"Ndadwala ndi Ndatopa" (*I am sick and I am tired*): Women's Caregiving and the Real Cost of Health Policy Reform in Malawi

By

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ABSTRACT

For the past twenty five years, governments throughout the developing world have been adjusting their economies and their social priorities in line with the free-market ideology of international financial institutions through Structural Adjustment programmes. Poor countries, such as Malawi, have undertaken a barrage of economic reforms as advocated by the World Bank and the International Monetary Fund which have systematically transferred responsibility from the state to the individual. We will show that this disinvestment in social welfare by the Malawian state has placed undue burdens upon the household. Health in Malawi has become a commodity through the process of Health Sector Reform, one component of Structural Adjustment which aims to remodel health care under the neoliberal economic tenants of cutbacks, privatization, liberalization and cost recovery. The commodification of health, devoid of any notions of rights, requires individuals and families to provide an increasing share of health care. This can be done either via cash payments or through the in-kind contributions of caring labour. To cope, families employ livelihood strategies and draw on women's hidden work within the household. This has been devastating for the women of Malawi.

Malawian women are struggling to cope with the assaults on their time and resources which have emerged due to high HIV infection rates, acute food shortages, endemic disease and a crumbling public health care system. Women are being asked to care for critically ill family members while still maintaining their household duties of childcare, water and fuel collection, cooking, washing, and crop production. For poor families, women's unpaid labour is the only asset which remains as the health crisis dismantles their livelihoods and they draw on it in an effort to cope. This can mean even drawing on women's principal asset: her own health. Women in Malawi are sick and tired, yet they continue to shoulder the burden of care which health policy has passed to them; formulated without acknowledging the real costs of exploiting women's labour as a substitute for genuine state-led health provision.

This thesis will show that the lived experiences of women caregivers in Malawi is inextricably linked to the policy environment governing the health sector of Malawi, and to the broader neoliberal economic project which has been directing development for the past twenty five years. Neither a structural political economy approach, nor a post-structural livelihoods approach is adequate as a means to understand the situation facing women in Malawi. It is in the meeting of the two levels of analysis, the structural and livelihoods approaches, when we see how policy affects the daily lives of women, where we can advance our knowledge and learn the real-world consequences of adopting particular policies in our societies.

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LIST OF ACRONYMS

ADMARC	Agricultural Development and Marketing Corporation of Malawi
AIDS	Acquired Immunodeficiency Syndrome
CBC	Community Based Counsellor
CIDA	Canadian International Development Agency
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GNP	Gross National Product
HBC	Home Based Care
HIPC	Highly Indebted Poor Countries initiative
HIV	Human Immunodeficiency Virus
HSR	Health Sector Reform
ICOCA	Intervention Counselling and Care
IMF	International Monetary Fund
KRTC	Kachere Rehabilitation and Training Centre
LDC	Least Developed Countries
MCP	Malawi Congress Party
MDHS	Malawi Demographic and Health Survey
MK	Malawi Kwacha
NGO	Non-Governmental Organization
PLWHA	Person Living With HIV/AIDS
PRSP	Poverty Reduction Strategy Papers
QECH	Queen Elizabeth Central Hospital
SAP	Structural Adjustment Programme
SAT	Southern Africa AIDS Training Programme
SDA	Social Dimensions of Adjustment
UDF	United Democratic Front
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
WHO	World Health Organization
WTO	World Trade Organization

