence followed. He then pointed an accusing finger on Mr. Kadetsa who didn't deny anything. He was later taken to Kawale police station in the company of the witchdoctor and the mob who were insisting on instant justice. The baby which was taken to the station in a sack was taken to the mortuary. A lot of members of the CCAP church from the neighbouring Masintha church came to view the lost sheep. "I had a premonition that today was not my day. Some inborn instinct told me I was going to have it thick today," Mr. Kadetsa said. The culprits disclosed that they had eaten half of the body the previous day and the remaining half was for dinner. Unfortunately in a twist of events they had been deprived of their feast on the baby. (Kayira 1997:2)

Magic may be the cause of disease or death. It may ensure financial success or trigger financial ruin. It may aid the acquisition of political power or initiate a fall from political grace. It may protect one's property from theft or one's self from the jealous machinations of others or it may give exceptional powers to wrongdoers. Stories abound about the use of magic. My research assistants and I once passed a village with a noticeably large population of goats running freely. Mr. Mataka explained that the owner of the goats protected his flock with magic so that if anyone stole or ate one of his goats, he or she will die. The owner died and now everyone is afraid to touch his goats, for fear they will die. The goats, now feral, run freely through the village, reproducing offspring who are also protected by the magic. The village has become well-known in the region and is now nicknamed "Goat Village." Newspaper articles also report on such uses of magic:

> Josefa Bikitoni Yolamu is one of the people whose facial appearance can wholly surprise physiognomists. It is a transformed human face which even his fellow villagers have difficulties to get used to seeing. "It needs courage for one to comfortably sit down and chat with him for quite along [sic] time," commented one of the people in the village when this reporter arrived at Yolamu's house in Mtemwende village, Traditional Authority Tambala in Dedza district for an impromptu interview.... Josefa Bikitoni Yolamu was born like any other person more than fifty years ago but has a painful story

> which dates back during his early twenties in his village. The story from the horse's mouth says that he unlawfully stole a cow in a kraal of one of the villagers who is now dead. "After eating the meat from the cow I stole, my handsome face started swelling and dropping down my chest," recalls Bikitoni sounding very regretful. He further adds that all efforts to have the problem reverse proved futile. Further investigations revealed that the deceased owner of the cow used some magical powers to punish Bikitoni. "Possibly he just wanted to turn him into a cow," suggested one relative who did not want to reveal his name. In July 1995, Bikitoni lost his sight due to an illness which nearly took his dear life away. "You know the devil is stupid, unkind... you see he tempted me to steal that cow," regrets Bikitoni while posing for a photograph.... [Chavunguma 1997:8]

Magic is considered a possible explanation in most every event, particularly the more perplexing ones. For example, Mr. Mataka explained the theft of my wallet from my locked and alarmed truck while I was leaning against the rear bumper on the rumor that the thieves in Lilongwe use magic. There were also rumors that Hastings Kamuzu Banda used magic to gain and maintain his political power (see Chapter 3).

For the most part, *wafiti* are believed to attack only relatives. A father may use *juju* to sacrifice a child in order to succeed in business, for example. However, there clearly is a fear that non-relatives might cause harm through the use of *juju* as illustrated by the newspaper articles on the hospital staff and Zambian soccer team being tormented by *juju*.

The most common reason a person may use *juju* on another, whether relative or non-relative, is because of jealousy. A person may use *juju* on another because of that person's financial or scholastic success, for example. Fear of being a victim of *juju* is a strong motivator to avoid conspicuous consumption and to share wealth with one's extended family. And it is commonly mentioned when commenting on someone's inappropriate behavior. For example, when driving through a remote area for interviews, we passed a home where a well-dressed woman was visiting. She wore a brand new, bright blue *chintenji*[8] and head wrap, bright yellow pumps, and carried a purse. Her clothing was so out-of-place in rural Malawi where most people don't even wear shoes let alone carry a purse, that all four of us in the car were stunned. Rose and Mr. Mataka both stated at once, "Oh, she's inviting *juju*, that one! Oh, oh, oh!"

Juju is also used to ensure one's success in business, school, or another endeavor, to avenge a wrong, or to bedevil an enemy. For example, Jane, my daughter's nanny, and James, the cook, constantly bickered and Jane was not shy about speaking her mind to James. Mr. Mataka, Rose, and Anita came to me one day to request that I speak with Jane. They feared that her outspokenness would lead "someone" to harm her with *juju*. The preparation of *juju* requires a *chizimba*, an activating agent.[9] Such an agent is usually an animal part or a human byproduct such as hair or urine. Human body parts are also used as *vizimba*. Newspapers regularly report crimes in which the intent is explicitly or implicitly attributed to the desire to procure human flesh for the preparation of *juju*:

---

[8] A *chitenji* is the rectangular cloth women wrap around their waist over their dress and use to strap children to their back.

[9] The ingredients of *juju* are not themselves poisonous in the way rat poison or insecticides are poisonous. The ingredients are harmful through their innate vital forces and their mixture together. *Juju* is distinguished from poisons. For example, young women in Lilongwe were said to be committing suicide by drinking rat poison, an act in no way associated with witchcraft.

About 23 dead bodies of infants at Zingwanga Cemetary in Blantyre, were exhumed between November last year and early January this year, according to reports reaching The Enquirer. The reports say that the bodies are being exhumed by unknown people around the township who are hired by some business people to use parts of the bodies for traditional medicine to boost their businesses. The "hired" people are reported being paid K150 per exhumed body and K350 extra if they bring clean body in time as per agreed. Blantyre City Council employees in the botanic garden near the cemetery who spoke on condition of anonymity, said that the tendency has been there for years, but it is only recognised by a few people. "I think it is so because these hired people always target their mission on the infants tombs because they are always dug by women as the custom demands and because they are always shallow," said one employee adding that these dead bodies are only wrapped in clothes and not in coffins which make their operation easy. Random interviews with some residents of Zingwangwa Newlines near the cemetery, indicates that the tendency has been there for so long. "We have been seeing people armed with pangas, shovels, hoes, and picks invading the cemetery during the night but none has developed the courage to question them," said one resident. Another resident said tombs mainly affected are those which are down near the Naperi river. Officials from Health Department at Blantyre City Council, said they are not aware of the tendency because nobody has referred the matter to them. ".... [D]on't quote me, but it is not true that dead bodies are being exhumed at Zingwangwa cemetery because we have our man responsible for cemeteries and he has never received any complaint," the official said. (Pinifolo 1997:1)

Five men who posed as good Samaritans to an expectant woman in Dowa on Saturday murdered her in a gruesome manner and made away with her foetus. According to Police Headquarters, 19-year old Elis Kasinkha was admitted to Mvera Hospital labour ward when on Saturday, five men convinced her and her guardian, Selina Chimwetu, 64, that the expectant woman would die if she delivered at that hospital. The five strangers told Chimwetu that the hospital did not offer enough care for expectant mothers and offered to take Kasinkha to another hospital in their car. Chimwetu and Kasinkha took the offer. However when they got to Dowa turn off on the Lilongwe-Salima road, the men stopped the car and ordered the two women out. Before the women knew why they stopped on the way, they hit Kasinkha on the head with an iron rod and she collapsed. Chimwetu fled. She reported the matter to nearby village headman Kayala who, together with other people, went to the scene only to find that Kasintha's stomach had been ripped open and the foetus removed. None of the five men was around and Chimwetu did not know the registration number of the car, according to Police Headquarters.... (The Nation 1997a:3)

Witchcraft, the accusation of witchcraft, attempts to ascertain if someone is a witch by means such as *mwabvi* (a poison ordeal, in which the accused drinks the poison and dies if a witch), and the making of poisons intended to harm others are crimes in Malawi by the "Witchcraft Act" of 1911. It was enacted by colonial administrators and has been maintained as law ever since. The intention of the Act ". . . is to prevent innocent people from being wrongfully accused and punished for actions which, by Western-scientific standards, are impossible for them, or any other mortal for that matter, to have committed" (Wendroff 1985:55). And, indeed, people do suffer when accused of witchcraft:

> A man accused in Nkhotakota of being a wizard was left homeless last Friday after his village went on the rampage, wrecking his home and throwing out his property. . . . [T]he entire village stormed the home of the accused and damaged 19 of his family's houses and numerous items all valued at K20,850, according to police (The Nation 1997b:4).

Despite the illegality of witchcraft and witchcraft accusation for nearly a hundred years, it continues to be a salient theory for one's perplexing misfortunes, including some illnesses.

That which is not caused by the ill-will of others or by one's ancestors is accepted as being the will of God. For some informants, God is perceived as punishing a person for failing to live according to his wishes. For the majority, though, God does not directly cause illness. Rather, God is the creator of all life and, thus, that which naturally occurs in life is ultimately from God (see Friedson 1996:42). Illness or conditions from God, then, are equivalent to Western notions of natural disease. People usually do not know specifically how an illness from God has occurred, much as many Westerners do not know what specifically has caused an illness.

It is important to note that one cannot predict the ultimate cause of a misfortune by the type of misfortune. Ultimate causality is arrived at over time through a combination of symptomatology, therapeutic experience, personal circumstances, and chronicity. Conditions that have sudden onset (or the perception of sudden onset) are more likely to be associated initially with *juju*. Common and widespread conditions such as malaria, measles, or conjunctivitis are more likely to be associated initially with natural illness. However, when measles leads to death or blindness, for example, thoughts of a more sinister ultimate cause are entertained. Likewise, when a condition proves resistant to indigenous or biomedical therapy and becomes chronic, *juju* is considered.

BIOMEDICINE

The presence of biomedicine in Malawi may be traced to missionary medicine first introduced by the physician and explorer, David Livingstone. Livingstone's Zambezi Expedition, from 1859 to 1863, brought the first Western (British) medical doctors to the area that would later become Malawi. Supported by the British government and the Universities' Mission to Central Africa (Cambridge, Oxford, Durham, and Dublin), the goals of the expedition were not medical, but rather the end of the slave trade and the spread of Christianity through the establishment of missions.

The medicine these doctors and nurses practiced had yet to be transformed by the important discoveries that distinguish it today. Western medical doctors had few effective medications, did not know the link between bacteria and infection or insect vectors and disease, anesthesia had only recently been discovered, and sterile surgical practices were yet to be discovered (King and King 1992:2). Many of the expedition members died of malaria and other maladies and their medical skills did not always outshine those of Malawians:

> Fleeing for their lives and hotly pursued, they reached the river bank about a cables' length ahead of our vessel, and plunged into the river. The woman in question, less fortunate than others, was struck down by an arrow as she rose to the surface. Entering just below the left shoulder blade, the cruelly barbed head passed into her lungs; and when Dr. Livingstone, Dr. Kirk, and Dr. Meller, saw her a few hours afterwards, it was decided by the council of surgeons that the attempt to extricate it would only add to her terrible sufferings, and cause her a more speedy death. Extraordinary to relate, the men of the village took upon themselves to do that which no one better versed in such matters dare justify for a minute. Fastening a piece of string to the iron head, they drew it back by main force, cutting off the entangled flesh from the large fang-like barbs, and actually repeating the same process as portions of the lung appeared! Our astonishment was complete the next day to find no fatal symptoms had set in. Each day I saw to her diet myself. She now came forward (twelve years later in 1875) to greet us, bringing me a present of a fowl, and from all appearances had shaken off the ill effects of a barbarous operation in every sense of the word. (E.D. Young 1877, quoted in King and King 1992:1)

Livingstone's expedition began the influx of missionary medical work, with Protestant and Catholic missionaries establishing clinics and hospitals throughout the region. The first colonial government doctor arrived in Malawi in 1891, primarily serving government forces, though also treating Malawians. The expansion of capitalist biomedicine within Malawi throughout the 20th Century is typical of its expansion in other colonial settings (see Vaughan 1991). Today, biomedicine is one option within a plural medical system.

Hospitals and Health Institutions

The modern government health care system is organized into three main levels of care: central hospitals, district hospitals and small health centers. There are four central hospitals, one in Mzimba in the northern region, one in Lilongwe in the central region, and one each in Blantyre and Zomba in the southern region. There are a total of 24 district hospitals. In the central region, where I conducted research, there are 8 district hospitals, one for each district except Lilongwe which houses the central hospital.

The Christian Hospital Association of Malawi (CHAM) coordinates the work of the various Christian churches providing health care services. CHAM developed from the World Council of Churches meetings in Malawi in 1965 to coordinate care and to serve as a liaison with the Malawi government. Eighteen Christian denominations are represented within CHAM, operating 20 hospitals, 32 primary health care centers, 83 health subcenters, 13 dispensaries, 1 mental health service center, 1 mobile unit, 2 health posts, and 13 health-related training schools (Kalinga and Crosby 2001:99; International Health Ministries Office 1998). In 1978, the Malawi government began subsidizing the salaries of Malawian professional staff working for CHAM centers (Kalinga and Crosby 2001:100). CHAM affiliated health care services represent 35% of the health services in Malawi (International Health Ministries Office 1998).

In addition to government and religious medical services, there are private clinics. These clinics typically are operated by medical doctors currently in government service, who have left government service, or have retired from government service. Their fees are steep and, thus, they cater to wealthier Malawians, Asians, and expatriates.

Medical Personnel

Medical personnel consists of physicians, medical assistants, nurses, and other allied health personnel. Physicians, until recently, had to be trained outside the country. In the late 1980s, the University of Malawi opened the country's first and only medical school and began graduating the first medical doctors in the mid 1990s.

The training of physicians is expensive, time-consuming and often a lost investment when the physician does not return to or stay in Malawi to practice medicine. Therefore, the vast majority of biomedical care is provided by nurses and medical assistants who receive fewer years of training within the country. Malawi has been training medical assistants and nurses since the colonial era, such training being a vital part of missionary activity.

There is an acute shortage of biomedical personnel in Malawi. Physicians and nurses leave the country for more profitable careers elsewhere or never return after receiving training abroad:

> Mrs. Kunkeyani, 36, is the stalwart nurse in charge of [Lilongwe Central Hospital's] main labor ward, where 10 overworked nurse midwives deliver more than 10,000 babies a year. But soon, she will vanish from this impoverished nation, joining thousands of African nurses streaming away from their AIDS-haunted continent for rich countries, primarily Britain. "My friends are telling me there's work there, there's money there," said Mrs. Kunkeyani, who will soon make in a day's overtime in Britain what she earns in a month in Malawi. "They're telling me I'm wasting my time here." The nursing staffs of public health systems across the poor countries of AfricaBgrossly insufficient to begin withBare being battered by numerous factors that include attrition and AIDS. But none are creating greater anxiety in Africa than the growing flight of nurses discouraged by low pay and grueling conditions. The result of the nursing crisisBthe neglect of the sickBis starkly apparent here on the dilapidated wards of Lilongwe Central Hospital, where a single nurse often looks after 50 or more desperately ill people. What is equally visible is the boon to Britain, where Lilongwe Central's former nurses minister to the elderly in the carpeted lounges of

> nursing homes and to patients in hushed private hospital rooms. (Dugger 2004)

Medical personnel also succumb to the same diseases as their patients: it is estimated that a quarter of public health workers in Malawi will be dead, primarily of AIDS and tuberculosis, by 2009 (Dugger 2004). And the country simply does not have the resources to train an adequate number of practitioners, even if there were no attrition or death of personnel.

For example, of interest to this research are the numbers of ophthalmologists and Ophthalmic Medical Assistants (OMAs) practicing at the time of research. There were only four ophthalmologist working in Malawi. Three were in government service and one worked at a private religious hospital. Only one of these ophthalmologists, Dr. Moses Chirambo, is Malawian. The others are expatriates, two of whom are on short-term contracts. The expatriate affiliated with the religious hospital was near retirement and planned to return to his home country after decades of service in Malawi. There were 40 OMAs. At the end of the research period, one of the OMAs trained in cataract surgery died and at least one of the district hospital OMAs planned to retire.

The shortage of medical personnel is not limited to ophthalmology. In a country of over 10 million people, there are only 124 physicians and medical officers in government service, the only biomedical care poor Malawians can afford. Table 23 lists physicians (by specialty) and medical officers in government service, clearly not enough to meet the needs of even a healthy, prosperous nation, let alone one plagued by disease and malnutrition.

Table 1

Government Physicians and Medical Officers

	Mzuzu Central Hospital	Lilongwe Central Hospital	Queen Elizabeth Central Hospital	Zomba Central Hospital	District Hospitals	Total
Surgeon		2	16	1		19
Dental Surgeon	1	2	1	1		5
Gynaecologist		3	6	1		10
Internal Medicine	1					1
Ophthalmologist		2	1			3
Pediatrician	1	2	12	1		16
Cardiologist (TB specialist)	2	1				3
Urologist	1					1
Anaethesist	1					1
Medical Officer	3	17	23	2	20	65
Total	10	29	59	6	20	124

(source: Ministry of Health and Population 2004)

The work of these biomedical personnel is supplemented by village health volunteers. These volunteers receive basic training in prevention of disease and in identifying disease. They theoretically serve as an important link in prevention education. However, in all my visits to villages for interviews and observations, the presence of village health volunteers and their influence upon community health was never mentioned. Thus, the vitality of this program is not clear, at least in the maintenance of eye health.

EYE CARE PROGRAM

The Eye Care Programme, a component of the government health service, is run by the Malawi government with support from several non-governmental organizations including Sight Savers International, International Eye Foundation, Operation Eye Sight, University of Canada, and The Lion's Club International. It was initiated by Dr. Moses Chirambo, the sole Malawian ophthalmologist. Dr. Chirambo's vision was to reduce the high rates of blindness through cataract surgery, medical treatments, and prevention. He lead the development of a rather ingenious program designed to bring eye care to the people and to strengthen medical resources such as training more health care personnel. The eye care program he initiated is based in Lilongwe and consists of three components: Human Resource Development, Ophthalmic Outreach Programme, and the Supply Programme.

Human Resource Development

Human Resource Development is the major and most well developed component. Ophthalmic Medical Assistants (OMAs) are trained at the Malawi College of Health Sciences in Lilongwe. OMAs are initially trained as medical assistants and then take an additional year of specialty training in ophthalmology.