Chapter 1: INTRODUCTION

1.1 Introduction

The idea for this project evolved through my experiences working as a physiotherapist in Malawi from 1999- 2001. Things seemed to be steadily getting worse for my colleagues, neighbours and patients and I found it difficult to understand how such a rapid decline was possible. Over the two years, more and more of my patients were coming to the hospital with HIV related disabilities and their families, having exhausted all other options, would bring them to our charity clinic, desperate for assistance. They would have already been to traditional doctors, their bodies marked with tattoo-like medicinal scarring and with pigeon blood rubbed onto their paralyzed limbs. They would have already visited hospitals and been told that there was no treatment available, save to go to the pharmacy in town and buy some aspirin or multi-vitamins. They would have done that. They would have already waited in long lines at hospitals and private clinics, spent precious kwacha in the hopes of levying better service and bought whatever medicine they could afford. They would have already tried all that was available to them. But the patient would still be sick, and getting sicker. As they lost function of their bladders, their wife, or mother or daughter would wrap colourful *chitenjes* around them to serve as diapers. As they lost the ability to swallow solid food, they would be fed soft porridge, carefully spooned into their mouths, taking hours to get through their meals. As they lost the function of their legs, they would be carried on the back of a family member and arrive at our clinic. *Thandizani*, madam. Help us.

What was going on? I wondered if it could all be due to AIDS, and furthermore, whether it was accurate to view the HIV/AIDS epidemic in Malawi as something

inevitable, as the government seemed to suggest, a disease following a course, unalterable save for changes in individual behaviour. I wondered about the government and the donor community's role in the unravelling that I witnessed all around me. I wondered what would be different if the government threw caution to the wind, refused to make debt payments and instead poured their resources into health care. Would things change? Would the legions of women that I met each day in the hospital look less weary, less hungry, less desperate? Would girls be in school, making plans for their futures, instead of providing care for their sick family members? Would the pervasive feeling of lost hope be lifted?

I returned to Malawi in July 2003 to do the fieldwork for this thesis after a two year absence from the country. While many things seemed the same at first glance, many things had changed. There were now advertising billboards all along the main roads in Blantyre and the increase in the number of vehicles made traffic congestion a daily experience. A new South African grocery store had opened and many of the goods which had been unavailable in Malawi were suddenly on the shelf. But there were many signs of social destruction visible on these same streets: a remarkable increase in the number of street children begging in the town centre; carpentry shops specializing in coffin-making had cropped up all over; traditional doctors had set up booths in the market offering 15 day treatments for HIV/AIDS; there were young people looking gravely thin and unwell on every minibus and sidewalk. Most personally was the absence of so many friends and colleagues who had died over the two years that I had been away.

Through a series of economic reforms over the past twenty five years, Malawi has had to make serious cuts in its social spending in line with World Bank enforced Structural Adjustment policies with a subsequent crumbling of investment for

government provided health care. In keeping with neoliberal theory, health policy has been created in Malawi which systematically transfers responsibility from the state to the individual. As traditional caregivers in Malawian society, women and girls are bearing the brunt of this burden, with enormous ramifications for their health, productivity, education and well-being, as well as that of their families.

Recent estimates by the UNAIDS indicate that 28.5 million adults and children live with HIV/AIDS in Africa, with some 2.2 million Africans having died of AIDS in 2001 alone surpassing any other cause of death on the continent (UNAIDS 2002). The epidemic is spreading at an unimaginable rate in southern Africa with no indication of a ceiling on infection rates. According to UNAIDS estimates, it is projected that, between 2000 and 2020, 55 million Africans will die earlier than they would have in the absence of AIDS. By all accounts, the worst is yet to come.

A report from the Malawi office of the UNDP reports that the magnitude of the HIV/AIDS pandemic is far misrepresented by statistics (UNDP Malawi 2003). In 1999, for example, the overall HIV sero-prevalence in adult pregnant women aged between 15 and 49 years was 24 percent, yet the report says that this only represents a fraction of the actual HIV prevalence due to under reporting and misdiagnosis. Even so, the UNDP report indicates that Malawi has one of the lowest life expectancies in the world, based on data from 2001, at 38.5 years. There are an estimated one million orphans in Malawi, which has a population of only 11 million people.

It would be easy to attribute the breakdown of Malawi's health care system to the demands of the HIV/AIDS epidemic which exists in the country, where approximately 30 percent of adults are now infected (GOM 2003). Women are struggling to cope with the assaults on their time and their resources which have emerged not just from high HIV

infection rates, but also acute food shortages, endemic disease and a crumbling public health care system. They have to care for critically ill family members while still maintaining their household duties of childcare, water and food collection, cooking, washing and crop production, with alarming implications for their health and welfare.