Some of the OMAs undergo further training to become cataract surgeons. These cataract surgeons are important in addressing the major cause of blindness in Malawi since the four ophthalmologists in the country cannot cope with all of the surgical eye needs of the population.

OMAs are posted at each of the District and Central hospitals, where they maintain an out-patient clinic, care for in-patients, and conduct mobile eye clinics and health education in the outlying areas of their district. For example, they may travel to clinics and schools in search of eye patients for surgery and, while there, conduct an eye health talk. OMAs provide the vast majority of eye health care in both rural and urban areas.

In addition to training OMAs, the program also trains medical students from the College of Medicine, University of Malawi. Students may do a rotation of 2 to 3 weeks in Lilongwe in ophthalmology.

Ophthalmic Outreach Programme

The second component provides various eye services throughout the country. The major focus is on organizing teams of eye surgeons to conduct eye operations at district hospitals. Eye surgery dates are set for various hospitals and the OMA for that district recruits patients prior to the arrival of the team. Although the teams are capable of doing any eye operation, their major emphasis is on cataract surgery. In fact, in observations, only cataract patients were recruited for these surgery dates. Recruitment is done during regular outpatient examinations at the district hospitals as well as during special recruitment trips to rural clinics.

Initially, OMAs made routine trips to outlying villages in mobile eye unitsBLand Rovers equipped with essential medical supplies to care for most eye needs. This aspect of the programme was, in theory, ideal. It brought eye care to the people, circumventing one known barrier to seeking treatmentBthe need for patients to travel long distances to hospitals and clinics. Today, however, most of the Land Rovers are parked outside the Eye Programme headquarters, broken down and useless. The costs of repairing and maintaining the vehicles became prohibitive, an expense the program could not sustain.

This programme also operates regular eye clinics and operations at the secondary and tertiary level. OMAs hold clinic hours and see patients during the week. Theoretically, the eye clinics are open specific days and times. However, in actuality, days and times of operation are fluid and depend upon the OMAs obligations or commitments. For example, when I made an unexpected visit to one OMA, he shut down his clinic for an hour to visit with me and give me a tour of the facility, leaving a room full of patients waiting. He declined my pleas that he continue his work while I observed. And in another example, when I arrived to meet with the Salima District OMA, I found he was home sick and a general medical assistant was seeing the eye patients. The medical assistant insisted on closing the clinic to take me to the OMA's home, telling the waiting patients to come back the following week. I was able to convince him to remain at the clinic and see to the patients.

Prevention efforts are also a part of this component. This appears to be the least developed aspect. OMAs state that their prevention efforts consist of giving a group talk on prevention to patients waiting for care at the eye clinics. Village health volunteers are also provided training by OMAs to assist in identifying patients and in promoting good eye health practices. However, in interviews, informants never mentioned village health volunteers as providing assistance in maintaining eye health.

Research is also embedded in this component. Actual research, though, is minimal because staff is limited and is needed in the clinics. The programme simply does not have the resources to maintain a vital research component, meaning program evaluations and community eye health assessments and outcomes are rarely conducted.

Supply Programme

This component provides surgical and diagnostic equipment and consumables to OMAs working in the District and Central hospital eye clinics. The programme has three low-cost machines, one at each of the tertiary centers, to manufacture eye drops. Antibiotic eye drops made from chloramphenicol and gentamicin, dilating drops, anti-inflammatory corticosteroids, and diagnostic drops are produced. They do not have the technology to produce ointments such as tetracycline.

Despite this equipment, though, the eye care program has a constant shortage of pharmaceuticals. OMAs reported that they only had adequate supplies for a brief time in the early 1990s due to donations from NGOs. As a result, OMAs are forced to ration their supplies. For example, during a visit to a rural health clinic to see eye patients, an OMA diagnosed trachoma in a young woman who had her infant daughter with her. When asked why he also did not check the daughter for trachoma, he replied, "We don't have enough medicine for her." In fact, he did not even have enough tetracycline ointment to provide the mother the required full treatment of six weeks.[10] Patients visiting the district eye hospital clinics are given only a few days supply of medicine and asked to return to the hospital for additional medicine to complete their therapy. OMAs also practice triage medicine. As an example, a patient with trachoma was not provided medicine because he had a telltale sign of AIDS, Kaposi's sarcoma. He was advised to go to the District Hospital for help. The OMA

---

[10] He did not explain this to the mother nor did he explain how to prevent reinfection and that the rest of her family is likely infected. This lack of communication is discussed in Chapter 6.

did not want to use precious medicine on a person who would be dead before becoming blind.

RELATIONSHIP BETWEEN INDIGENOUS MEDICINE AND BIOMEDICINE

While these two "medicines" clearly derive from quite different epistemes (in Foucault's [1994] use of the term), one should be aware that for the Malawian seeking healing, these medicines are not thought of primarily as competing systems (see Wendroff 1985:82, Friedson 1996:49). The average Malawian understands biomedical diagnostic practices and therapies within the model of indigenous medicine (see Friedson 1996:49). Western medical personnel may draw upon indigenous theories of disease to explain cases not cured by biomedicine. Informants reported that they sometimes were advised by hospital personnel that their condition could not be treated at the hospital and to seek help from indigenously-derived medicine. Likewise, indigenous practitioners may utilize the symbols and pharmacopoeia of biomedicine. Friedson (1996:49), in his study of Tumbuka healers in northern Malawi, describes this syncretism:

> When a Tumbuka utilizes Western medical facilities, he or she does so within a traditional framework. X rays are conceived of as a kind of divination, and drugs such as penicillin and chloroquine are thought of qualitatively in the same terms as *mankwhala*, indigenous medicines. This conceptual framework has also engendered an interesting kind of appropriation of certain aspects and symbols of Western medicine by traditional healers.... One *nchimi* I knew, for example, would don a white doctor's frock he had somehow procured from the government hospital in Rumphi, and at 2:00 P.M. every day would make the 'rounds' of his patients. Other *nchimi* had collections of vitamins and antibiotics that they used as part of their pharmacopoeia. Nchimi Mulaula even claimed to be in touch with the spirits of Mzungu ['white', in this case biomedical] doctors who helped advise him on cases that were caused by God. Tumbuka healers and their patients see

> Western and traditional medicine not in opposition to each other but rather as forming a continuum.

While Malawians have integrated the two medical traditions into their health seeking behavior and do not perceive them as incompatible, they are aware that they do not derive, historically, from the same roots and that they represent different traditions and values. Thus, they are acutely aware that biomedical personnel do not approve necessarily of indigenous therapies. This leads patients seeking biomedical therapies to lie about prior therapy efforts. For example, as one sighted informant explained, if a patient has attempted self-treatment prior to going to the hospital, he or she is likely to lie to the doctor and state that a friend or healer provided the traditional medicine. This is to distance oneself from responsibility and to avoid being chastised by the doctor for attempting self-treatment.

CHAPTER 5
EYE HEALTH IN MALAWI

For this research, blindness is defined as a best corrected visual acuity of 3/60 or less in the better eye, meaning that an individual is able to read only, at 3 meters, letters large enough for a normally sighted person to read at 60 meters. This standard, set by the World Health Organization, is believed to provide a fairly good indication of functional capacity. Visual acuity at or below 3/18 is considered incapacitating to some degree. An individual's productivity and quality of life may be diminished, particularly without low vision aids and training.

However, such universally-applied definitions do not always resonate with an individual or group. A person's vision objectives and the context in which vision is used, including various political, economic, and psychological factors, will help shape whether a person considers him or herself incapacitated or merely inconvenienced. Likewise, this context will also influence the perceived seriousness of eye symptoms. And regardless of perceived seriousness, a person's response to eye symptoms is determined by his or her access to treatment options.

In this chapter, I examine Malawian conceptions of healthy vision based upon the context in which Malawians use their vision. I then describe the biomedical conditions significant in causing blindness. Finally, I provide Malawian lay classifications of eye conditions and compare them to biomedical classifications. Chapter 6 then integrates this information by describing what Malawians do to prevent and treat waning vision and troublesome eye conditions.

CONCEPTS OF HEALTHY VISION

Conceptions of healthy vision are not culturally unified and clearly stated. Healthy vision is far more linked to personal experiences and expectations than, for example, height and weight. As with notions of "normal": and "healthy" for general health described in Chapter 3, though, notions of healthy vision are remarkably forgiving in comparison to Western notions.

A lay definition of healthy vision is tied to functional capacity. As long as vision loss does not hamper a person's essential routines, it is usually not considered an acute problem. What are considered essential routines obviously depends upon the individual and his or her obligations and responsibilities. Since few Malawians are employed in work that requires seeing intricate detail and farming may still be done with quite poor vision, changes in visual acuity are typically not deemed serious until the changes are quite dramatic.

OMAs tell anecdote after anecdote of men and women who are clinically blind, but deny vision problems. For example, the Salima and Kasungu OMAs laughed when reminiscing about an elderly blind man who rode his bicycle to the clinic. They marveled at his ability to find his way along the road, but the man did not consider himself blind because he was able to carry out his normal routines. In another case, an elderly man did not seek help for his vision loss until he could no longer move about his village without a guide. When asked why he did not seek help sooner, he said he was seeing fine because he was still able to move about on his own.

Vision loss is considered a normal, though not inevitable, part of aging. Elderly do seek treatment for vision loss. However, elderly living within the extended family have fewer productive responsibilities so their threshold of tolerance for vision loss may be greater than among younger people whose productivity is still so vital to family survival. And those who are dependent upon a caretaker for health care may not receive treatment if the caretaker feels it is not worth the time and money to obtain treatment for a person they perceive as a financial burden.

Families with a history of vision loss may have an expectation of vision loss and, thus, do not seek treatment for what they feel is inevitable. Mr. Gondwe, the Salima OMA, describes one case:

> She is a girl of about 15 years old and she has got bilateral cataract. We have tried to convince her for almost three months [to have an operation]. She wants to be operated but the parents say no. They say her grandfather had the same type of thing and he died of it. And then the uncle of the mother had cataract as well, so he died of it. [They say,] "He just died when he had that cataract, so this [daughter] we cannot agree to operate on. It is just from our own clan so there is no problem." We have talked to them but they don't see it as a problem.

These notions of healthy, or more appropriately adequate, vision may be understood within a framework of a "hierarchy of problems." Amongst the many problems faced by the poor Malawian, waning vision is not an immediate concern, for the seriousness and long-term consequences of that waning vision are not fully contemplated. One may still functionBfetching water and firewood, cooking, farming, walking to the market, caring for the children, repairing the home, and yet have so many other concernsBtaking care of your child's acute illness, finding food for the next meal, harvesting the crop, obtaining money for school fees. This is most clearly demonstrated in the story of the Ntholo family. Both parents are blind and depend heavily upon the assistance of their three year old son. Their son, however, is clinically blind, something the Ntholos and their fellow sighted villagers did not know since he ably serves his parents. He is functioning at an acceptable level, so no one questioned the status of his vision.

On the other hand, during visual acuity testing of sighted informants, they often wanted to test my uncorrected vision for fun. Shocked by the results, they always considered me blind and marveled at how well I could function even though with corrective lenses my vision is normal. Indeed, 58% of the sighted people I tested had 6/5 or 6/6 visual acuity, giving the false impression that one was either blind or perfectly sighted in Malawi. Of course, refractive errors are a problem in Malawi, but the lack of people wearing eyeglasses in rural areas means many Malawians are not familiar with their importance in correcting vision and preserving functional capacity. More often than not, eyeglasses are considered an article of vanity and wealth like a wristwatch. And such a perception is a strong deterrent to wearing eyeglasses, for one risks being a victim of witchcraftBthe great socioeconomic equalizer.

BIOMEDICAL CLASSIFICATIONS OF EYE DISEASE

The etiologies of informants' vision loss were not easily determined. Informants rarely knew the biomedical classification and seldom stated a lay classification for their blinding condition. It is also highly likely that there were multiple factors leading to most cases of blindness. The only definitive causes of blindness were those cases associated with measles, for the link was unmistakable, and one case of retinitis pigmentosis diagnosed at a South African eye clinic. Some individuals also stated they had *sanga*, a Chichewa term covering both cataracts and corneal scarring. However, some people who clearly had cataracts because of their surgical history and aphakic lenses were adamant that they had never had *sanga*.

Following is a biomedical description of the leading causes of blindness in Malawi. These conditions are not the only causes, but rather the conditions most likely experienced by those in the research area. For example, onchocerciasis occurs in Malawi but is not a problem in the research area. Therefore, it is not described here. Also, the etiologies described here are the most direct causes of blindness. As is discussed later, there is a cascade of causes leading to blindness and these direct causes are not the most important factors for understanding the persistence of blindness or for preventing blindness.

Cataracts

Cataracts, an opacity of the ocular lens, are the greatest cause of blindness throughout the world, including Malawi where they are the cause of 40% of visual impairment and blindness (Chirambo and Tizazu 1983:1773). Cataracts are commonly associated with aging, though other conditions such as eye trauma and diabetes may also lead to cataracts. Excessive exposure to sun, poor nutrition, and repeated episodes of diarrhoea in early life are also associated with increased rates of cataract (Schwab 1990:43), all conditions endemic to Malawi.

Cataracts caused by trauma or other conditions are preventable through early detection and treatment and practicing eye safety measures. Cataracts due to age are not believed to be preventable (though improved nutrition and sanitation and minimizing ultraviolet light exposure would seem appropriate preventive measures), though are curable with surgery by removing the lens (Schwab 1990, Shock 1992). In wealthier nations, an artificial (intraocular) lens is implanted during cataract surgery. However, this is more expensive and, thus, the vast majority of cataract patients in Malawi must wear aphakic eyeglasses after surgery.

Conjunctivitis

Conjunctivitis, or inflammation of the conjunctiva, is the most frequent eye complaint worldwide. It is most commonly caused by infectious agents. All infectious eye diseases, combined, are the second leading cause of blindness in Malawi accounting for approximately 30% of blindness (Chirambo and Tizazu 1983:1773).

Bacterial Conjunctivitis: Bacterial conjunctivitis may be caused by any of a number of bacteria (e.g. *Neisseria gonorrhoeae*, *Streptococcus pneumoniae*, *Staphylococcus aureus*, *Haemophilus influenzae*). It is characterized by a profuse, pussy discharge, moderate tearing, and mild itching and infect one or both eyes.

Acute conjunctivitis caused by some bacteria such as *Haemophilus influenzae* may be self-limited, but can become chronic especially in malnourished individuals. Other bacteria, such as *Neisseria gonorrhoeae* or coliform (intestinal bacteria), may cause severe corneal damage leading to blindness. Gonococcal conjunctivitis and keratoconjunctivitis (corneal involvement) are serious infections in both newborns and adults leading to blindness if not treated intensively (see *Ophthalmia Neonatorum* below).

Bacterial conjunctivitis is easily spread. Flies may spread the disease from person to person by feeding off of the exudate. Self-inoculation occurs with genital bacterial infections. The sharing of clothing or wash cloths with infected persons also spreads infection. And the use of urine as a lay or indigenous treatment for some eye diseases may cause gonococcal conjunctivitis if the bacteria are present in the urine.

Prevention is through regular hand and face washing, not sharing wash cloths, prevention and treatment of sexually transmitted diseases, and control of flies. Treatment depends upon the specific microorganism causing infection, but includes topical and sometimes systemic antibiotics and frequent cleaning of the eye to remove the infectious discharge.

Trachoma: Trachoma is caused by the microorganism *Chlamydia trachomatis*. It is a chronic conjunctivitis usually first acquired in childhood. It initially resembles bacterial conjunctivitis. Severe scarring and shrinkage of the conjunctiva occurs over time leading to entropion (a curling inward of the lids). Entropion of the upper lid causes the eyelashes to scrape across the cornea, a condition known as *trichiasis*, resulting in severe corneal ulceration and scarring, bacterial infection, and incurable blindness.

As with bacterial conjunctivitis, trachoma is easily spread and all household members tend to be infected. Prevention efforts are the same as with bacterial conjunctivitis. Preferred treatment in Malawi at the time of research was with tetracycline 1% ointment applied to both eyes three times daily for six weeks.[1] Reinfection is common and all household members need to be treated to end the cycle of reinfection.

---

[1] Oral azithromycin treatment has recently shown promise in treating trachoma and minimizing reinfection rates. The oral drug has easier dosing (once a week for three weeks) and treats extra-ocular (e.g., nasopharyngeal, rectal, genital) *C. trachomatis* infection, believed to be the source of reinfection through autoinoculation (see Dawson et al. 1997, Schachter et al. 1999).

Viral Conjunctivitis: Viral conjunctivitis is caused by several different viruses, many self-limited in duration. The viral infection of greatest concern to this study is measles. The measles virus infects epithelial surfaces including those of the conjunctiva and cornea (Schwab 1990:109). Ocular symptoms typically occur before the familiar skin outbreak of measles infection and progress to keratoconjunctivitis. In healthy individuals, this is usually the extent of ocular involvement. In immunocompromised individuals, such as the malnourished, however, secondary bacterial, viral, and/or chlamydial infections occur causing severe corneal damage and vision loss (Schwab and Dawson 1992). This is discussed further in Nutritional Blindness.

Prevention is through measles immunization. There is no specific treatment except in immunocompromised patients with secondary infections, which describes the majority of Malawian children suffering from measles.

Ophthalmia Neonatorum: Opthalmia neonatorum applies to any conjunctival infection in the newborn. The most common is gonococcal neonatal conjunctivitis, which is spread from an infected mother as the newborn passes through the cervix and vagina. This infection causes corneal ulceration (see below) and blindness if it is not treated at once (Schwab and Dawson 1992:121; Schwab 1990:99-100). Other agents of ophthalmia neonatorum are chlamydia, staphylococci, pneumococci, herpes simplex virus, and *Haemophilus* (Schwab and Dawson 1992:121).

Allergic Conjunctivitis: Individuals with allergies such as asthma or hay fever may experience allergic conjunctivitis with its characteristic itching, tearing, and redness of the eye. Vernal conjunctivitis or keratoconjunctivitis is a severe childhood allergic disease more commonly affecting boys. Itching is severe and a stringy discharge and photophobia are present. Corneal scarring and vision loss or blindness may occur. This is a condition of particular concern to the OMA in Salima because his son suffers from it.