Yet the reality that I witnessed in Malawi points to a more complex explanation for the poor health of so many. The shift in health policy from Primary Health Care to policy which follows neoliberal economic lines has reduced the access and availability of government health services in a country of increasingly sick and poor people. The policies not only result in cutbacks on government spending on health, but also open the door for the implementation of user fees and privatized services.

This thesis aims to answer the question as to whether the experiences of excessive burdens of care by women in Malawi can be traced back to the neoliberal shift in health policy and the intrinsically-related HIV/AIDS epidemic, or are they solely the product of an unalterable biomedical process. It will answer this question by exploring the theoretical issues surrounding health and development, including gender. The study will then move to an investigation and analysis of the health policy which has been created over the course of Malawi's history with an eye to the shifts in policy direction that have taken place. Finally, we will do a gendered analysis of health policy in Malawi by examining the experiences of women in Malawi through their narratives of caregiving.

It is difficult to articulate the experience of bearing witness to the devastation of a land. I once heard a British doctor who has worked in Malawi for over a decade describe it as drowning in other people's sorrows. It is hard to describe the incredible burdens that women carry in their efforts to manage their daily labour as well as the increasing demands of caring for sick family members. I watched as households fell apart because

of these demands. Caring for critically ill people is a full time endeavour, made more difficult by uncertain water sources, shortages of fuel wood and expensive and distant medical care. As a result, food was not produced, assets were sold, children were kept out of school in order to help at home, and households fell into situations of stark uncertainty. In the face of such a crisis, the government of Malawi continued to table health policy which decreased access to public health services and increased the burden of care for families. The policies seemed so incongruent with the health situation on the ground in Malawi that I wondered if they could be the source of so much of the suffering which I witnessed daily at my work and in my community.

Through study, I have strengthened my understanding of the complex economic forces that direct the policy changes which I witnessed in Malawi: including the introduction of user fees in hospitals, the loss of government subsidies for agricultural inputs, and the low salaries of public servants. As the political economy of the health crisis facing Malawi became clearer, so did the realization that the experiences of the women I talked to as a physiotherapist were inextricably linked to these macro processes. Social and cultural forces (including decades of male out-migration to work in neighbouring countries) have shaped gender roles within Malawian society such that women are left to hold together the pieces of the family unit. How can you till the soil, grow the crops, feed the family when disease stalks the land? The HIV/AIDS pandemic in southern Africa has shown that the incessant, irreversible, cumulative death of so many productive members of society means that ultimately, in the words of novelist Chinua Achebe, *things fall apart*. But to understand this process we need to learn from those who are struggling to hold it together: the women who are caring for the sick and dying, raising the young, growing the food and inventing new ways of doing things to ensure

their survival. The stories of women in Malawi, used as data in this thesis, tell us something of their individual efforts to maintain their families' livelihoods. Yet it is in the linking of their stories to the broader policy environment that we can advance our knowledge of the successes and failings of the policies which guide our globalized world. These are the policies which we depend upon to create the structures and safety of our societies and therefore it is imperative that we understand the real world effects of adopting them.

To further our knowledge of the problematic of women's caregiving in Malawi's health crisis, we can look to the main schools of development thought for explanatory narratives. The broad theoretical project which is reflected in this thesis is an attempt to develop knowledge at a crossroad: at the meeting place of the structural and post-structural schools of thought; at the intersection of the macro and the micro; and at the juncture of the modernist focus on global structures with the postmodernist attention to individual livelihoods. The development problematic in this thesis is at the nexus of international economic policy and the women in Malawi who are caring for their families. It is at this meeting point, where policy lands directly on the shoulders of poor women, with no filters to soften the blow, that we must turn our attention as development thinkers.

To make some sort of sense of the misery in southern Africa, we can't look only to the household, as postmodernism or livelihood studies might do, chronicling individual experiences and voices, with detailed descriptions of the "local". Nor can we look solely to the global economic system as structuralists might do, focusing entirely on the policies directed by international financial institutions in the North and passed along, through World Bank and IMF policies in the form of Structural Adjustment and now Poverty

Reduction Strategy Papers (PRSPs), to the government of Malawi and its health sector. It is in the analysis of the intersection of the two, policy and everyday lives, that we can best understand the health crisis facing Malawians. It is through the voices and experiences of poor Malawian women who are at the forefront of the health crisis that we can begin to understand the real world consequences of adopting a particular model for our world. Privatization, liberalization, and other tenets of free market ideology are not simply ideas discussed in boardrooms. They are the beams around which our societies are constructed: the rooms we live in, the communities we work in, the nations we are citizens of, are all built around these ideas. It then follows that what we experience within these spaces has a direct relationship with the structures which define the spaces themselves. The best explanation for these experiences lies not in structural or post-structural analysis alone, but in the meeting of the two. This is the overall theoretical framework of the thesis.

The excessive burden of caring labour by women caregivers in Malawi cannot be attributed solely to the epidemic but must also be traced to the neoliberal shift in health policy which has absolved the state of responsibility for the well-being of the population and put the responsibility onto households. Furthermore, government policies can be seen to have helped fuel the spread of HIV/AIDS by not investing in health, calling only on individual behaviour change as the solution and neglecting to acknowledge the low social standing of women in the country. Pursuing an economic bottom-line at all costs means that people, instead of flourishing and developing to their greatest potential, are simply coping.

In the context of the HIV/AIDS crisis in the country, the massive responsibility for care is falling to households as directed by the government's Home Based Care policy.

This thesis will use Malawian women's stories and experiences as a source of knowledge which links our understanding of the impact of structural forces on the individual lives of people. It will show that the health policy which has been created in Malawi, in keeping with the guiding principles of neoliberal economics, is detrimental to the well-being of the country's poor. It has been formulated to explicitly use women's caring labour as a substitute for government services, without acknowledging the costs of this burden for women and their families.

Again, the question to be answered in this thesis is whether the experiences of excessive burdens of care by women in Malawi can be traced back to the neoliberal shift in health policy and the intrinsically-related HIV/AIDS epidemic, or are they solely the product of an unalterable biomedical process.

The thematic focus of this thesis must therefore transcend the usual boundaries of health research, which often limits itself to a technological approach to healing, an over-medicalization of life and of the human condition itself. It will move beyond a narrow view of medicine and instead grasp health as the crux upon which all other factors contributing to well-being (economic status, education, and political freedom) are based. From there, this thesis will extend from the micro-level analysis of individual well-being to a broader analysis of how a macro system operates and reaches down to affect the individual lives of those on the ground. As diverse as those individual lives may be, there is a bigger lesson to be drawn from their experience because the very same system is in operation on a global level, affecting so many other lives. Global capitalism has altered social policy throughout the world by commodifying health as something to be bought and sold on the open market. The pressure of this shift can be felt here in Canada, just as in Malawi.

The approach taken in this thesis does not deny the variable of human agency, the capacity of individuals to respond in a variety of ways to any particular influence. But what it does say is that there is only a limited space to manoeuvre when you are backed into a corner. Instead of focusing on the minutiae of how different people may deal with their individual predicament, we will focus on what forces have put them into that position in the first place. Our analysis of health cannot be isolated from the structural forces of global economics which govern those issues critical to health itself: access to nutritious food, education, healthcare, income and opportunities.

The linking of the crushing burdens facing poor women in Malawi to the policy environment which governs the health sector demands some synthesis of a few related analytical projects. First, at the micro level and using a livelihoods approach, is an examination of the coping strategies employed by women caregivers in an effort to preserve their livelihoods. We will see what women are doing in order to manage the burden of caring labour that they have shouldered in addition to the already heavy responsibilities of labour and social reproduction which shape their daily lives.