Prevention requires identification and avoidance of the allergen. Topical corticosteroids are used to treat vernal conjunctivitis. However, complications of corticosteroid use are severe (cataracts, glaucoma, opportunistic infections) and, therefore, the patient needs to be closely monitored, a situation often difficult to achieve in Malawi.

Keratitis with Corneal Ulceration and Scarring: Keratitis is the inflammation and infection of the cornea, which may be caused by any number of bacteria, viruses, and trauma. Systemic diseases such as Herpes simplex, syphilis, tuberculosis, leprosy, and onchocerciasis are all implicated. Symptoms include vision loss, pain, and clouding of the cornea.

Keratitis and other conditions may lead to corneal ulceration and scarring, a common occurrence in Malawi. Corneal ulcers are the eroding and infection of the cornea and lead to perforation, scarring, vision loss and blindness. They may be caused by viruses, bacteria, fungi, or trauma such as from trichiasis. Symptoms include pain, tearing, purulent discharge, red conjunctive, and vision loss. Scars are visible white spots on the cornea. Treatment for ulceration depends upon the specific cause. Vision loss and blindness from scarring may only be treated with corneal transplantation (keratoplasty). Keratoplasty is not an option in Malawi where there are few acceptable donors (due to AIDS and other conditions), inadequate medical facilities for storage of the eyes, inadequate expertise in the procedure, and too many post-graft management problems (Chirambo, personal communication).

Blinding Malnutrition: Vitamin A is vital for the growth and proper functioning of the cornea, conjunctiva, and retina. It is stored in the liver where it is released when dietary intake is insufficient. When there are not enough vitamin A stores, ocular abnormalities occur, collectively called xerophthalmia. Xerophthalmia includes drying of the conjunctival and corneal epithelium, called xerosis. In the severest stage of xerophthalmia, keratomalacia or the melting of the cornea occurs. This leads to permanent blindness.

Vitamin A deficiency and xerophthalmia are the result of malnutrition and illnesses such as diarrhoea, pneumonia, and measles which worsen a person's nutritional status. In Malawi, measles combined with vitamin A deficiency accounts for 15% of blindness (Chirambo and Tizazu 1983:1773). Night blindness is the earliest symptom of chronic vitamin A deficiency. Corneal xerosis leads to opportunistic infections by bacteria, viruses, and fungi leading to ulceration and scarring. If a child survives keratomalacia and the associated malnutrition, blindness is almost inevitable.

Prevention includes proper nutrition and measles vaccination. Treatment requires hospitalization and intensive therapy including vitamin A supplementation and antibiotic therapy to moisten the epithelium and prevent secondary infections.

Glaucoma: Glaucoma is responsible for 8% of blindness in Malawi (Chirambo and Tizazu 1983:1773). Intraocular pressure is excessive causing damage to the optic nerve and retina. Blindness from glaucoma is incurable, though vision loss may be prevented if treated early enough. Glaucoma may occur at any age, though rates increase with age. Medical management and surgery are used to relieve pressure and prevent continued vision loss.

Uveitis: Uveitis is the inflammation of the uveal tractBthe iris, ciliary body, and choroid. It is mentioned here because there are numerous causes of uveitis including several systemic diseases that are public health problems in Malawi: tuberculosis, leprosy, syphilis, AIDS, and onchocerciasis. All of these conditions may lead to blindness if left untreated.

Retinitis Pigmentosis: One informant was diagnosed with retinitis pigmentosis at a South African eye clinic. I suspected that two other informants, brothers, had retinitis pigmentosis because of their symptoms. It is a degeneration of the retina inherited as an autosomal recessive, autosomal dominant, or X-linked recessive trait. Night blindness and gradual peripheral vision loss are characteristic. Blindness cannot be prevented.

MALAWIAN CLASSIFICATIONS OF EYE DISEASE

Most Malawians have fairly detailed knowledge of the names and symptoms in the lay classification of eye diseases. The older the person, the greater their knowledge indicating the importance of life experience in gaining expertise. Following is a description of the eye diseases discussed by informants and those people surveyed:

Liwombo

Liwombo (translated as fontanelle) is a disease of infancy when the fontanelle is still present. The defining symptom is a sunken fontanelle which no longer "breathes" or pulses. The child is in pain and cries constantly. Infection may be accompanied by fever, diarrhoea, and a sore throat. The eyes are affected and become swollen. There is a bloody discharge and the child may not be able to open his or her eyes. The most commonly cited cause is *litsipa* or severe headache. The eyes are affected when the fontanelle sinks, because it puts pressure on the eyes or nerves to the eyes. A sighted informant describes it as such:

> When the baby is born, the liwombo sinks and when it sinks the eyes swell and maybe even blood comes out of the eye. I hear people say that the liwombo, when it sinks, beats the eyes or gets in forceful contact with the eyes. Children of the size of Anna[2] and below her [are affected by this disease].

OMAs associate this syndrome with xerophthalmia, malnutrition, dehydration, and concurrent infections. The only specific treatment mentioned was wearing bracelets containing medicine obtained from healers.

Nthola

Nthola is also a disease of childhood. Some define it as the ocular symptoms of *liwombo* while others consider it a distinct disease. *Nthola* is not as widely known as *liwombo.* The eyelids swell and turn outwards, the eyes become red, and there is a bloody discharge and tears.

---

[2] Anna, my daughter, was 12 months old at the time of this interview.

It is caused by the mother consuming too much salt, red pepper, or tomato during pregnancy. Three treatments were described. The first is to place herbal medicines in cuts (*mphini*) around the eyes. Second, the child may wear a bracelet containing medicine. Finally, the parents may chew salt, red pepper, or tomato leaves and then blow their essence into the child's eyes. The OMAs associate *nthola* with ophthalmia neonatorum.

Maso

Maso is a common, general eye infection. It causes redness, tears, purulent discharge, and pain. It is caused by flies, lack of cleanliness, eating too many beans, *litsipa* (severe headache), dust, and sand. Treatment includes: 1) eye drops made from penicillin tablets dissolved in water, and 2) eye drops made from water infused with herbal medicines. OMAs associate *maso* with general conjunctivitis.

Sanga and Ng'ala

Sanga and *Ng'ala* refer to the same blinding condition. A white spot, referred to as *mwana* (literally "child"), grows in the center of the eye. The eye may be cloudy and there is vision loss or blindness. The condition is often described as painful. The main cause is untreated infection with *maso*. It is also caused by *litsipa* and injury from a foreign object such as sand, wind, tree sap, or an insect. One traditional treatment is to put unspecified, small seeds in the eye which scratch away the *mwana*. However, informants stated that this was a treatment from the past and is no longer used.

OMAs associate this condition with both corneal scarring and cataracts. Informants descriptions clearly demonstrate that they do not distinguish between these two biomedical conditions. However, there are informants who had cataract surgery but state that they did not have *sanga*. They did not know the cause of their vision loss, though. Some attributed it to magic.

Nyangu

Nyangu begins with intense itching. Sores develop on the inside of the eyelid and the eyelashes bend inwards scratching the eye. The eyes are red and there is a discharge. Vision loss and blindness may result. Causes include *litsipa*, dust, contaminants in the wind, flies, poor hygiene, and untreated *maso* or *liwombo*. One treatment is to prepare an eye solution made from herbal medicines soaked in water. Other treatments are to wash the eyes and face with your urine or with water that doves have used for drink and bathing. *Nyangu* and trachoma are the same condition.

Nkungudza

Nkungudza is not as widely known. Many do not know it as an eye condition, but only as the name of a type of tree. The majority state that it is another name for *nyangu*. One woman stated that the *nkungudza* tree is used to make medicine to treat *nyangu*, which may suggest an origin for the term in describing *nyangu*. For some, it is a separate infection described as causing intense itching, tearing, and brown or red eyes.

One OMA associates this disease with allergic conjunctivitis. However, from informant descriptions it is more descriptive of a trachoma-like infection. One treatment is to wear bracelets containing indigenous medicines.

Sokera

Sokera is a swelling on the edge of the eyelids. It is considered a minor problem. The only stated theory for its development is that the sufferer refused to provide assistance to someone in need, especially a pregnant woman. It may be treated by wishing it upon someone else, soaking it with a warm compress and then squeezing it, or simply waiting for it to burst on its own. This is equivalent to the biomedical condition known as hordeolum or stye.

Table 2 lists the lay classifications of eye diseases, their biomedical equivalents, symptoms, etiology, and lay treatments.

Table 2

LAY CLASSIFICATIONS OF EYE DISEASE

Eye Condition (Chichewa)	Biomedical Equivalent	Symptoms	Etiology	Lay Treatments
Liwombo	xerophthalmia and concurrent infections dehydration	fever sunken fontanelle swollen eyes discharge from eyes unable to open eyes	When the fontanelle sinks, the weight of the fontanelle puts pressure on the eyes or nerves to the eyes causing disease. Headaches	Bracelets containing medicine worn by the child.
Nthola	ophthalmia neonatorum (conjunctivitis in children)	swollen eyelids bloody discharge red eyes	Mother consumed too much salt, hot pepper, or tomato during pregnancy. The ocular manifestation of liwombo.	Traditional herbal medicines placed in cuts (called *mphini*) around the eyes. Essence of salt, hot pepper, or tomato leaves blown into the eyes Bracelets containing medicine worn by the child.
Maso	general conjunctivitis	redness tears purulent discharge	flies lack of cleanliness eating too	Make drops from herbs soaked in water and drop in eyes. Make drops with crushed

		pain	many beans *litsipa* (severe headache) dust sand	penicillin tablets purchased at groceries and drop in eyes.
Sanga/Ng'ala	corneal scarring cataract	white spot in the eye cloudy eye pain vision loss blindness	maso *litsipa* (severe headache) injury	Put seeds in the eye to scratch away the *mwana*.
Nyangu	trachoma	sores on the eyelids eyelashes fall out or curl inwards itching pain vision loss blindness	headaches dust flies poor hygiene maso liwombo	Make drops from herbs soaked in water and drop in eyes. Wash face and eyes with human urine. Wash face and eyes with water used by doves for drink and bathing.
Nkunguza	trachoma allergic conjunctivitis	sores on the eyelids eyelashes	headaches dust	Wear bracelet containing indigenous medicines.

		fall out or curl inwards itching pain vision loss blindness brown or red eyes tearing	flies poor hygiene maso liwombo	
Sokera	hordeolum (stye)	swelling of eyelid	Refused to help someone, especially a pregnant woman.	Wish it upon someone else. Use a warm compress and then squeeze it. Let it burst on its own.

People were also questioned about specific conditions known to biomedicine as causing eye problems. The first three conditions are systemic diseases or conditions and were asked using the chiChewa word. The remaining conditions were asked using the English terms.

Chikuku

Chikuku corresponds to measles. It is known as primarily occurring in children. It is a systemic disease that also affects the eyes and may cause blindness if not properly and promptly treated. It starts with the eyes turning red. The person then becomes weak and develops a fever. Eventually, sores develop over the entire body including the eyes. It is highly contagious. The most well-known treatment for the ocular symptoms is to make an ophthalmic solution from *chewe* leaves (a common plant in the sesame family). A 36 year old informant describes the preparation of *chewe*: "They take the plants and pluck off the leaves, then put the leaves in a cloth and tie it. They soak this in water and then they squeeze it and drop the drops in the eyes." The majority of people do not know the cause of *chikuku*. Others state that it may come from God or magic.

Chilengweleza

Chilengweleza is a person with albinism. In one study in the Central and Northern regions of Malawi, the prevalence of albinism was 1 in 34,000 people, though this is believed to be an underestimate (Bar 1993:11). Everyone was familiar with the condition. Albinism was not considered a disease, but simply the "way God has made him" or "due to nature." Everyone knew that albinos have vision problems, especially sensitivity to light.

Khate

Khate is leprosy, a disease known to everyone. Everyone is familiar with the bodily symptoms, however, not everyone was aware that it may affect the eyes.

Cataract

Out of 177 people surveyed, only three had heard of the English term cataract. One woman who lived in Lilongwe and had completed Form 4 (equivalent to a high school diploma) stated it was the same as *ng'ala* and was caused by a long-term infection with *maso*. Another woman simply described it as a "whitish patch in the eye" and another woman stated it "can make a person become blind." Only one interviewee, a man who had received cataract surgery, had heard the term.

Trachoma

Twenty out of 177 people surveyed had heard of trachoma. Interestingly, 17 of these 20 lived in Lilongwe (two lived in Dowa and one in Kasungu). Ten of the 20 had never heard the chiChewa term *nyangu*. None of these ten were Chewa and, thus, although fluent in chiChewa it was not their first language. It is described as a disease common in the south of the country causing itching, sores, redness, curled eyelashes, and puss. It is caused by flies. Those who know *nyangu* never make an association between it and trachoma. Many have only heard of the disease, but do not know its symptoms or cause. Others state various causes such as hot weather, cataracts, tsetse flies, and dirty water. None of the sighted or blind people interviewed had heard of trachoma.

Glaucoma

No one interviewed or surveyed had heard the term glaucoma. There was no lay classification describing a condition similar to glaucoma, despite it being the third leading cause of blindness. The absence of a lay classification may be because of the absence of symptoms except for peripheral vision loss, and sometimes pain, gradually leading to total blindness. Given the nature of glaucoma, this type of vision loss may be associated with magic (see Magic below).

Vitamin A Deficiency

Of 177 people surveyed, 55 have heard of vitamin A deficiency. The most common description is feeling weak, being pale or yellow, and having difficulty seeing, especially at night. Two people in Salima mentioned the role of medical personnel at the hospital in teaching them about vitamin A:

> Sometimes you cannot see well and when you go to the hospital, they tell you that you are lacking vitamin A.
>
> I know this from the hospital. We receive tablets for this.

THE ROLE OF MAGIC IN EYE DISEASE AND BLINDNESS

As discussed in Chapter 4, magic and its practitioners are pervasive in Malawi. Given the importance of magic as an explanatory model for misfortune, people were asked about the role of magic in the misfortunes of eye disease and blindness.

While magic is given credence by most people at some level, not everyone believes it has a role in eye disease and blindness. Of the 177 people surveyed, 71 (40.1%) say magic may be responsible for eye disease and blindness. Eight people were not sure of the role of magic and the remainder say magic can not cause eye disease and blindness.

In deeper discussions with informants who dismiss the role of magic, it is apparent that Christianity has influenced their beliefs. They state that they are Christians and, thus, do not believe in such things. For example, in response to my asking if magic can cause blindness, one 80 year old woman stated,

> As I have told you earlier on that I have never visited a healer. Others, of course, maybe they can believe that their blindness is through witchcraft. I always tried to avoid this sort of suspicions that this person did this to me. I believe in God, so I don't believe in such things.

Some blind described an initial belief in magic when their eye diseases led to blindness, but then of letting go of the belief because it fostered hostility. A frequent comment by skeptics was that magic only created problems and hatred in the community.

However, many Malawians clearly do believe magic can have a role in eye disease and blindness. There are two situations in which it is deemed responsible for blindness. The first is when attempts to cure eye disease at the hospital, with biomedical pharmaceuticals bought from groceries, or herbal remedies do not cure the eye disease. In this case, the sufferer is seeking an explanation for the ultimate cause of their misfortune and the failure of treatments. For example, all people know that infection with measles *(chikuku)* may lead to blindness. They are aware that measles is a contagious disease common to children. However, this does not explain why someone contracted measles and why he or she is now blind. This question is sometimes explained by personal circumstances, for example the magic of a relative, as the following case demonstrates.

The Case of Helen: Helen is a 24 year old woman who has just completed Form 4 (year 12) at school. I interviewed both Helen and her mother separately. Helen became blind at the age of 4 years from measles. She does not remember having sight. Helen's first symptom was a very high temperature. She then developed sores over her entire body, which was easily identified by her mother as measles. When sores appeared in her eyes, her mother applied herbal medicines in her eyes suggested by friends as well as a biomedical antibiotic ointment, known generically as *shulushulu*, bought at a small grocery.

Approximately one week after the symptoms appeared, when these treatments failed and the mother noticed Helen's eyes had deteriorated, the mother took her to Kasungu Hospital:

> We stayed at the hospital for some days and when the doctors took a look at her, they discovered that the sores in the eyes have grown so large so much so that the eyes were already rotten and then they transferred her to Lilongwe. And when they saw that she wasn't given any treatment in Lilongwe, they transferred her to Blantyre where they removed one eye and the other eye they just made a hole in it so that fluid could drain. That hole was full of puss.

After the surgery to remove her one eye, Helen was told that she would feel pain, which she continues to feel today. She was told to return later to receive a glass eye. However on their return trip to Kasungu (an approximately 20 hour journey), the bus they were in had an accident. This frightened the mother enough that she refused to return to Blantyre for the glass eye. Helen, to this day, still does not have a glass eye and has never made inquiries about receiving one although she would like one.

Later during the same year as Helen's hospitalization in Blantyre, a *sing'anga* was visiting the village and noticed Helen. He offered to try to cure Helen but he was unable to do so. However, in his attempts he divined the cause of Helen's affliction with measles and subsequent blindness. The healer discovered that Helen's father had acquired *juju* from a witch to kill one of his children in order to succeed in his grocery business. The *juju* was delivered in sand, which was sprinkled on their doorstep. When Helen stepped on the sand, she developed measles. However, as it turns out, the father had misinterpreted the witch's instructions and the wrong child was afflicted with measles. He was meant to kill the youngest child and not Helen. Helen was blinded by the measles and the father was eventually able to kill the youngest child through measles. As a result of this revelation, the mother and father divorced.

The second situation in which magic may be considered responsible for blindness is when it appears suddenly. The blindness may be accompanied by a headache, but not with other symptoms such as itching, redness, or a discharge. This would be the case, for example, with cataract and glaucoma.

While a Westerner may not consider the progressive loss of vision from cataract or glaucoma as sudden, Malawian and Western notions of time are quite different. What is described as sudden or quick by a Malawian, is most likely considered slow or gradual in Western time. Also, as discussed in relation to conceptions of healthy vision, the actual loss of vision is not considered significant until it interferes with what one considers vital. The following case demonstrates the assumption of magic based on a lack of other symptoms and the speed of vision loss:

The Case of Dick: Dick is a 66 year old man whose eye problems began in 1995. He wears aphakic spectacles indicating he has had cataract surgery. When asked what caused his eye problems, he states with conviction that it was from magic:

> You have asked a good question! I received a letter from Chinthebwe in Ntchisi. So as soon as I finished reading the letter, my eye problem started. The letter said that I should send the names of 20 people to the enclosed address and if I will send these names I will receive K1,000. But, unfortunately, I didn't send the names so when I failed to send the names I received another letter and it said that I will have a severe headache. Then the eye problem started.

The letters were not signed so he does not know who sent them. The two letters mysteriously disappeared shortly after reading them. His eyesight immediately started to grow faint and within a month he was unable to see.

During that month of waning vision he was not too concerned because he could still see a little and move about on his own. However, when he could no longer see and had to be guided places, he became concerned. Because of the suddenness of vision loss and lack of any other symptoms, he suspected magic and visited a *sing'anga*. The *sing'anga* divined that his eye problem was caused by magic from relatives. The healer applied herbal medicine to his eyes but the treatment failed. He visited a second healer who also provided him with herbal medicine and stated that two people induced the blindness. She did not, though, name the people.

After two weeks of trying these healers' treatments, he decided to go to Lilongwe Hospital. He did not bother going to the nearest hospital, Kasungu District Hospital, because he wanted the best possible treatment which he felt would be found at Lilongwe Central Hospital. There he met with an OMA who told him that his blindness was, indeed, due to magic but that the hospital, contrary to popular belief, could help him. They operated on one eye and then two days later on the second eye. A month after the operation he received aphakic spectacles and could see sufficiently to carry on a normal life. He is very pleased that he is able to move about by himself without a guide.

Neither the healers nor the hospital staff named his ailment except to say that he was a victim of magic. He clearly had cataract surgery at Lilongwe Hospital. However, he was adamant that he did not and never has had *sanga*. He was not familiar with the English term cataract.

Dick is one of only two informants who said that hospitals could treat magically-induced illness. He was quite excited to talk to me about this because he wanted people to know that doctors could help them. As a result of his experiences, he has completely lost faith in healers' abilities to heal.

CHAPTER 6
BECOMING BLIND

Becoming blind is a process. Everyone interviewed had a narrative of how he or she came to be blind. Those too young to remember still have narratives passed on to them by those who witnessed or shared the process. The narratives are remarkably detailed, with people recalling exact symptoms or even remembering exact dates of significant events such as the onset of sudden vision loss or visits to hospitals.

In this chapter, I describe the process of becoming blind, one that naturally varies by person and circumstances, but one that nonetheless remains remarkably similar in significant themes. These themes, such as the order in which therapies are attempted and the reasoning behind such an order, illuminate the numerous constraints upon people's perceptions and actions. These constraints are multiple and form a cascade of increasingly intractable barriers to maintaining vision.

PREVENTION

While prevention was never an element of a person's narrative of how he or she came to be blind, people's general ideas about prevention are important and support the finding that there are circumstances in life beyond the control of most Malawians. In interviews and surveys, I asked both sighted and blind people if it is possible to prevent eye disease or blindness and, if it is, how.

There is not a strong belief among Malawians in the ability of the individual to prevent illness through particular behaviors. The vast majority simply state that nothing can be done to prevent disease, except to seek the help of a doctor. In part, this response appears to arise from the Malawian habit of perceiving knowledge as hierarchical. Only certain people have access to certain knowledge and Malawians are not keen on speculating about or exhibiting information that is normally in the domain of a specialist. Thus, when asked if eye diseases can be prevented, many state something to the effect of "Only the doctors can know that."

This does not mean that Malawians do not understand the notion of prevention and do not practice preventive measures. Many Malawians, particularly those who have had at least a standard 8 education, the year in which eye diseases and eye disease prevention are discussed, do know certain measures that will prevent the spread of eye disease. For example, keeping the home compound clean and free of flies, washing one's face daily, receiving immunizations, and eating nutritionally balanced meals were preventive measures cited by informants. And within the realm of indigenous medicine, an eye solution of rabbit dung soaked in water is believed to prevent *maso*. However, the majority of people simply do not believe in their ability to prevent eye disease in the current circumstances of poverty, limited resources, and inaccessible health care. Indeed, suggesting people eat nutritionally balanced meals is futile, when they do not have the resources to do so. Thus, while some have received public health messages for prevention, putting these messages into action appear to be another matter. Common statements were:

> [We cannot avoid eye problems] because diseases just come from God and others say they are from flies, but how can we avoid flies?
>
> It is difficult to avoid diseases.
>
> How can we avoid what we don't know?

> It is difficult [to avoid eye diseases] because the wind and flies are the major causes [of eye disease]. And it is difficult to avoid these causes.

SEEKING TREATMENT

As described in Chapter 4, Malawians theoretically have a choice of therapeutic approaches, stemming from indigenous medicine or biomedicine. What a person or her caretaker chooses first to do in managing an eye complaint depends upon several factors: the person who is ill, family economics, access to health care options, prior experience with health care options, religious beliefs, perceptions of the severity of illness, the type of illness, and the concurrent duties and responsibilities of the sick individual or caretaker. Any or all of these factors may influence what will first be done to heal the sick.

We can discern among informants and survey participants, though, patterns of preferred or likely order in which treatment will be attempted. The typical patterns of seeking treatment are best described by referring to the provider of care rather than the medical system to which the provider belongs: lay providers or professional providers.

In order to understand "ideal" patterns of treatment, I asked 176 survey participants: "If you or your child had an eye problem what would you do first to treat it? If that did not work, what would you do? If that also failed, what would you do?" The majority, 57%, state they ideally would attempt treatment at a hospital or clinic first. The remaining 43% state they first would attempt treatment at home with the help of family or friends or with self treatment. It is significant that no one stated they first would attempt treatment with a *sing'anga* and only 16% said they would visit a *sing'anga* for their second treatment attempt.

In fact, 38% report that they would never see a *sing'anga*. And the majority of people (36%) report that their overall preferred order of treatment would be: lay treatment--hospital--*sing'anga*. Only 10% would rely solely on hospital providers.

Table 3
Provider Preference, n (%)

Provider	**First Choice**	**Second Choice**	**Third Choice**
Lay Provider	75 (43%)	44 (25%)	11 (6%)
Hospital Provider	101 (57%)	75 (43%)	28 (16%)
Asing'anga	0 (0%)	28 (16%)	71 (48%)

Table 4
Preferred Order of Treatment

Preferred Order	**Number**	**Percent**
Lay Treatment **Hospital** ***Sing'anga***	63	36%
Hospital **Lay Treatment**	36	20%
Hospital ***Sing'anga*** **Hospital**	28	16%
Hospital only	18	10%
Lay Treatment **Hospital**	12	7%
Hospital ***Sing'anga*** **Lay Treatment**	11	6%
Hospital **Lay Treatment** ***Sing'anga***	8	5%

Examining the in-depth interviews with informants, we can make sense of these ideal patterns in seeking treatment. Informants' descriptions of going blind reflect all of the patterns survey participants reported. Their reasons for seeking treatments in the order that they did demonstrate the social, political, and economic factors that impinge upon people's real choices.

In order to understand people's actual behavior in seeking treatment, it is necessary to understand their experiences with each type of provider. In the following discussion, I lay out the reasons informants chose the treatments they chose and their experiences with such treatments.

The First Step: Lay Providers

The most common first response to eye disease, no matter the condition, is to attempt treatment at home with the assistance of a lay provider. Lay providers include family, friends, or one's self. Such providers have no formal training in medical care and are not recognized as *asing'anga* or health care providers. Lay providers rely upon experience and word-of-mouth. As is typical throughout the world, the mother is the primary health care provider and typically the first lay provider to attempt treatment of children (see McClain 1989).

Lay providers utilize both home-made medicines and biomedical pharmaceuticals. Home-made remedies are those produced at home from readily available products. For example, ingredients in homemade eye remedies described by informants and survey respondents included human urine, clean engine oil, pepper, warm salt water, water that has been used by doves for drink and bathing, and various plants such *mpungabu*, *msangu*, and *jere jere*,

Biomedical pharmaceuticals are also very popular among lay providers. These medicines are purchased from a grocery or may be a left-over prescription from a previous illness. The pharmaceuticals usually are not specifically manufactured and marketed for eye diseases. The product is purchased and then altered at home for use in the eye. For example, numerous informants and survey participants reported purchasing penicillin tablets, crushing and mixing them with water, and then dripping the solution in the eyes. Alternatively, the crushed penicillin may be mixed with petroleum jelly to make an eye ointment. On occasion, in some areas, ophthalmic ointments may be available at groceries. The ointments are said to have been stolen from the government hospital supplies or have been smuggled in from Mozambique.[1] The most common biomedical pharmaceuticals mentioned were penicillin, chloramphenicol, and tetracycline.

Lay providers may also attempt treatments such as the removal of foreign objects or the cleansing of wounds that do not involve medicines, but rather manipulations, incisions, or piercings. For example, one informant describes his parents' treatment of his sister's eye infection:

---

[1] Theft of hospital pharmaceuticals by hospital personnel is not uncommon according to OMAs. Stealing and reselling drugs is an easy means for desperate people to make money.

> My sister had her eyeball swollen so that it looked like a fish eye and for her to feel better, my parents were taking a pin and pricking a hole in her eye. Then the blood and pus came out and she felt better.

It is here, in seeking treatment with lay providers, that people "delay" seeking professional biomedical therapy. The perception among health care workers is that people delay getting biomedical care at hospitals and clinics because they seek treatment from *asing'anga* first. In fact, though, this research suggests that the *sing'anga* also may lament the delay of treatment. People self-treat or receive treatment from kin and neighbors before seeking professional help. Self-treatment is free or low-cost, does not require a disruption in work or travel long distances, and does not expose one to the harsh realities of unequal access to care. It makes logical sense to attempt self-treatment before expending scarce, and often nonexistent, resources.

But why do Malawians appear to wait until a disease process is too far gone to preserve sight before giving up on self-treatment and seeking professional care? Biomedical health care workers repeatedly state that people come for treatment when it is too late to provide treatment. The damage is irreversible. I believe there are three explanations for this delay.

The first explanation is that there may actually not be a delay in seeking treatment for certain conditions. I believe some, though certainly not all, people seek treatment from professionals as soon as it is obvious their self-treatments are failing. However, the progression of some diseases, such as measles, in this population is likely far faster than would be expected in an otherwise healthy person. In malnourished individuals, a decline in health status is far more rapid than in well nourished and normally healthy individuals. The malnourished simply succumb more quickly to disease and are more seriously affected (see Scrimshaw et al. 1968). A well nourished and healthy child with measles will never suffer eye symptoms; the virus will be a passing disease episode from which they fully and quickly recover. A malnourished child with measles, who in all likelihood is suffering numerous other maladies such as malaria and intestinal parasitism, will progress rapidly to a more severe disease with more serious complications. This supposition is supported by some informants' narratives of their vision loss. They report seeking treatment within a day or two of failed treatments at home, yet it still being too late for assistance.

The second explanation is that poor Malawians, as I have explained in Chapter 3, have a distorted conception of "healthy," one that classifies deadly and disabling conditions as expected and minor. They have been prepared their entire lives to expect less well-being and to tolerate severe dis-ease. It is quite possible that any other conception of health is inconceivable. Such a distorted perception of healthy conspires against timely treatment of disease or injury.

The third explanation is that Malawians have low expectations for assistance from professional providers. People do not rush to professionals because prior experience with professionals indicates the odds for successful, if any, treatment are rather poor. Given the expenses involved in seeking professional help and the low expectation of being successfully treated, any delay in seeking help is understandable. This is more clearly understood by describing the experiences of informants in seeking professional help.

The Second Step: Professional Providers

If lay treatment fails, the typical next step is to seek treatment from a professional provider. By professional providers, I am referring to those men and women who have received some type of training or experience which qualifies them to act as and be recognized as healers by the community. Professional providers, then, include healers and practitioners of indigenous medicine, biomedical physicians, medical assistants, nurses, and other allied biomedical health care providers. The most common second choice of treatment among informants was from providers at government hospitals or clinics.

Biomedical Providers

> [If I have an eye disease] I can first wait for a day and then try washing my face with water. If the washing doesn't help, then I go to the grocery and buy penicillin capsules and apply it to my eyes. If that doesn't help, then I go to the hospital to get treatment.

When lay treatment failed, most people sought assistance from a hospital or clinic. The hospital offers one significant advantage over the alternative professional, the *sing'anga*Bhospitals theoretically provide free diagnosis and treatment. For the majority of Malawians, this economic factor is substantial. The economics of being ill and procuring therapy was the paramount concern of research participants which informed all decisions and guided almost all experiences.

And while Malawians do seek treatment from hospitals and clinics, doing so is an often difficult task and they have little faith they will be treated. Why is seeking hospital treatment difficult? The most obvious reason is that professional biomedical services are not easily accessible. There are few hospitals and clinics and fewer practitioners, meaning most people live at least an hour or longer walk from the nearest staffed clinic. Given the long lines of patients once one reaches a hospital or clinic, seeking professional care can become an entire day's project. Most everyone I interviewed had to walk to a hospital or clinic the majority of the time because of lack of funds for a bus. Such an investment of time means other duties such as childcare, cooking, farming, gathering firewood, collecting water, and cleaning must be neglected. If one is quite ill, such a journey becomes that much more daunting, if not impossible. In fact, numerous informants and survey participants stated that one reason they may not visit a hospital is if they are too ill to walk there. Thus, even though diagnosis and treatment are ostensibly free, there are quite steep hidden costs (see Farmer 1999 and Lewallen and Courtright 2000, 2001).

Once a person has made the decision to visit a hospital and has accepted these hidden costs, they still have little faith they will receive treatment. Previous experiences in trying to procure therapies for all types of illnesses typically involve futile trips to hospitals where doctors are absent, clinics are closed, drugs are insufficient or not available, therapies fail, and patients feel humiliated and ignored. My research is replete with informants' stories and my own observations and experiences of inadequate or failed therapeutic attempts.

Clinic operating hours and days are not consistent. As described in Chapter 4, it is not unusual to arrive at a clinic to find the OMA absent and the clinic closed. When I visited the Salima District Hospital Eye Clinic one day, I found the clinic closed and the Dental Medical Assistant attending to eye patients, though he did not have the use of the Eye Clinic facilities and medicines.

> Even more damaging to the reputation of biomedical treatments is that there are not enough medicines. OMAs report not having sufficient drug supplies

> to treat everyone, yet they seem rarely to explain this shortage to patients, telling them instead to return later for more medicine or to take an analgesic to alleviate pain. One elderly woman (R:) explained to me (I:) the mistrust that develops when there are insufficient drugs and no explanation: I
> What do you think of the health care you get at the hospital?
> R: The treatment is not enough, because if you have fever they just give you one tablet of aspirin and send you back home. That's all! It doesn't help. They really don't assist you because you can't leave here, go all the way to the hospital and be given only a few tablets of medicine. That's not being helpful!
> I: Why do they only give you a few tablets of medicine, you think?
> R: I don't know whether it is because the doctors don't want to give us more or because there is no medicine. I don't know, because had it been that there wasn't any medicine, they could have told us that there isn't any medicine. But maybe it's because the doctors don't want to give us medicine.
> I: So you think that maybe they think they are wasting the medicine on people?
> R: Yes! You can just imagine giving us one tablet!

A very common statement among Malawians regarding health care at the hospitals is that, "When you go to the hospital with malaria, you are only given Panado (a pain reliever)." This is usually accompanied by laughter at the absurdity of the situation.

When medical personnel do not have the necessary supplies to effect a cure, the reputation of the entire biomedical system is damaged. And, of course, not all therapies are successful, further damaging the reputation of biomedical therapies. An 80 year old woman (R:), who attempted to treat her *sanga* at three different hospitals approximately ten years earlier, explained to me (I:) how failed treatments damage reputations:

> R: To become blind, I had *sanga* in this one eye. I was worried and I visited Nkhoma Hospital for treatment. From there I went to Zomba for treatment. I faced problems in Zomba. They didn't treat me very nicely. They took the plaster, cut it into a small piece, and then sealed it in my eye. They did this with the assistance of other medical assistants who held down both my hands and opened my eye. And you can just imagine when a little thing enters in your eye, you feel a lot of pain. So that plaster was big and it pained a lot. So I went to the hospital in Blantyre. They decided to operate on my eye. They wanted to operate on both eyes, but I refused since I could see with my

> other eye and I could even read with it. But they insisted and operated on both eyes. That's where I became completely blind.
>
> I: Were you angry with the doctors for operating on the good eye?
>
> R: Yes, I was very angry that they wanted to operate on my other eye. I refused but they told me that tears will be coming from the bad eye to the good eye and that will cause infection and I would have to go back to the hospital for another treatment, so it was better that they operate on both eyes. So I gave in and they operated on me, but I wasn't happy with it.
>
> R: After the operation, you told them you couldn't see. What did they say about that?
>
> I: They didn't say anything. They just said that I should go back to my village and come back after some time so that they could remove the stitches in my eyes. So when I went back they refused to remove the stitches saying they can't because my eyes were already destroyed so if they remove them then the eyes will fall out.
>
> I: And so then what happened?
>
> R: They just sent me back home.
>
> I: And so you have never seen anyone since then for your eyes?
>
> R: No, why should I go since my eyes were already destroyed? But I stayed for almost a year feeling great pain in my eyes.
>
> I: How do you feel about those doctors?
>
> R: I was very angry because of my good eye which they destroyed. Had it been they just gave me instructions so that I should be caring for it or maybe when sleeping I should be very careful when turning so that my good eye shouldn't be affected, I could have been doing all that. But to just destroy it, it really made me mad!
>
> I: There was no one to complain to?
>
> R: I couldn't do anything more.