Second, there will be an analysis of the political economy of health and health policy in Malawi. This will be reinforced using the women's stories as the foundation for gendered analysis. This is sometimes called the "meso" level of analysis and connects the micro with the macro levels in its examination of the national level forces which affect women's caring labour such as health policy and the reform of the health care system. It will point to the gaps and deficiencies in health policy which have led to women carrying incredible burdens of care during a time of health crisis.

The final level of analysis is the macro level, which will situate the case study of health in Malawi within its broader, global environment. This level involves an

investigation of the action, or inaction, of international actors which contribute to a global system of health and income inequity which manifests itself in our particular study of women's caregiving in Malawi.

1.2 Thesis Statement

While HIV/AIDS is clearly overtaxing the health care system and a poor country's capacity to meet the demands for service, it is the shifts to market principles in Malawi's health policy which have led to the widespread experience of crushing burdens of care for women in Malawi. Shifts in donor policy, including health sector reform, are aimed at replacing an overall notion of the right of access to health with policies based solely on neoliberal economic principles such that health care is now seen as yet another potential commodity on the market, joining the long march and expansion of public goods turned commodities in our global economic system. The commodification of health, devoid of the notion of rights, involves a transfer of responsibility from the state to the individual in the provision of health care. The resulting requirement is that the individual and family must provide an increasing share of health care either via cash payments or through in-kind contributions of caring labour.

Since the capacity to absorb the transfer of responsibility is different for wealthy and poor families, the latter must draw even further on women's hidden work within the household, in an effort to handle that which has been passed to them. In a desperate attempt to preserve their livelihood, this can mean even drawing on women's principal

asset: her own health. Women in Malawi are sick and tired, yet they continue to shoulder the burden of care which health policy has passed to them.

Individual coping or families managing to eke out a survival strategy are not enough and cannot be a substitute for a broad, collective state-led health policy which is adequately funded to provide for rising needs and to meet the right to health for all people. This becomes clear as we do a gender analysis of the impact of health policy on women's caregiving and look to the coping strategies which they have to use as a way of compensating for the failure of policy to ensure health for all.

This thesis will show that the lived experiences of women caregivers in Malawi is inextricably linked to the policy environment governing the health sector of Malawi, and to the broader neoliberal economic project which has been directing development for the past twenty five years. Neither a structural political economy approach, nor a post-structural livelihoods approach is adequate as a means to understand the situation facing women in Malawi. It is in the meeting of the two levels of analysis, the structural and the livelihoods approaches, how policy affects the daily lives of women, where we can advance our knowledge because it is here that we learn the real-world consequences of adopting particular models for our world and policies in our societies.

1.3 Structure of discussion

This thesis follows a format of five chapters.

The first chapter outlines the context and objective of the study. It is an introduction to the problematic: the question to be answered in this thesis. It introduces

the main themes that direct the discussion and proposes the problematic as the thing which remains unanswered. A hypothesis is offered.

The literature review follows, presenting the landscape of the debate which exists in the field of study of health and development through two main grouping of development theory. We will explore what has been written about the political economy of health under the State-Led theories of Modernization and Redistributive approaches to development. Next we will investigate the theories on health and development which emerge under a Market-Led approach to development. Theories on gender, health and development will also be examined under the framework of Market-Led development theory and will provide the link between the macro level approach of development theory presented up to that point and the micro level, livelihoods literature which follows. Lastly, the methodology of the study is explained.

The third chapter presents the political economy of the health crisis in Malawi. It looks at the particular kind of health policy and the subsequent style of health care under the three different periods of development in Malawi: in colonial Nyasaland (1891-1964), in newly independent Malawi (1964-1994) and finally in democratic Malawi (1994-2004 present). Health policy is analyzed and critiqued using the literature on health and development from Chapter Two.

It is in the fourth chapter where we learn the real life consequences of the policies which guide Malawi's health care sector in our analysis of the impact of health sector reform on women in Malawi. This is done by linking women's stories of coping collected during fieldwork in Malawi in 2003 with the particular set of policies which have guided the reform of Malawi's health sector. This gendered analysis of health policy will add to the theoretical criticisms made in the previous chapter by showing the

real lived experiences that these policies create. It is then possible to evaluate the gaps and failures of health policy as it currently exists in Malawi through the use of women's stories.

The fifth and final chapter is a discussion of the findings which emerge from the data presentation. Conclusions are made and general policy recommendations are offered based upon the analysis.

Chapter 2: LITERATURE REVIEW OF HEALTH AND DEVELOPMENT

2.1 Introduction to Health and Development

The expanding arena of health and development studies has grown far beyond an epidemiological project, which looks only at disease processes and transmission, to a broad-based discipline which incorporates social, economic, cultural and gender considerations. Within this arena, two highly contested terms are joined and thus demand some explanation: "health" and "development". What is meant by "health"? It has only recently been widely accepted that the state of health does not merely mean the absence of disease, but rather a broader state of well-being. Under this definition, advocated by the World Health Organization (WHO), one cannot be considered healthy when undernourished and working in hazardous conditions, for example, even when there is no active disease process. Equally contested is the notion of "development". For the purpose of this thesis, development will be regarded as the economic, political and social process whereby the human potential is realized in improved living conditions, nutrition, freedom and the ability to chart one's own destiny.

Many explanations of poor health outcomes in Africa link the situation to political instability or poor governance. The example of Malawi does not support this explanation: it has some of the poorest health outcomes in the region while enjoying a relatively stable political system. More recent views on the abominable state of health in southern Africa have attributed the widespread suffering to the HIV/AIDS pandemic. In particular, experts have told us that women have been differentially affected by a disease process in

which they are significantly more vulnerable, both to the transmission of the virus (more readily passed to women anatomically) and to the deleterious effects of infection (women get sicker more rapidly due to the reproductive demands on their bodies) (Barnett and Whiteside 2002). However, this medical model cannot adequately explain the horrendous conditions that shaped the lives of the women I saw every day while working as a health professional in Malawi. The social, economic and personal devastation that lies in the wake of the Human Immunodeficiency Virus cannot be denied. But what this thesis will show is that the ravished landscape left behind cannot completely be explained by a biomedical process. It cannot explain orphans in societies with complex and embedded extended family structures; stark poverty and famine in an agricultural society which has always fed itself; elderly women raising a generation of grandchildren, at a time when they traditionally should be looked after themselves; and an economy brought to a standstill by the deaths of so many workers. Surely, HIV/AIDS must be seen beyond the boundaries of a medical process in order to understand the interconnections between health, society and development. It is a phenomenon which exists within a social, cultural, economic and political framework, and must be studied within this framework in order to find some explanation for the devastation that exists in southern Africa.

Thus, we are entering the field of social sciences and medicine. But not merely the study of social, cultural, or historical disease processes which is the standard form of research in this field, nor the description of the impact of a particular disease upon a society. For what is of interest is the development problematic which emerges from the intersection of disease with a particular social, economic or political system and the relationship between the disease progression and the political and economic choices made. HIV/AIDS has emerged as a development issue in southern Africa because it threatens to

dismantle all aspects of society: from the negative effects on the economy through the deaths of society's most productive members, to the instability of political systems who lose their leaders, to the enormous damage to the collective psyche of a people facing illness and death in such proportions. HIV/AIDS is a development issue because all sectors of society are affected and the impact is felt everywhere. Whether it is a child kept from school to care for a sick parent, a family destitute by the sale of their livestock to pay for medicine or a crop left unattended for lack of hands to hoe, these experiences affect development when multiplied across households in every village and town, throughout every district of the country and neighbouring countries in the region. When government departments come to a standstill because of the deaths of so many trained employees or an NGO dismantles after the deaths of its directors, the course of development is altered.