Patients return to their homes and tell friends and family of their experiences. They become the most potent purveyors of information about professional biomedical treatment, for the dissemination of health care information to lay people is minimal and hampered by limited avenues for educating people. For example, few people are exposed to consistent formal education or to mass media. Thus, people repeatedly expressed skepticism to me about the success of biomedical therapies:

> If I went to the hospital for treatment and the doctor said the only way to treat me is through an operation, first I would not accept it. I would come back from the hospital and try the healers. If the healers failed then I would go back to the hospital

> for an operation. The reason for not accepting the operation the first time, is that doctors take short cuts. They may make a mistake.

And while medical personnel may consider the therapy successful, the patient may not. He or she may have quite different expectations. Informants and survey participants reported knowing people who had surgery and were supplied eyeglasses (a clear indication the surgery was for cataracts, though not explicitly stated so by informants), yet who still could not see.

> I don't know [if I would accept surgery], because I know someone who saw the doctors and they scraped the eyes[2] and after that when the doctors give these eye glasses, he said, "I can't see."

On the other hand, there were reports of successful treatments. For example, Dick, described in Chapter 5, was extremely pleased with his cataract surgery and wanted others to know of its success.[3] And one woman, who attended a rural clinic being visited by the Salima District OMA, danced and clapped with joy when the OMA presented her with a new pair of aphakic spectacles to replace her scratched ones.

Lewallen and Courtright (2000, 2001) report that a lack of knowledge of services also may be a significant barrier to receiving services. My research confirms this. Ten

---

[2] Lay Malawians often refer to eye surgeries as "scraping."

[3] Of course, he did not know he had had cataract, or *sanga*, surgery and so his effectiveness in promoting *sanga* surgery was limited. Instead, he wanted his fellow villagers to know that the hospital could treat magically-induced blindnessBa very hard sell, for it goes against Malawian experience and common sense.

survey participants said they would refuse eye surgery, because they did not believe it was possible to operate on eyes. They had never heard of such operations.

Those people already receiving biomedical therapy also lack crucial knowledge of services. Narratives repeatedly reflect the failure of the hospital staff to convey to patients their medical condition, the cause of their condition, the purpose of surgery or treatments, or the expected outcome. As is typical of most encounters between patients and biomedical personnel, patients report not being told the cause of their problem, not being given a name for their problem, and not being informed how to avoid the problem again. For example, in the operating theater at the Lilongwe Central Hospital Eye Unit, Dr. Chirambo prepared to operate on a middle aged man with glaucoma. The surgery is done to relieve pressure so as to preserve vision. It is not done to an eye already blinded by glaucoma nor is it done to improve vision. The patient, already laying on the operating table and being prepped for surgery, became very agitated and confused when it became clear that the doctor was going to operate on his good eye. The medical assistants and nursing staff had failed to explain to the patient exactly what was being done in the operation. Dr. Chirambo explained to the patient what was going to happen and then proceeded to berate his staff:

> This is the problem! You are to explain to the patient what we're doing, otherwise they come here thinking they will be able to see better! How many times do I have to tell you this! Why don't you do it!

These were not questions Dr. Chirambo intended to be answered and the staff did not reply but continued their duties, chagrined.

Similarly, for bilateral cataract surgery, patients are provided aphakic glasses and theoretically will see an improvement in vision.[4] However, if the surgery was unilateral, glasses are not provided and a patient will see no improvement in vision. If this is not clearly explained to the patient, he or she is left disappointed and confused about the purpose of the surgery.

Or there may simply be confusion about what is done during surgeries. Some informants believed there are only two types of surgery performed at hospitals: complete removal of the eye and cleaning or "scraping" of the eye. One told me that the hospital wanted to replace her eye with a goat's eye, so she refused the operation. Confusion and misinformation about surgeries is common.

A lack of knowledge about services and the causes of disease is not a problem unique to eye care. Mr. Mataka, my research assistant, for example, went to the hospital with an intense toothache. The dental assistant pulled the tooth and Mr. Mataka asked what he could do to avoid this happening again. The assistant waved him away and said, "I don't have time for your questions. Come back if you have a problem." Mr. Mataka's question was the result of hours of listening to me whine in frustration about the importance of people understanding the problems plaguing them. He laughed, saying it was not a thought he had before and to demonstrate his point, he asked Jane if she thought to ask the doctor what had

---

[4] I say "theoretically" because we do not have any research indicating the level of satisfaction with vision after cataract surgery and the provision of aphakic eyeglasses.

caused her problem the last time she went to a doctor. She laughed saying, "No, the important thing is to get better. What do I care what caused it?"

The results are constant reinfections, constant return visits to the hospital or attempts at other therapies from *asing'anga* or lay providers, and eventual discouragement over the lack of effectiveness of treatments. Eventually patients give up returning to the hospital. One man, whose mother is blind from trachoma, has been returning to the hospital approximately every two months for the same problem over a period of six years. His description of the symptoms and the treatment regimen indicated he was also suffering from trachoma and it was confirmed by a hospital ticket listing the diagnosis. I asked him if anyone at the hospital ever told him either in Chichewa or English what he was suffering from? "No," he replied. I asked, "Did anyone ever tell you how people get this disease?" "No," he replied. I try again, "Did anyone ever tell you what to do to avoid getting this infection?" Again, he replied, "no." He tells me that he is only told to apply the medicine and if he gets the problem again to return to the hospital for more medicine. When I ask him if he would like to know what he has and how he can avoid it, he is very grateful and eager to learn. He is tired of returning to the hospital every few months. He also has seen his mother's difficult life and does not want to become blind himself.

The lack of knowledge of services is also seen in a linguistic confusion between lay and biomedical disease classifications. This confusion further exacerbates understanding of biomedical therapies. As noted in Chapter 5, Malawian lay classification of eye diseases includes *sanga*, a condition in which a white spot (*mwana*) is on the eye. *Sanga* translates to the biomedical classification of two distinct conditions: cataract and corneal scarring. These two conditions have two very different therapeutic possibilities. Cataracts may be treated with surgery, whereas corneal scarring cannot be treated.[5] Thus, it is quite obvious in interviews and surveys that there is a great deal of confusion among people about whether or not biomedical health professionals can effectively treat *sanga*. In the survey of 177 people, 99 people (56%) felt biomedical practitioners were best at treating *sanga*, 41 people (23%) felt lay treatment was best, 27 people (15%) felt *asing'anga* were best, while three people stated it could not be treated and seven people did not know if it could be treated. An example of people's fear of hospital treatment of *sanga* is one young man's statement: "It is best treated by healers. It is bad at the hospital because they just remove the eye." OMAs are aware of this confusion, but have given little thought to the implications of it. People who have been told *sanga* (corneal scarring) cannot be treated by the hospital are not likely to seek treatment for *sanga* (cataracts) at the hospital.

The final problem in receiving treatments at hospitals and clinics is that the experience itself is a test of one's status within society. Malawi does not have sufficient medical resources to meet the needs of its people. Thus, medical resources are rationed and become available first to those who have wealth or patronage. The vast majority of informants feel that the wealthy receive better care at hospitals and clinics than do the poor. The wealthy are able to pay or "tip" for services and medicine. As one informant explained:

> What I have seen is that when the medical assistants have worked at the hospital for a long time, they get to know a lot of people and they make friends with these people. When they realize that a person is rich, they become close friends so that they may receive favors from the rich. That's why things can't go well with someone who is poor because the poor can't

---

[5] Corneal transplants are possible, but are not available in Malawi.

> give anything to the medical assistants. This happens because of the love of money here on earth.

Informants reported that they are more likely to receive sufficient help from a medical assistant if they have some connection with the medical assistant, such as common ethnicity. For example, one informant described an incident in which he sought help for a non-eye related condition. The medical assistant at first told him there was no help for him. However, after further discussions, the two men realized they were from the same area and had relatives in common. After this discovery, the medical assistant provided the patient with medication.

In my visits to villages for interviews, I was constantly besieged by people requesting a "note" to take to the hospital. Early on, I was baffled by these requests and thought that people could only be seen at the hospital if they had received permission from some unknown authority. As it turns out, these people were simply hoping to establish a patronage relationship with me in the hopes that their connection to me would provide access to medical care.

In fairness to the eye care program, I never witnessed OMAs treating patients disrespectfully or refusing to at least examine a patient. They were always extremely courteous and respectful. However, they certainly practiced triage: denying trachoma medicine to a man with AIDS and not examining the infant of a woman with trachoma are two examples already described in Chapter 5. And it is not sufficient for only the eye care program personnel to treat patients equitably. The entire medical system represents its components and a bad experience in any area of the hospital taints its entire reputation. I clearly remember an encounter I had with Isabel, my host family's maid, and Ellen, another domestic worker for a neighboring family. Ellen was painstakingly saving her money to take her son to a private eye clinic, an effort she had been working on for months. I asked Ellen why she did not go to the Lilongwe Central Hospital Eye Clinic where treatment was free. Isabel could no longer tolerate my naive ignorance and snapped in disgust at me, "Madam, you do not understand! You just don't understand! We Africans don't get treated there! We are no use to them there!" As she stormed out of the room, I knew she was very serious in her anger and frustration with me, for Isabel detested Ellen and had never defended Ellen before or since. The next eleven months of research taught me exactly what Isabel meant.

Given this description of therapeutic experiences with professional biomedical providers, it is understandable why people may delay in seeking treatment. They have had few experiences indicating it would be worth the costs of seeking help from biomedical providers. However, once they have accessed the system and have been offered free therapy, such as cataract or trichiasis surgery, why do so many people still decline the treatment? Even when barriers, such as travel to the hospital, are eliminated by having the OMA pick up people at their homes, people refuse the surgery. Certainly, many people lack trust in the outcome of surgery. Prior experience with biomedical health care instills a healthy skepticism.

However, even for people who are willing to risk surgery, there are, once again, hidden costs to surgery. The patient cannot fulfill his or her regular duties and responsibilities during the surgery and recovery. For example, numerous people stated that they would have to decline a previously scheduled surgery if they had a funeral[6] to attend or if their child was ill. The patient also needs the assistance of a caretaker to help feed and care for him or her during recovery. Again, numerous people stated that the lack of a caretaker would prevent them from having surgery.

Indigenous Providers

Finally, when biomedicine has failed to treat a condition, patients may turn to *asing'anga* for treatment. For the majority of people, *asing'anga* are a last resort for treatment for two reasons. First, *asing'anga* require money and many people stated that they could not afford the services of *asing'anga*. Second, experiences with *asing'anga* often are no more fruitful than with biomedical practitioners. They simply have a bad reputation for treating eye diseases. Some conditions are believed to be better handled by *asing'anga*, such as *liwombo*. In the survey of 177 people, 110 people (62%) felt *liwombo* was better treated by *asing'anga* or from lay people using indigenous medicine.

However I heard very few stories of successful treatments received from *asing'anga* for any eye conditions. As with biomedicine, stories of failure with *asing'anga* are just as destructive to their reputations. One sighted informant explained why she is not sure an *asing'anga's* medicine can help with eye disease:

---

[6] Attendance at funerals is extremely important. To miss a funeral is disrespectful and also opens one to accusations of witchcraft and, thus, being responsible for the deceased's death. Several people noted that they would have to ask their chief if they could miss a funeral in order to have surgery.

> I don't know because I can say some people are trusting those African medicines. Like children suffering from *liwombo* are treated by taking the medicine and applying it in the eyes as well as the *liwombo* (fontanelle). Like my young sister at Area 3 (in Lilongwe), her daughter was having that and the *liwombo* was sinking and the eyes were big and they went to see the doctor and they were admitted to the hospital for one month without changing and some people were saying you can go to Chigwirizano Village after Likuni and you can get African medicine and give it to your child and she will get better. She went there and the child never recovered until she died.

NARRATIVES OF BECOMING BLIND

The sequence of "self treatment--hospital treatment--*asing'anga* treatment" is the typical pattern gleaned in narratives. Treatment attempts do vary and, of course, do not end once all three options have been attempted. People continue seeking treatment over years, returning to previously failed treatments and trying several therapies at once as their condition worsens and the number of failed attempts mount. And, even if a person has seemingly resigned herself to blindness, if an opportunity for possible treatment arises, she is likely to grasp that opportunity. Thus, many blind people told me of meeting *asing'anga* who offered their services and of accepting the offer to no avail. And, of course, there were those who met me and hoped that I might be an avenue for better treatment from the hospital, asking me for a "note" for them to take to the hospital.

I end this chapter with two narratives. These narratives reflect patterns of seeking treatment and the numerous barriers people face.

Mrs. Ntholo: Mrs. Ntholo's eye problems began when she was nine years old:

> It started in 1970. I was playing on sand and the sand entered my eyes accidentally, so then I went to my mother to tell her about it. When I told her, she told me to wash my eyes and face so that she should apply medicine. And she applied the medicine in my eyes, but not the traditional medicine. When my father suffered from an eye problem he went to the hospital and was given eye medicine. So the medicine I was given was the one my father received from the hospital when he had an eye problem. Since he got cured, he kept the medicine which remained. [I was given the medicine], then the whole night my eye pained so much so that I couldn't sleep the whole night. I still felt pain in the morning so then my parents decided to take me to the hospital where they gave me medicine to apply in my eyes. But it didn't help. Then the other eye started to feel pain and I wondered why since the sand only entered in one of my eyes and yet the other eye started to pain also. So they decided to try traditional medicine and after two months the eye which had sand in it dropped out of the eye socket. Then we went to Lilongwe Hospital, for the situation was now worse. So when I was there, the people there put the eye back into its place and gave me medicine and when I was better they sent us back home. The doctor said that I was now okay and I can go home. When I went home I could see using the other eye, but I lost hope for the one eye since it couldn't see. Then in 1971 I was okay and I couldn't feel any pain. In 1972, my father decided that I should go to school since my eyes were damaged. But I was surprised. How was I going to learn since I had the eye problem? He assured me that he will send me to the school for the blind in Kasungu. So in October 1972, I went to school. Then in 1973, I became very sick with the same eye problems. I went to Kasungu Hospital. They only gave me medicine to apply in my eyes. They only told me that I had many blisters in my eyes and asked if I was suffering from measles and I said, "No." So they said there were blisters as if I was burnt with fire. So they gave me four tubes of medicine to be applying in my eyes. So I was applying the medicine until the blisters healed and I felt better... [But] that sickness damaged the other [sighted] eye. Then I just knew that I will be blind in both eyes. But I could walk very well because I was trained at school.

Mrs. Ntholo has continued to have pain periodically in her eye damaged in 1973. She did have slight vision in this eye. However, this later changed:

> [The doctors] tried [an operation] in Lilongwe in 1983 on the 13th of January. After they tested my eyes, they said that they should scrape my eyes. So

> they only scraped my one eye. So when I came back home I thought maybe it was going to help me in both eyes, but nothing improved and my other eye, it went completely blind. It only pained. So then I used to go to Kasungu Hospital with that same problem for treatment. So they gave me medicine and the pain stopped. I was going there every month, but I didn't go back so that they should scrape me again. I thought that [this blindness] was the way God intended.

Mrs. Ntholo, however, does feel that her one eye still has "some life" in it:

> This other eye, I feel it still has power because it pains mostly and when I apply medicine in it, the pain ceases so I know that it is still powerful. I know that this eye still has some life. I don't want the eye to be scraped, but only applying medicine as I do now.

Mrs. Kalenji and Laika: Mrs. Kalenji's 13 year-old daughter, Laika, is blind:

> I realized Laika was going blind when I would be coming to the children and the other children would see me but she could not. She only heard her friends calling me. She could come to welcome me, but I was surprised that she would pass me without seeing me. Then I knew she could not see me. She had started to have an eye disease (earlier). She suffered for one month. I started taking her to the hospital but there was no help. The doctor[7] gave me medicine to be applying in her eyes. Then after applying the medicine, that is when the white thing appeared [in her eyes]. Then I tried the traditional medicine of tying the medicine around the neck. Because her eyes were still red and also most people in the village believe that if the white thing appears in the eyes, they tie that medicine around the neck and the things dissolve. So I also wanted to try it. [I took her to the healer] and he just said that they are *mwana* or *sanga*. So for them to be removed, he has to tie the medicine around her neck. So he tried, but I did not stop going to the hospital. At the hospital they gave me medicine yellow in color to be applying in her eyes, but there was no change again.

I asked if the doctor had explained what was wrong with Laika's eyes.

> No, he just said that they can't treat her here, but they will send us to Lilongwe Central Hospital. He said the eyes are just okay, but they only need cleaning and then she will be given eyeglasses. That was last year. So when he told me that, I came back home. So when the date for the trip to

---

[7] Although she refers to the practitioner as a "doctor," he was the OMA for the district hospital. Lay Malawians often refer to medical assistants as doctors.

> Lilongwe came, a car came here to pick us up to go to Lilongwe. But that day I wasn't here. I had gone to a funeral. My brother's child passed away. Then I missed the car that day. So when I went to the hospital to tell them to come and pick me up on another day, so that I can first find money to be using at the hospital, the doctor did not agree. So he did not come again.

I asked her what she thinks of the treatment they have received from the hospital.

> They don't give us enough treatment. They just give us the solution medicine. When we go there he [the OMA] can tell us to come back another day or if we are lucky we are just given the solution medicine. When a person is sick you go to the hospital to be helped and treated but if you go there and they don't give you enough treatment, you get discouraged to go there again. But I have been going there many times. Up to now I still go.

CHAPTER 7
BEING BLIND

In the previous chapter, I examined the process of becoming blind. Informants all had narratives describing this process. These narratives did not end, though, with the loss of sight. Narratives continue with stories of being blind. In this chapter, I examine what it means to be blind and how blindness affects various aspects of one's life.

DEFINING DISABILITIES

Anthropological research has sufficiently demonstrated that a disability is, to a certain extent, culturally constructed. There is no denying that an alteration in bodily function, such as blindness, affects functional capacity. However, it is the context in which one lives that determines whether or not this change in functional capacity is disabling.

Physical impairments, such as blindness, are present in all societies (Scheer and Groce 1988). What is considered a disability, however, varies across cultures and time and is a reflection of the values, expectations, material culture, and physical environment of a society. In addition to defining who is disabled, social, political, and economic processes pattern societal responses to and individual experiences of disability.

Hanks and Hanks (1948) were the first anthropologists to attempt a cross-cultural discussion of disability. They noted the cultural relativism of "handicap" and the dearth of information on disability in the ethnographic literature. From a review of the ethnographic literature they found that the social position of the disabled was as diverse as it was for a "normal" person. They then focused on five variations in social position (pariah, economic liability, tolerant utilization, limited participation, laissez-faire) which, they felt, were determined by how a society defines its obligations and rights of the group to the disabled and how it defines the meaning of the disabling symptom.

Anthropological studies of disability since Hanks' and Hanks' review have been carried out, almost without exception, in the United States. These studies have focused primarily on mental and psychiatric disorders (Edgerton 1967, Estroff 1981), congenital disorders (Ablon 1984, 1992; Frank 1986), deafness (Becker 1980, Groce 1985), and para- and quadriplegia (Murphy et al. 1988) in order to understand society's perception and treatment of the disabled and how the disabled themselves perceive their roles and status within society. Three major theoretical orientations have been presented by social scientists for understanding disability: stigma, embodiment, and liminality.

The stigma approach, derived from the social deviance model (Goffman 1963, Davis 1961), puts emphasis on how the stigmatized person manages his or her stigma in interactions with "normal" people (e.g. Ablon's [1984] studies of dwarfism). The embodiment approach, influenced by the phenomenology of Merleau-Ponty (1962) and Zaner (1964) and the existentialism of Sartre (1957), rejects the Cartesian separation of body and mind in understanding the lived experience of disability. Thus, people's conceptions of themselves and their place within the world are emphasized over society's perceptions (e.g. Frank's [1986] studies of congenital limb deficiencies). The liminality approach draws upon studies of ritual (van Gennep 1960; Turner 1969). It views the disabled as occupying a "liminal," ambivalent, or transitional and ill-defined position within society. The disabled are considered isolated, marginal people without a defined status or role making interactions with them troublesome and awkward (e.g. Murphy et al.'s [1988] study of para- and quadriplegia).

Although these approaches have been extremely informative, we have no evidence of their applicability in cultural contexts outside the United States. What we do know from present research is that there is variation across and within societies in people's expectations of vision, beliefs about the causes of blinding eye conditions, attitudes about appropriate treatment, and experiences of blindness as a disability. Lane et al. (1992) found that rural Egyptians who are considered blind by WHO standards did not consider themselves visually disabled, a finding echoed in this research. Scott (1969) claimed that American society views the blind as helpless and actually pushes them into a role of disability, a finding confirmed by autobiographies of blind individuals (Keller 1914; Chevigny 1946; Mehta 1957). Anthropological research by Gwaltney (1970) in Mexico and Deshen (1992) in Israel and a psychiatric study by Anumonye (1981) in Nigeria, which focus on accommodations to vision loss and society's attitudes towards the blind, also confirm cultural diversity in response to blindness.

In this research, I sought to understand Malawian concepts of disability or *grumala*. What is a disability? Informants provided a range of definitions for disability, the majority associated with the normal functioning of the body and the ability to work. Typical definitions included:

- If any part of your body is not functioning the way God created it.
- Being unable to work.
- If we say that some parts of a person's body are bent or abnormal from the way his friends' bodies are seen, then that is a disability.

- The failure of some parts of the body to work effectively.
- If someone has got one of his parts of his body that is lame or different from other people.

Malawians commonly associate disability with two issues, the visibility of the impairment and the functional loss associated with the impairment.

Thus, Malawians tend to associate disability with a visible physical impairment. For example, mental illness is considered an illness, *matenda*, not a disability, *grumala*. Likewise, deafness was not always defined as a disability. If people were asked to list the disabilities they know of, they quite often did not mention deafness. However, if prompted, they would say that, yes, of course, deafness is a disability for a part of one's body is not working properly. A social worker with the Malawi Council for the Handicapped (MACOHA) confirms this, stating that there are several deaf students at the University of Malawi but that they do not perceive themselves as disabled. In conversations with Malawians, people state that one can easily communicate with the deaf and that their hearing loss doesn't affect their ability to work or participate fully in life.

On the other hand, impairments such as paralysis or blindness, which are easily discerned by others, are considered a disability especially if the impairment affects the person's mobility or work capacity. Visible abominations of the body, such as a disfigured face, that do not affect functional capacity, while still defined by most as a disability, are not a concern. For example, Mr. Mataka once borrowed a novel I had on the bookshelf, Ernest Gaines' *The Aviator*, about an American pilot badly disfigured in an accident. Mr. Mataka later expressed to me his surprise about the isolation and rejection the pilot experienced because of the disfigurement:

> Here in Malawi we don't find it very strange or very shameful when someone has got his face disfigured. In some places, the aviator was not feeling comfortable to be there like in any public place due to his face. People in different organizations failed to employ him due to his problem even if he had experience in his work. This is very unusual here because once someone is educated, no matter what kind of face he has, I don't think his face can be a burden to him. The disabled person himself won't be feeling ashamed to associate with his friends even in public places. It is only if you have got a disfigured face and you are lazy so much that you don't depend on yourself like maybe cultivating in the fields. Then you can face a lot of problems. The problems can be that you can not be accepted by women to marry because you will be known by two bad names, one being someone who is not handsome and the other one is poverty. A woman will not care about a disfigured face if you are a well-to-do man or a well educated man, because he can secure a good job to feed his family no matter what disability he has.

Of greatest concern is a person's ability to work. In a society where the majority lack basic needs, people rarely allow the luxury of vanity to guide important decisions such as a marriage partner. Far more important is a person's ability to provide for the needs of the family. If the disabled person is economically secure, then people overlook the disability. When the disabled person is poor, though, then the disability becomes his or her major identity.

BLINDNESS AS A DISABILITY

For Malawians, there is no question that blindness is a disability. Every person interviewed considered blindness a disability and the vast majority considered it the worst possible fate one could suffer. I asked 181 survey participants to tell me, in a comparison of blindness to several other conditions, if they had to choose, which condition they would rather suffer. Their responses are a clear expression of the fear people have of blindness. The vast majority chose any condition other than blindness, except for mental illness.

Table 5

If you had to choose, which condition would you choose between?

(Not all respondents answered each comparison)

Compared Conditions	**Condition Chosen**	**Percent**
Blind	5	3.3
Deaf	145	96.7
Total	150	100.0
Blind	33	22.3
Crippled Legs	115	77.7
Total	148	100.0
Blind	30	20.3
Crippled arms/hands	118	79.7
Total	148	100.0
Blind	11	7.3
Mute	139	92.7
Total	150	100.0
Blind	7	5.0
Disfigured Face	134	95.0
Total	141	100.0
Blind	30	20.6
Leprosy	116	79.4
Total	146	100.0
Blind	7	4.8
Albinism	139	95.2
Total	146	100.0
Blind	115	81.0
Mental illness	27	19.0
Total	142	100

People's responses and explanations reflect significant themes surrounding vision and the loss of vision: independence, the ability to work, the fear of isolation, vulnerability, and even the very meaning of what it means to be a complete person:

- Being blind is the worst because it is the same as if you are not yet born. For everything you depend upon others, even walking.
- To be a human means to be able to see things.
- Being blind is the worst because for someone to be a person, you have to see things.
- Because I feel it's like you are dead when you are blind because you can just be hearing people talking and yet not seeing them and you don't see anything so you are half dead.
- Being blind is the worst because you just hear from friends what is happening around you on this earth and you don't exactly see for yourself.
- [Blindness is the worst] because a blind baby cannot even find his own mother.
- Being blind is the worst because you just stay at home.
- Being blind is the worst because you are always having big troubles doing your day-to-day work.
- Being blind is the worst because he has problems finding his own food.
- Being blind is the worst because you depend upon begging in town.
- Being blind is the worst because I see these people every day and they have problems. In town, they always depend on begging.
- Accidents might happen to a blind person because he cannot see dangers.
- [Being blind is the worst] because you always need someone to guide you. You cannot move about without someone.

These themes are reflected in a song written and performed by one of my blind informants, a middle aged man blinded as a young man:

My friends, I am just staying here on earth
My friends, I am just staying on earth
I am just staying because I am disabled
What else can I do because I am disabled
I will just be crying
I can only be crying, what else can I do!

All my friends now are disabled
My friends I had have all run away
They ran away because I am disabled
They ran away because I am disabled
Because my disability is so visible
Because my disability is so visible
There is another disability of the heart
There is another disability of the heart

All my friends I had on earth
All my friends I had on earth
They have left me because I am disabled
They have left me because I am disabled
What else can I do
What else can I do
(Translated from chiChewa)

LIVING BLIND

What is everyday life like for the blind? How are the blind integrated into the family and community? There is no question that blindness circumscribes one's opportunities and chances in life. However, a people's beliefs about and attitudes towards the blind influence the way the blind are treated and accepted within the community. And these beliefs and attitudes are molded by the social, political, and economic conditions of the state.

In this section, I describe key features of life for the blind, which reflect the prominent themes associated with blindness. I begin with the story of a family of three, a mother, father, and young son. Their story, while unique in its specific details, exemplifies the conditions under which the blind must make a life:

The Ntholo Family Story: To reach the Ntholo family's home, you must turn left off of the Lilongwe-Mzuzu tarmac road onto a dirt washboard road that passes one of Kamuzu Banda's imposing palaces. Several miles on, you turn onto another smaller dirt road. which, in the rainy season, becomes choked with vegetation and impassable in some spots. The Ntholos live in the original village of Mr. Ntholo's parents. Although they are both Chewa, a matrilineal ethnic group that typically sends their son's to live near the daughter-in-law's family, this area has been influenced by the patrilineal northerners and, thus, Mrs. Ntholo came to live with her husband on land that was his parents and that was given to him by his older brother, the current chief of the village. The immediate compound is home to several other families too.

The Ntholo's home is a traditional mud and wattle home. It is less than a year old, having been recently built to replace their crumbling10 year old home. In this area people paint decorative scenes on their homes, but the Ntholo's have not done this. The roof is thatch and needs replacing for it leaks. Mr. Ntholo would normally be responsible for thatching, but is unable to because of his blindness. So the Ntholos wait for assistance from family to repair the roof. Inside the approximately 15 square foot home there is a 3/4 high wall partially dividing the space in two. Upon the top of the wall rests their possessions: a second pair of pants and shirt of Mr. Ntholo's, a second blouse and *chitenji* of Mrs. Ntholo's, a thick plastic bag, their son's health card from the hospital. None of the Ntholo's own a pair of shoes. On the other side of the wall, where they sleep, they keep their woven sleeping matts. They do not own a blanket. In their old home, just twenty feet across from their current home, they cook their food and store their kitchen supplies: a large metal pot, a small metal pot, three metal bowls, a metal cup, a large wooden spoon, and a leaky metal bucket to collect water.

Mr. Ntholo's brother and sister-in-law live in the sharpest home at the compound, demonstrating their greater wealth. The sister-in-law, having finished standard eight, is a primary school teacher and therefore the only member of the community with a steady income. On our first visit with the Ntholos, Mr. Ntholo's sister-in-law hosts us. We sit on a matt inside her home, a home dramatically different from the Ntholo's. She has a small three-shelf bookcase full of school books and homemade teaching aids. There is a wooden table with four wooden chairs. Hanging from the ceiling is a lightbulb tied to a string. (It took me several hours before I realized the incongruity of a lightbulb in a village without electricity. It is a decorative touch.) There are several rooms to her home divided by full walls, rooms that I did not see. Our visits to this home were the only visits of the more than 70 interviews we conducted in which we were offered food: nsima, *usipa* (tiny dried fish), and water. It is here that I first met the Ntholos, interviewing them separately as we sat on a woven matt on the floor.

Mrs. Ntholo is a 35 year old woman who stands erect and smiles only with prodding. However she does not give the impression of being overly serious, just perhaps tired. She immediately distinguishes herself as the most articulate person I interview, launching into stories and explanations with little probing. She is completely blind, having no light perception. Mr. Ntholo, 44 years old, smiles more readily. He has no light perception in his right eye and 2/60 visual acuity in his left eye. He does not see colors, but can distinguish some shapes.

Mr. and Mrs. Ntholo met at school, a school for the blind where they learned routine subjects such as chiChewa, English, health, science, history and civics as well as adaptive skills for the blind such as reading and writing braille, cooking and mobility. Mrs. Ntholo completed standard 6 and Mr. Ntholo completed standard 7, both well educated by Malawian standards. Mr. Ntholo also had an additional year of agricultural training at a training center for the blind.

The damage to their eyes is easily visible to the casual observer, but a biomedical classification of the cause of blindness is no longer possible. Their three year old son Fred is also blind. This they did not discover until several months after our first visit, when I offered to take him to a private clinic (where I knew we would receive quick attention and medicines). There he was diagnosed with malaria, anemia, intestinal parasites, a severe ear infection, and blindness. I paid the over 100 kwacha (approximately U.S. $7) bill for his medicine, a sum the Ntholo's would not likely see over the course of six months nor ever be able to accumulate. In a later visit, I took Fred and his parents to the OMA for Kasungu District, who evaluated Fred's vision. Fred's visual acuity is assessed by asking him to pick up objects off of the floor. The OMA determines that Fred is indeed blind.

The Ntholo's are astounded by this discovery. At the age of three, Fred is so capable helping his parents find misplaced objects or warning them of objects obstructing their path that they never suspected his poor vision. Although his poor vision is clear to me and my research assistants from his unfocusing eyes and constant attempts to situate himself with his searching hands, it apparently is not something that fellow villagers questioned or thought necessary to bring up with the Ntholos. No one ever told them their son seemed to have a problem seeing.

Fred is actually the Ntholo's fourth child, but the only one still living. Their first daughter died at the age of six. Her only symptom, Mrs. Ntholo states, was coughing. On their way to the hospital she died. The second daughter died at four years of age. Mrs. Ntholo describes her death,

> Since she was born, she never ate anything but breast milk. When we tried to give her *nsima*, she was refusing. So when I weaned her she was just staying without eating anything except *phalla* [corn meal porridge] and then her whole body started to swell for one month and then she died.

Mrs. Ntholo did take her to the Kasungu District Hospital where she met a man who sympathized with her plight. He provided milk for her daughter. Their third daughter died at the age of three and a half. She had bloody diarrhea for one month before passing away.

Mrs. Ntholo did take her daughters to the hospital when they became ill. It is not clear at what stage in their illnesses she sought treatment, but there were no medicines for her at the hospital and certainly none that she could afford from a private clinic or grocery. She also did not take them to a healer for healers charge a fee for their services, something the Ntholos cannot afford.

Mrs. Ntholo at first suspected that magic was the cause of her first daughter's death. It is the Ntholos' perception that the blind are particularly vulnerable to magic:

> For us the blind, we are easily attacked by witches, because people don't like us here in Malawi and they know that even if they can bewitch us we won't be able to know who has done the magic. But the sighted are able to know who has done the magic [and will try to deal with him].

When her other two daughters died, she let thoughts about magic go and suspected that it was God's will. She was, perhaps, influenced by her participation in the Church of Central African Presbyterian (C.C.A.P.), which prohibits belief in witchcraft.

The Ntholos depend upon the food they can grow on their two acre plot of land and the odd bit of money Mr. Ntholo makes selling mangoes, bananas, or other produce he is able to find. The Ntholos have never been able to grow enough maize to last them a year. The year I interviewed them, their maize lasted only one month after harvesting. Maize for the remainder of the year had to be bought with the money Mr. Ntholo could earn. They also grow pumpkins, beans, cassava, sweet potatoes, and other vegetables. Friends provide seeds and cuttings for these vegetables. Because they are not able to produce enough on their land to feed themselves the year, the Ntholos typically go without food for one to two days a week. Because they were unable to obtain fertilizer on credit, they did not plant maize for the next season. Mr. Ntholo's brother and sister-in-law are using the land for a new endeavor, the growing of tobacco to sell on the Lilongwe tobacco floors.[1]

---

[1] When land is not used by one member of the group, he forfeits his rights to grow on that land and someone else from the clan may use the land.

Their cooking fuel is wood collected by Mr. Ntholo. In the traditional division of labor, Mrs. Ntholo would collect fire wood, but because of her complete blindness, it is easier for Mr. Ntholo to find wood. When they have enough food, they eat two meals a day, one at mid day and one in the evening. Their meals consist of *nsima* and vegetable relish. They never eat meat, an unattainable luxury. Mrs. Ntholo does all of the food preparation and cooking, a skill she learned in school.

Their source of water is a small, filthy pond about a quarter mile from their home along a narrow dirt path. The pond is shared with cattle and other wildlife, who defecate and urinate in the water. Mrs. Ntholo fetches water at least twice daily, finding her way to the pond without a guide or the use of a cane. She uses an old, leaking metal bucket she carries on her head. She situates the bucket so that the water leaks out in front of her face rather than down her side or back.[2] They do not boil the water, fire wood being a precious and difficult-to-obtain commodity.

The Ntholo's precarious nutritional status is reflected in their son. Although I did not measure or weigh him, a quick comparison to my daughter indicated his stunted growth. My daughter visited the Ntholos with me on two occasions. When she was one year old, she was, according to U.S. height and weight charts, in the fiftieth and tenth percentile respectively; a small child by U.S. standards. Yet Fred, a full two years older, was barely an

---

[2] My father who, along with my mother, visited me in Malawi and met the Ntholos, was quite distressed by this leaking bucket and tried to repair it. He eventually plugged the whole with dried grasses.

inch taller than she. He was lethargic, never smiled, and hardly ever uttered a word even when his parents spoke directly to him. He was not well (and I suspect no longer alive).

The Ntholo's daily routine consists of fetching water and fire wood, searching for food, preparing and cooking meals, and keeping the home clean. Mr. Ntholo will travel some distance in search of food for the family or for fruits to sell. When they have a garden, they both work daily in it. On Sundays, they attend church, walking several miles to worship and visit with friends.

Services for the Blind

Considering the economic state of Malawi, the nation has an impressive array of social services for the handicapped and for the blind in particular. While these services do not nearly address all the needs of the disabled in Malawi, they do have a tremendous impact upon many lives.