HIV/AIDS is not only a tragedy for the family and friends of the infected individual; it is a tragedy for entire nations as the advances of fifty years of development are undone. Carefully planned economic systems are being destroyed, newly created political systems are being upset, plans for the future are being put on hold and furthermore, the ancient and enduring concerns of humanity are being undermined. These concerns, which cross political borders, class boundaries and ethnic divides are somehow universal in their desire for what Nelson Mandela calls "the simple opportunity to live a decent life": to have proper shelter and food to eat, to be able to care for your children and to live with dignity, to have good education for your charges, and your health needs cared for (Thomas 2001).

Yet the spread of HIV/AIDS has simply followed the fault lines of a globalized world increasingly without boundaries. The disparities between health and wealth of the

South and the North can only remind us of the massive economic, social and political inequities in our world (Barnett and Whiteside 2002). While medical advances have downgraded the illness from fatal to chronic in rich countries, it continues to prey on the vulnerability of the largely poor countries of the South, where it meets a complex condition of poverty, underlying ill-health and weakened health care systems. Public health care has been critically undermined in countries undergoing Structural Adjustment through health and economic policies which release the state from the duty of social service provision and transfer the responsibility onto individuals and households. This thesis will look at the particular intersection of neoliberal health policy with women's caring labour with the goal of determining whether the crushing burdens of care that women are experiencing are the product only of a biomedical process or the product of neoliberal health policy. Some claim that these policies have actually helped fuel the epidemic through their neglect of the critical relationship between health and poverty (Whiteside 2002).

It has been well documented that ill health can be both a cause and a consequence of poverty. On an individual level, poverty and disease follow a cyclical relationship: poverty increases ill-health and ill-health increases poverty, in what is known as the poverty/disease cycle (Whiteside 2002). It is also clear that many factors influence the health of an individual or population. These include access to nutritious food, clean water, adequate clothing and shelter, and the means for the hygienic disposal of human waste; freedom from contamination by hazardous substances and environmental pollutants; and relevant information and skills (Bloom and Lucas 1999). Many, if not all, of these factors tend to improve with rising incomes and it is the common experience that declining levels of poverty are generally associated with improving health status.

A recent report entitled Improving the Health of Canadians strengthened the health-to-wealth link that has been postulated for years. The top 20 percent of income earners in Canada live, on average, about five years longer than the lowest 20 percent, according to the report (CPHI 2004). The authors point to the choice and control over all aspects of life that come with having decent income levels and say that many of our choices are determined by material resources.

For countries, the relationship between disease and poverty can affect their overall social and economic development. For example, of the world's total malaria cases, 80 percent are found in Africa which, according to the World Bank, accounts for 11 percent of the continent's disease burden and costs many African countries more than 1 percent of their annual GDP (Barnett and Whiteside 2002, p.127). Overall 36 million people in the world today are infected with HIV and some 95 percent of them live in the global south, in conditions of poverty (Cheru 2002). This understanding of the close relationship between health and development is not new as people have known about it for centuries. Ancient texts such as the Jewish and Christian Bibles make references to disease, such as the association of plagues with social crisis in the Book of Revelations (McNeil 1989).

Disease has affected the development of societies throughout history, affecting which areas were settled, in the case of malaria and the colonization in Africa. Smallpox infested blankets were used to spread disease and decimate Native populations during the settler expansion in North America (McNeil 1989). Modern day examples include the effects of the SARS crisis on Asia's economy and the effects of BSE on Canada's beef industry. Epidemic impacts are history-changing events. They terminate some lives, incapacitate others and stunt the capabilities of those who have to divert energy and time into care. In the end, sufficient numbers of deaths and illnesses make a society take a

path other than that which it would previously have followed. As Diamond has written in the popular book *Guns, Germs and Steel*, North America would have a different population composition, culture, economy and political system had 95% of the indigenous population not been wiped out by microbes originating in Europe (Diamond 1999: p.211).