In 1971, by an Act of Parliament, the Malawi government established the Malawi Council for the Handicapped (MACOHA) as a Statutory Corporation. MACOHA's mission is to ". . . provide rehabilitation services and promote public interest towards persons with disabilities for the improvement of their welfare, care and standard of living to enable them [to] contribute to the socio-economic development of the nation" (Malawi Council for the Handicapped 1996:8). MACOHA receives most funding from the government which is augmented by external aid organizations such as Sightsavers. Prior to the establishment of MACOHA, there had been a disjointed effort by missionaries and NGOs to assist the disabled.

MACOHA introduced voluntary registration of the disabled in order to assess the needs of clients. Registration is conducted by Social Welfare Officers who are employed by the Ministry of Women and Children's Affairs, because MACOHA itself does not have the personnel to do the registration. Social Welfare Officers identify and assess the needs of disabled people in the community. Hospital personnel then assess the limitations of the disabled person. Finally, MACOHA conducts an assessment through its Community Rehabilitation Officers (CRO) who are based in communities. These officers supervise projects and assist the disabled within the community. CROs are university graduates with an education in sociology and additional training from MACOHA. There were two CROs each for Lilongwe and Salima districts and one CRO for Kasungu district. Thus, as with health care personnel, there are clearly not enough CROs to respond effectively to the needs of the disabled.

Education

Formal special education for the blind started in 1950 with the opening of the Kasungu Blind School, which later became Chiranga, by the C.C.A.P. church. Shortly afterwards, the South African Evangelical Fellowship opened a residential school, Lulwa, for the blind. And in 1965 the Royal Commonwealth Society for the Blind introduced integration of the blind and sighted in education.

In 1967, the Malawi government introduced special education into the public educational system, with British funding, by establishing Montfort Teacher Training Centre. Montfort provided free education to the blind and training of specialist teachers for the blind. At the same time, the Malawi government, with NGO assistance, also began providing free education to blind students at all grade levels. Today, there are two residential schools for the blind, thirteen resource centers at the primary level, six resource centers at the secondary level, and Montfort Teacher Training Centre which now exclusively trains teachers of the blind. Resource centers integrate blind and sighted students. In addition to these specialty blind schools, blind students are integrated with sighted students at all levels. This is accomplished with an Itinerant Teaching Program, where specially trained teachers commute to different schools to teach blind students. The program is currently run in seven districts.

Those who have attended school learn the regular curriculum provided to all students as well as skills necessary for the blind such as braille. Thus, all of the blind people I interviewed who had attended school knew braille and some own braille bibles donated by missionaries. The oldest man I interviewed, 95 year old George, spent each evening under a tree reading from his braille bible, after a long day spent working his garden. Another man capitalized on these donations, selling the numerous braille books he received from a British missionary society to the fish mongers in Salima who used the thick pages to wrap fish.

The provision of free education to the blind is a significant benefit. All other students, prior to the change in government in 1994, paid a fee which prevented many from attaining more than a few years of education. Ironically, because of this policy, the blind are often the most educated members of the family and even community. Because the blind are generally not believed to able to help the family cultivate or otherwise earn money, they are also less likely to have their education disrupted. And such education has also served to increase the status of some blind. For example, Lawrence, a blind secondary school student explained that he was isolated and teased by fellow children up until he began attending school. The fact that he was able to attend school and learn things that others did not know, changed people's attitudes. Today, he is the most educated member of his family, soon graduating from Form 4.

In addition to regular schooling for the blind, there is the Mulanje Training Centre, operated by the Ministry of Women and Children's Affairs, where blind individuals may go for life skills training including mobility, cooking, weaving, farming, carpentry, and music. When a person first arrives at the training center, the first question from fellow students is if he or she is partially or totally blind. Students categorize each other based upon one's vision, for the partially sighted may help the completely blind. The partially sighted frequently demand payment from the completely blind for help. And, as it happens, the partially sighted are accused of taking unfair advantage of their sight, such as taking the largest pieces of meat when serving themselves. This contributes to the resentment and distrust some of the blind feel towards the sighted.

Fellow villagers do not always understand how training enables a blind person to work and live independently. Some view it as a waste of time. For example, people teased a sighted woman whose blind husband was sent for training. They said, laughing, "Is he going to see after his training!"

The Blind within the Family and Community

To a certain extent, the blind and sighted occupy worlds unknown to each other. Many sighted people are hopelessly ignorant of the capabilities of a blind person. A blind person is considered incapable of taking care of himself or his family. In a society in which life is precarious and each person is expected to become a contributor to the family's economic well-being, blindness is a serious deterrent to achieving that expectation.

The blind, on the other hand, question the veracity and motives of the sighted. It is not uncommon for the blind to interpret any laughter as being directed at them. Being unable to see a person's facial expressions and actions hinders a blind person's ability to make judgements about an interaction. For example, one informant explained that women have a way of using facial expressions rather than words to mock a person, a slight that cannot be caught by a blind person. Informants told story after story of slights, injustices, teasing, and humiliation.

Most blind report that they were or still are isolated and sometimes ridiculed or teased because of their blindness. Some sighted people also confirm this, though, of course, all stated that they would never do such a thing themselves. In fact, the experiences of blind people within the family and community vary widely. I interviewed a few men and women well integrated into family and community life and clearly well respected. In interviews with these individuals, it was clear that they had been raised in families where they were taught self-sufficiency and confidence in their abilities. They also had at least one person in their lives who encouraged and helped them to achieve independence. Most had received specialized training, though not all. These men and women served as inspirations to their families and neighbors. After interviewing one middle-aged woman who lived alone, farming her own land, a cousin came by to praise her. She had great pride in her cousin, saying to me, "Look, she cultivated all this on her own!"

On the other hand, I also interviewed men and women clearly isolated within their communities. Many had never traveled beyond the borders of their villages and had no responsibilities or tasks beyond sweeping the home. These people came from families that perceived the blind as incapable of independent function. They had received no specialized training and had no person in their lives who encouraged their development and growth into independent adulthood. Some had simply been abandoned by family and community. One teenage boy was convinced his mother left the family because of the burden of his blindness.

In the most extreme example of isolation, one woman in her mid-twenties had been abandoned as a child by her parents and shuffled among other relatives. Although the woman had been identified by MACOHA volunteers as needing assistance and was set up in a series of training programs and income-generation activities, her uncle and other relatives always sabotaged her efforts (see below for an explanation of resources to help the blind). In one scheme, she was taught to sew and was provided a sewing machine. The uncle promptly stole the machine and sold it. When I attempted to interview her, nearly twenty villagers surrounded us, laughing at and mocking her. It took angry yells from Mr. Mataka, Mr. Kumbwenza, and me to get the villagers away from her. They stood in the distance watching us, causing great discomfort and fear for the woman who was near tears.[3]

---

[3] This was the most disturbing and disconcerting interview for all of us. I ended the

One informant equated the blind to the elderly and orphans, stating that these three groups were the least cared for in society. This prompted me to ask others if they agreed and most understood the connection. What these three groups have in common is the need for assistance from others, beyond the usual assistance provided within the family and community, and a perceived inability to defend oneself or have family to protect them. They are, in other words, vulnerable:

> I think the orphans, the blind, and the old people are mistreated the same because they say that the orphans have no parents to go and complain to, the blind because they can't see anyone who is mistreating them, and the old people because they know that they are useless nowBthey are behaving like a child now and they know that they have no power. They can't run after me. People who have crippled legs are not laughed at like the blind or orphans because these they have got eyes to see and they know who is trying to say something behind their backs, so people don't laugh at them. People know that when we laugh at this one, he will see us. And for orphans and the aged, they know that they have nowhere to complain.
>
> [These three categories of people are alike] .....because, for example, the blind, sometimes when they want to get something which is far from them like food and they don't have children around and maybe there is somebody around (whom they ask for help), that person can be saying [sarcastically], "Maybe you became blind because of me!" if he is [too] bored or tired [to help]. For the orphans, someone may tell the children [needing help], "Was I the one who caused your mum's death? I thought your mother died of AIDS because of her prostitution!"

---

interview when her discomfort became clear, though it was not soon enough. We ordered 10 sleeping mats (the latest income-generating activity she had been set up in) from her, mostly to have an excuse to return and check on her well-being. The MACOHA volunteer was aware of her situation, but was helpless to intervene. Mr. Kumbwenza, always scheming to help his fellow blind, was plotting to introduce her to another blind man in the hopes they would marry and leave behind her uncle's village.

Sentumbwe (1995:162) also speaks of this vulnerability:

> Ann Goerdt (personal communication) observed in her study of physical disability in Barbados that the assumed vulnerability of blind people contributes to the negative perception of their disability. In spite of being aware of what blind people were capable of doing, most Barbadians named blindness as the worst handicap one could have. They made references to the blind person's lack of function and, in particular, to the vulnerabilities of the blind. 'Hence, when Barbadians identify the worst handicaps one could have, they reveal their concern with the control of self and the fear of being vulnerable to the control of others' (Goerdt 1984:13).
>
> In Uganda, the helplessness and implicit vulnerability of the disabled and the blind in particular are manifest in the terms *kateyamba* and *agoro*, which the Baganda and Acholi ethnic groups respectively use to categorize the physically disabled. *Kateyamba* means unable to help oneself, and *agoro* may be translated as frail or helpless person. The perception of the blind as "useless" implies that they are often regarded as the most helpless of those believed to be unable to help themselves.

Age and Blindness

A person's age when he or she becomes blind may have an important impact upon his or her experience of and adjustment to blindness. There is a certain expectation that poor vision accompanies old age. In intact families with a good network of support, the elderly often have fewer responsibilities and so their vision loss is not seen as incapacitating as it is among those whose labor is still needed. If the individual has had a successful career and has secured himself and his family financially, then the blindness is not as destructive to the family's well-being. For example, I interviewed one elderly man blind for about five years. He had a large, intact family with several children and their spouses living with him. He had been a successful farmer prior to his blindness and was able to maintain his status with the labor of his children. The entire family lived well.

On the other hand, for those blinded in adulthood, they have less access to the limited resources available to the blind, such as free education. As a 45 year old man, blinded at the age of three, said:

> . . . [F]or us who became blind while young, we had the chance of going to school where we learned to walk or do farming and many thingsBhow they can be done if you are blind. But if you become blind while an adult, you can't have that opportunity to go to school and start again to learn how to walk and do all the things they teach.

Additionally, if there is disruption in the family and a lack of support, as is common in Malawi, blindness in adulthood can be a serious threat to well-being.

Of course, the most vulnerable are those blinded in infancy and childhood. Infants and children are always the most vulnerable in an impoverished nation. One needs only to see the infant and child mortality rates to realize this fact. Although I did not collect data on the death rate of blind infants and children, health workers felt that the majority of blind children do not survive. They eventually succumb to the conditions that blinded them or to other maladies.

Marriage

Marriage and children are significant life course events in any society and Malawi is no exception. I sought to understand marriage for blind Malawians. While I did not determine the marriage rates of blind men and women, I did discuss people's perceptions of a blind person's marriage prospects. Most people felt that the blind were as likely as the sighted to marry. The majority, though certainly not all, of the people I interviewed who were blinded before marriageable age had married. Many, though, were divorced.

Those who provide services to the blind, such as teachers at blind schools and training centers, explicitly discourage the blind from marrying each other. They want the blind to marry sighted spouses in order to improve the welfare of the family. However, marriage between fellow blind happens often, for they go to school together and share experiences that the sighted do not understand.

Although marriage between the sighted and blind occurs, few sighted people told me they would marry a blind person. When I questioned one young woman why she would never marry a blind man when she had just told me the blind were not a burden, she sat quietly for a moment and then admitted that, yes, the blind are a burden, one she was not willing to take on. One of my research assistant's aunts had received a marriage proposal from the only blind lawyer in the country, which she turned down because she did not want to be burdened with a blind husband. Many years later, she is still single and believes that she is, perhaps, being punished for refusing his proposal.[4]

Informants reported that one benefit to marrying a blind woman is that the bridewealth is less than if the man were to marry a sighted woman. Accruing bridewealth can be very difficult. By the same token, blind men have difficulty earning the bridewealth to marry a sighted woman.

---

[4] I had hoped to interview this unusual man, for he had accomplished what so many young blind men and women dreamed of--a higher education and a professional career. Unfortunately, he died unexpectedly before I had the chance to interview him.

Making a Living

Making a living is perhaps the most significant issue facing the blind. It is blind people's diminished prospects of supporting themselves and their families that makes blindness so feared. Indeed, the majority of the blind are amongst the poorest of the poor in Malawi. A blind person's low status in society is linked to his or her poor employment prospects and poverty. As one 54 year old sighted man stated,

> [The blind] are not respected. They are very poor. A blind person cannot be respected because there is nothing in him that people can see and respect.

This poverty had a profound impact upon my research assistants. Mr. Mataka, in particular, was stunned by the poverty he witnessed and took it upon himself to educate his family and friends on the importance of eye health in order to avoid such a fate. The poverty of the blind, of course, is relative, for Mr. Mataka and his neighbors living in the squatter settlement outside Lilongwe are also impoverished, unable to afford adequate diets and health care.

Most people associate the blind with mendicancy. In the cities and towns, one does see the blind, along with other disabled people, begging in the streets. In Lilongwe, the Muslim leaders, in order to curtail the constant begging at the Mosque, designated Fridays as the day in which alms would be given to beggars. Each Friday, there is a long line of disabled and otherwise destitute people along the entrance to the mosque.

This association to mendicancy is humiliating to the blind and is also used by some sighted to humiliate and embarrass the blind. One man stated,

> I refuse to use a stick (to guide himself) because mostly here in Malawi what people do is they can throw banana peels at you or any other fruit peels because they think you are a beggar. I really hate that, so I prefer [to be guided by] being held by the hand.

And another man described being mistaken for a beggar:

> When I went to town one day, some people were laughing and the child who was holding my hand and guiding me told me that the people were laughing at us. The people were saying that we were going to beg.

I interviewed several people who occasionally resorted to begging, an act they detested.

Those who have never received training or education or who lack confidence and the support of family face the severest difficulties. These are the individuals who have never left their own villages, who have never worked beyond the most minimal responsibilities such as sweeping or pounding maize. They live in isolation beyond the companionship and help of family. Individuals report having been left alone, even locked, in the home while parents are in the fields working all day. They do not marry. Many blind are convinced they are incapable of work. The chief of one village held his head down and covered his eyes in shame while we talked. He had been blind for nearly two years and was convinced he was no longer capable of performing even simple tasks.

Those who have received training from their families or from schools or who simply have greater confidence in their abilities have better prospects for supporting themselves. For example, one woman, who enjoys the support of her daughter and son-in-law, describes how she still cultivates in her garden:

> I don't have much trouble working, because I even cultivate in my garden alone. I trained myself. I used my brains. I remember the way I was cultivating when I had vision and how I might be able to do it now that I am blind. So that is how I do it now. I hold the plant in one hand and use the other hand to weed, so that I don't cut down the plant as I weed.

However, the support of family is still vital, as the Ntholo family's story reveals. Although the Ntholos received a better education and training than most Malawians, they were destitute because of a lack of family support. They used to receive support from Mr. Ntholo's parents, but since his parents passed away, the remaining family members have not extended sufficient support.

CHAPTER 8
THE POLITICAL ECONOMY OF BLINDNESS AND DISABILITY

Malawi is a desperately poor nation, burdened by astonishingly high rates of disease and death. This poverty, borne of more than a hundred years of oppressive and exploitive rule, is the reason so many people suffer from preventable and curable blindness. The wealthy simply do not succumb to blinding trachoma, measles, or vitamin A deficiency and they have access to quality biomedical procedures to prevent the blindness of cataract and glaucoma. And it is Malawi's long history of oppression and exploitation that has drastically constricted people's ability to respond effectively and timely to debilitating and deadly disease.

THE BARRIERS TO PREVENTING BLINDNESS

This research has compiled a lengthy list of barriers preventing people from seeking timely biomedical care for blinding eye conditions and, once having sought treatment, preventing successful treatment. These intractable barriers are the direct result of an unfair, inequitable political economy in which the vast majority of Malawians struggle for their basic needs.

Much research exploring people's health seeking behavior focuses on individual responses to disease and attitudes towards various healing practices. Examinations at this level often reveal many barriers to receiving successful treatment, but fail to recognize larger, political economic factors that are the ultimate source of constraint upon people's perceptions and actions.

Can larger political economic factors influence individual action and beliefs? Yes, they can and do, for these factors form the infrastructure within which people understand what is "normal," "right," and "possible." If a person cannot conceive of something, then it cannot exist for her. Thus, in a community in which no one experiences true health without the constant threat of hunger and multiple debilitating and deadly diseases, then a distorted perception of "healthy," in which grave illness and malnutrition come to define "normal," develops. In a community in which no one has ever procured adequate health care, then diminished expectations of treatment develop. And in a community in which no one has ever been empowered to effect change without the threat of severe punishment from tyrannical rulers, then convoluted and often ineffectual actions to effect change, at the best, develop. At the worst, inaction is the result.

In Malawi, we find several clear barriers to seeking and receiving effective treatment for preventable and curable blinding conditions. These barriers all point to the larger political economy of Malawi, a political economy which has resulted in a nation with one of the most grossly inequitable distribution of resources in existence today.

1. Distorted Perceptions of "Healthy"

The majority of Malawians live in a constant state of deprivation, severely distorting their expectations of health. Their acceptance of quite severe disease and debilitation as "healthy" and "normal" can not be attributed to "cultural beliefs," for they are the outcome of diminished expectations and limited opportunities. Such distortions conspire against timely treatment of deadly and debilitation diseases.

2. Insufficient Patient Capital.

Although biomedical eye treatments are ostensibly free, no health care treatment is truly free. Costs of treatment include lost productivity, child care, transport to the hospital, the assistance of a guardian to accompany one to the hospital, and food and other care while hospitalized. And, in order to prevent recurrences, patients must have resources to lead healthy lives, such as adequate food, safe water, and appropriate sanitation, resources out of reach for most Malawians. Finally, Malawians have learned that in order to achieve most anything in Malawi, one needs a "patron" or other form of access to power. It is through connections to others that one gains access to scarce resources. Once again, poor Malawians lack these vital patron-client relationships. The lack of "capital" to effect action conspires against timely treatment of deadly and debilitating diseases.

3. Limited Access to Biomedical Resources.

Biomedical health care resources are limited and rationed. The majority of people live long distances from health care facilities making timely travel to a facility extremely difficult. For those who make it to a health care facility, the functioning of the facility is so severely compromised that adequate care is rarely received. Patients may spend an entire day seeking treatment, exacerbating the costs of seeking treatment. Or they may arrive at a facility to find it unexpectedly closed. Health care facilities lack sufficient medicines and health care personnel to meet the needs of patients. Thus, patients may receive inadequate or ineffectual medicine to effect a cure or may not receive any medicine. This limited access to biomedical resources, conspires against effective and timely treatment.

4. Low Expectations of Treatments.

People learn of treatments from friends and family. When biomedical health care is of such poor quality that treatments fail or worsen conditions, this destroys the reputation of all biomedical health care. Additionally, patients are not educated on prevention. Other sources of infectious disease, such as family members, are not treated. Thus, reinfection is common. Why don't biomedical staff provide information to help people prevent problems? The reasons are numerous, but the encounter described in Chapter 3, in which the medical assistant found it useless to advise a mother on proper nutrition for her son because she was too poor to follow the advice, was telling. The medical assistant taught me a valuable lesson. Information does not equal prevention, for other issues, such as poverty, impinge upon a person's ability to act upon that information. Thus, poor medical care, poor prevention efforts, and the inability to implement preventive efforts conspire against effective treatment of debilitating and deadly disease.

5. Lack of Knowledge of Biomedical Conditions and Treatments. Biomedical health care personnel often fail to explain to patients what they are suffering, the purpose and expected outcome of treatments, and how to avoid reinfection. Explanations for insufficient or a lack of medicine are not given to patients. Patients, thus, have misconceptions about biomedical practices. Inadequate medicine is perceived as ineffectual. Surgeries that do not lead to the restoration of sight are perceived as failures or as more damaging than no treatment. Additionally, the equation of *sanga* to mean both cataracts and corneal scarring, further exacerbates the confusion patients face in understanding biomedical treatments. When people are not informed, then their misunderstandings conspire against timely treatments.

THE CONSEQUENCES OF BEING BLIND

Just as the political economy forms the infrastructure within which people develop expectations about health, it also forms the infrastructure within which people define and understand disability. A society's ability to care for those members unable to care for themselves is a reflection of that society's resources and the equitable distribution of those resources. The same may be said of the family, for a family's ability to care for its members is a reflection of its resources and the equitable distribution of those resources.

In a country in which the majority of people are consigned to poverty, struggling to provide themselves and their families with basic needs, a person's ability to work takes on tremendous significance. It becomes one of the most important identities of the individual, for any factor that diminishes one's ability to work affects one's life chances.

In Malawi, over one hundred years of oppression and exploitation have resulted in a society with insufficient and inequitably distributed resources. The result is a society in which any impairment in bodily function that affects the capacity to work is considered a grave disability. Impairments that do not lessen a person's productivity, such as deafness, are not considered disabling.[1] And for those with grave disabilities who have economic means, then their disability loses significance as a defining characteristic, for they are able to fulfill their supportive obligations.

---

[1] In a largely agricultural society, deafness is not a barrier to working the crops and providing for the family.

Thus, in Malawi, blindness is perceived as a serious and frightening disability. They are vulnerable to even greater poverty than the average Malawian. They represent the poorest of the poor. Society can only partially buffer this experience of disability. With the help of aid agencies, Malawi is able to provide education and training to some of its blind citizens, but it does not have the resources to meet all of their needs. The family, too, can buffer this experience of disability. A supportive and intact family can extend support to its blind members, providing opportunities to learn life skills and to become productive workers. But if that support is lacking, even the blind with education and training struggle to support themselves and family members.

BIBLIOGRAPHY

Africa Watch
1990 Where Silence Rules: The Suppression of Dissent in Malawi. New York: An Africa Watch Report.

Amin, Samir
1972 Underdevelopment and Dependence in Black Africa: Origins and Contemporary Forms. Journal of Modern African Studies 4:503-521.

Baer, Hans
1982 On the Political Economy of Health. Medical Anthropology Newsletter 14(1):1-2, 13-17.

Baer, Hans, Merrill Singer, and John Johnson
1986 Towards a Critical Medical Anthropology. Special Issue of Social Science and Medicine 23(2).

Baer, Hans, Merrill Singer, and Ida Susser
1997 Medical Anthropology and the World System: A Critical Perspective. Westport, CT: Bergin & Garvey.

Bar, G.
1993 Albinism in Malawi. Malawi Medical Journal 9(2):10-11.

Bourgois, Philippe
2002 In Search of Respect: Selling Crack in El Barrio. Cambridge: Cambridge University Press.

Canguilhem, Georges
1991 The Normal and the Pathological. Zone Books.

Carbone, Maurizio
2003 "Green Gold": Tobacco as Malawi's Lifeline. The Courier 201:51-52.

C.C.A.M.
1992 Malawi Traditional and Modern Cooking. Blantyre, Malawi: Chitukuko Cha Amayi m'Malawi.

Chavunguma, Tendayi
1997 Josefa Yolamu: A man with a face people refuse to look at twice. The Weekly Chronicle, February 21-March 2:8.

Chevigny, H.
1946 My Eyes Have a Cold Nose. New Haven: Yale University Press.

Chimwaza, Edward
1997 Woman Scares Zambian Team. The Star, January 24:1.

Chirambo, M. C. and L. Schwab
1989 Ophthalmology in Malawi. Archives in Ophthalmology 107:1826-1829.

Chirambo, M. C., J. M. Tielsch, K. P. West, J. Katz, T. Tizazu, L. Schwab, G. Johnson, J. Smartwood, H. R. Taylor, and A. Sommer
1986 Blindness and Visual Impairment in Southern Malawi. Bulletin of the World Health Organization 64(4):567-572.

Colson, Elizabeth
1984 The Reordering of Experience: Anthropological Involvement with Time (based on the 70th Annual Faculty Research Lecture, University of California at Berkeley, April 20, 1983). Journal of Anthropological Research 40(1):1-13.

Courtright, Paul
1994 Acceptance of surgery for trichiasis among rural Malawian women. East African Medical Journal 71:35-36.

Courtright, Paul, Susan Lewallen, Steve Kanjaloti, D. J. Divala
1994 Traditional eye medicine use among patients with corneal disease in rural Malawi. British Journal of Ophthalmology 78:810-812.

Courtright, Paul, Steve Kanjaloti, Susan Lewallen
1995 Barriers to Acceptance of Cataract Surgery Among Patients Presenting to District Hospitals in Rural Malawi. Tropical and Geographic Medicine 47(1)15-18.

Daily Times
1997 Alleged witchcraft: staff desert hospital. Daily Times, January 21:2.

Dawson, C. R., J. Schachter, S. Sallam, A. Sheta, R. A. Rubinstein, H. Washton
1997 A comparison of oral azithromycin with topical oxytetracycline/polymyxin for the treatment of trachoma in children. Clinical Infectious Diseases March, 24(3):363-8.

The Democrat

1997 Advertisements. The Democrat, January:8.

Deshen, Shlomo

1987 Coming of age among blind people in Israel. Disability, Handicap and Society 2(2):137-149.

Dugger, Celia W.

2004 In Africa, an Exodus of Nurses. The New York Times, July 12.

Eloff, J. and A. Foster

2000 Cataract surgical coverage: results of a population-based survey at Nkhoma, Malawi. Ophthalmic Epidemiology 7(3):219-21.

Evans-Pritchard, E. E.

1937 Witchcraft, Oracles and Magic among the Azande. Oxford: Clarendon Press.

Fanon, Frantz

1963 The Wretched of the Earth. New York: Grove Press.

1967 Black Skin White Masks. New York: Grove Press.

Farmer, Paul

1999 Infections and Inequalities: The Modern Plagues. Berkeley: University of California Press.

Forgacs, David, ed.

2000 The Antonio Gramsci Reader: Selected Writings 1916-1935. New York: New York University Press.

Foucault, Michel

1994 The Order of Things. New York: Random House.

Friedson, Steven

1996 Dancing Prophets: Musical Experience in Tumbuka Healing. Chicago: University of Chicago Press.

Gwaltney, John L.

1970 The Thrice Shy: Cultural Accommodation to Blindness and Other Disasters in a Mexican Community. New York: Columbia University Press.

Hanks, J. R. And L. M. Hanks
1948 The Physically Handicapped in Certain Non-Occidental Societies. Journal of Social Issues 4:11-20.

Iliffe, John
1987 The African Poor: A History. Cambridge: Cambridge University Press.

Ingman, Stanley, and Anthony Thomas, eds.
1975 Topias and Utopias in Health: Policy Studies. Hague: Mouton.

International Health Ministries
1998 Christian Health Association of Malawi (CHAM). Electronic document. http://www.pcusa.org/health/international/profiles/cham.htm

Joint United Nations Programme on HIV/AIDS
1998 Report on the global HIV/AIDS epidemic. United Nations.

Kalinga, Owen and Cynthia Crosby
2001 Historical Dictionary of Malawi, 3rd Edition. Lanham, Maryland: The Scarecrow Press, Inc.

Kaunda, Jonathan
1992 The Administrative Organization and the Processes of National Development Planning in Malawi. *In* Malawi at the Crossroads: The Post-Colonial Political Economy. C. Z. Mhone, ed. Harare, Zimbabwe: SAPES Trust.

Kayira, Jenala
1997 Church elder in witchcraft scandal. The Weekly Chronicle, April 21, 27:2.

Keller, Helen
1914 The World I Live In. New York: The Century Company.

King, Michael and Elspeth King
1992 The Story of Medicine and Disease in Malawi: The 130 Years Since Livingstone. Blantyre, Malawi: The Montfort Press.

Laguerre, M.
1987 Afro-Caribbean Folk Medicine. S. Hadley, MA: Bergin & Garvey.

Lane, S. D., B. I. Mikhail, A. Reizian, P. Courtright, R. Marx, and C. R. Dawson
1992 Sociocultural Aspects of Blindness in an Egyptian Delta Hamlet: Visual Impairment vs. Visual Disability. Medical Anthropology 15:1-16.

Leatherman, Thomas, Susan Luerssen, Lisa Marowitz, and R. Brook Thomas

1986 Illness and Political Economy: The Andean Dialectic. Cultural Survival Quarterly 10(3):19-22.

Lewallen, Susan and Paul Courtright

2000 Recognizing and Reducing Barriers to Cataract Surgery. Community Eye Health 13(34):20-21.

2001 Blindness in Africa: present situation and future needs. British Journal of Ophthalmology 85:897-903.

Lock, Margaret, and Nancy Scheper-Hughes

1987 The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. Medical Anthropology Quarterly 1(1):6-41.

Lwanda, John

1997 Promises, Power, Politics & Poverty: Democratic Transition in Malawi. Glasgow: Dudu Nsomba Publications, Ltd.

1993 Kamuzu Banda of Malawi: A Study of Promise, Power, and Paralysis (1961 to 1993). Glasgow: Dudu Nsomba Publications, Ltd.

Mandaza, Ibbo

1992 Foreward. *In* Malawi at the Crossroads: The Pos-Colonial Economy. C. Z. Mhone, ed. Harare, Zimbabwe: SAPES books.

Marx, Rani

1988 Sociomedical Aspects of Trachoma. Acta Ophthalmologica 66(Supplement 183):9-63.

McClain, Carol Shepherd

1989 Women as Healers: Cross-Cultural Perspectives. Newark, New Jersey: Rutgers University Press.

Mchombo, Sam

1998 Democratization in Malawi: Its Roots and Prospects. *In* Democratization in Late Twentieth-Century Africa: Coping with Uncertainty. Jean-Germain Gros, ed. Westport, Connecticut: Greenwood Press.

Mehta, Ved

1957 Face to Face: An Autobiography. Boston: Little, Brown, and Company.

Merleau-Ponty, M.
1962 Phenomenology of Perception. New York: Humanities Press.

Ministry of Health and Population
2003 Malawi: Health Management Information Bulletin, Special Issue 2002. Electronic document. http://www.malawi.gov.mw/health/Information/health%20Bulletin%202002-%20for%20verification%20only.pdf

2004 A List of Doctors in Government Hospitals. Electronic document. http://www.malawi.gov.mw/health.htm

Mitchell, J. Clyde
1956 The Yao Village: A Study in the Social Structure of a Malawian People. Manchester: Manchester University Press.

Morris, Brian
2000 The Power of Animals: An Ethnography. New York: Berg.

Morsy, Soheir
1979 The Missing Link in Medical Anthropology: The Political Economy of Health. Reviews in Anthropology 6:349-363.

1990 Political Economy in Medical Anthropology. *In* Medical Anthropology: Contemporary Theory and Method. T. Johnson and C. Sargent, eds. New York: Praeger.

Mpasu, Sam
1995 Political Prisoner 3/75 of Dr. H. Kamuzu Banda of Malawi. Harare, Zimbabwe: African Publishing Group.

Naipaul, Shiva
1979 North of South. New York: Penguin Books.

The Nation
1997a Imposters murder woman. The Nation, March 27:3.

1997b Suspected wizard takes refuge at police station. The Nation, April 21:4.

National Economic Council
2000 Profile of Poverty in Malawi, 1998. Lilongwe, Malawi: National Economic Council Poverty Monitoring System.

National Statistical Office

2002 Malawi: An Atlas of Social Statistics, 2002. Electronic document. http://www.nso.malawi.net

1998 1998 Population and Housing Census. Electronic document. http://www.nso.malawi.net/

Navarro, Vicente

2002 A Historical Review (1965-1997) of Studies on Class, Health, and Quality of Life: A Personal Account. *In* The Political Economy of Social Inequalities: Consequences for Health and Quality of Life. V. Navarro, ed. Amityville, New York: Baywood Publishing Company.

Nelson, Harold D., Margarita Dobert, Gordon C. McDonald, James McLaughlin, Barbara Marvin, Donald P. Whitaker

1987 Malawi: A Country Study. Washington, D.C.: Foreign Area Studies of The American University.

Ngugi wa Thiong'o

1981 Detained: A Writer's Prison Diary. Oxford: Heinemann.

Onoge, Omafume

1975 Capitalism and Public Health: A Neglected Theme in the Medical Anthropology of Africa. *In* Topias and Utopias of Health. S. Ingman and A. Thomas, eds. The Hague: Mouton.

Pinifolo, Phinleys

1997 23 dead bodies exhumed in Blantyre. The Enquirer, January 24-January 28:1.

Platt, Anne

1996 Infecting Ourselves: How Environmental and Social Disruption Trigger Disease. Washington, D.C.: Worldwatch Institute.

Reniers, Georges

2003 Divorce and Remarriage in rural Malawi. Electronic document. http://www.demographic-research.org

Richards, A. I.

1956 Chisungu. London: Tavistock.

Sartre, J.

1957 Being and Nothingness. New York: Washington Square Press.

Schachter, J., S. K. West, D. Mabey, C. R. Dawson, L. Bobo, R. Bailey, et al.
1999 Azithromycin in control of trachoma. Lancet, August 21, 354(9179):630-5.

Scheer, J. and N. Groce
1988 Impairment as a Human Constant: Cross-Cultural and Historical Perspectives on Variation. Journal of Social Issues 44(1):23-37.

Scheper-Hughes, Nancy
1992 Death Without Weeping: The Violence of Everyday Life in Brazil. Berkeley: University of California Press.

Scott, R. A.
1969 The Making of Blind Men. New York: Russell Sage.

Scrimshaw, N. S., C. E. Taylor, J. E. Gordon
1968 Interaction of Nutrition and Infection. Geneva: WHO.

Sentumbwe, Nayinda
1995 Sighted Lovers and Blind Husbands: Experiences of Blind Women in Uganda. *In* Disability and Culture. B. Ingstad and S. Reynolds Whyte, eds. Berkeley: University of California Press.

Singer, Merrill, Hans Baer, and Ellen Lazarus, eds.
1990 Critical Medical Anthropology: Theory and Research. Special Issue of Social Science and Medicine 30(2).

Starn, Orin
1992 Missing the Revolution: Anthropologists and the War in Peru. *In* Rereading Cultural Anthropology. G. Marcus, ed. Durham, N.C.: Duke University Press.

Stillwaggon, Eileen
1998 Stunted Lives, Stagnant Economies: Poverty, Disease, and Underdevelopment. New Brunswick: Rutgers University Press.

Taussig, Michael
1978 Nutrition, Development, and Foreign Aid: A Case Study of U.S. Directed Health Care in a Colombian Plantation Zone. International Journal of Health Services 8(1):101-21.

Turshen, Meredith

1984 The Political Ecology of Disease in Tanzania. New Brunswick: Rutgers University Press.

1986 Health and Human Rights in a South African Bantustan. Social Science and Medicine 22(9):887-92.

Vaughan, Megan

1991 Curing their Ills: Colonial Power and African Illness. Stanford: Stanford University Press.

Wendroff, Arnold

1985 Trouble-Shooters and Trouble-Makers: Witchfinding and Traditional Malawian Medicine. Ph.D. dissertation, Department of Sociology, City University of New York.

WHO

1987 WHO Expert Committee on Onchocerciasis. Geneva: World Health Organization.

Williams, T. D.

1978 Malawi: The Politics of Despair. Ithaca: Cornell University Press.

World Bank

1996 Malawi Human Resources and Poverty: Profile and Priorities for Action. The World Bank, Southern Africa Department.

1998 World Development Indicators. Washington, D.C.: World Bank.

1999 World Bank Atlas 1999. Washington, D.C.: World Bank.

Young, E. D.

1877 Nyassa, A Journal of Adventures. London: John Murray.

Zaner, R. M.

1964 The Problem of Embodiment: Some Contributions to a Phenomenology of the Body. The Hague: Martinus Nijhoff.

Zeleza, Tiyambe

1992 Smouldering Charcoal. Oxford: Heinemann.