In his 1949 inaugural speech President Truman declared, *"We must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas"* (Truman quoted in Esteva 1990: p.6). This heralded the beginning of the development project, with its implications for health. The post war reconstruction of Western Europe, funded through heavy investments from the United States through the Bretton Woods institutions, focused on rebuilding infrastructure and industry. Water and electrical systems were rebuilt and upgraded, public housing projects were established and hospitals and schools were constructed. This massive effort was fueled by the belief that a healthy population, once "back on their feet", would get back to the business of being economic actors and Europe's speedy recovery under the Marshall Plan lent support to this idea. Thus the model of modernization and industrialization, through Western financing and via a Western model, as the means leading to prosperity was exported throughout the developing world (Brohman 1996). Many of the original theories of development were first and foremost theories of economic growth and economic transformation, without consideration of political and cultural factors (Martinussen 1997).

Debates about health and development have fallen prey to these same economic theories. There is a substantial body of evidence to support the central connection between health and economics. All major indicators show how much greater the

incidence of ill-health is among people in both poorer countries and poorer families (Wagstaff 2001). The key role of poverty as an underlying determinant of health is undisputed, even within the World Bank, with the risk of ill health now recognized as a characteristic dimension of poverty itself (World Bank 2000). There is also a political economy aspect of health, which indicates that health and economic growth have a bi-directional relationship: good health is an indicator of economic growth just as economic growth indicates improved health (UNDP 1995). The World Health Organization has recently established a Commission on Macroeconomics and Health, headed by Jeffrey Sachs, to further explore the links between health and economic development. With nearly ten percent of the world's economic resources devoted to health care, it is crucial for any development thinking to incorporate an understanding of the issues of human misery and well-being. It follows that we can trace particular shifts in the approach to health and health policy through the guiding framework of development theory, albeit, through a predominantly economic lens.

We will start with State-led approaches to development and then move on to Market-led approaches, and explore what kind of debates on health and development exist under each approach to development theory.

2.2 State- Led Approaches to Health and Development

For the purpose of our review, I will take a broad view of state-led development theory which encapsulates all theories which view the state as the engine and director of economic and social development. Implied is the role of the state as the guarantor and protector of its population and therefore, responsible for providing and directing health

care. Thus, in this section, I will look at Modernization and the redistributive theories of dependency and Marxism, Keynesianism and finally more recent views of state-led development. We will look at how their common development model which gives a central and strong role for the state affects the area of health and development.

2.2.1 Modernization Theory (1940s – 1960s)

Modernization theory dominated the early decades of development theory, the 1940s, 50s and into the 60s with development being conceived narrowly as economic growth. This era is often called "The Golden Age of Capitalism", as there was unprecedented economic growth in the West and in Asia. These years helped to secure the belief that the capitalist structure was the best one from which development could happen. Modernization theorists focused on the positive aspects of "modern" society that the sociological work of Max Weber and Emile Durkeim presented in the late 1800s and early 1900s. Weber attempted to explain why "modern", Western societies were different from others particularly with respect to industrialization. He focused on the emergence of a Protestant work ethic and frugality based on religious strictures against waste and extravagance as the West's key to economic success (Brohman 1996). Durkeim differentiated between two basic types of society, traditional and modern and laid the basis for Talcott Parson's later work on 'pattern variables' which he claimed differentiated traditional and modern societies. They believed that the principal barriers to development are found in the traditional sector but should gradually disappear as this sector is displaced by the forces of modernization (Martinussen 1997).

Modernization theory rests on the idea of "modern" society as the goal of development. At its centre is a vision of democratic, capitalist societies like the USA, UK

and France as models. Economic development and growth in poor countries involved a process of becoming like these modern societies. It would be achieved essentially as those societies had achieved it: through economic changes focused around industrialization, through social changes that would introduce the Western institutions of universalism and achievement based on merit and through political changes marked by secularization and the bureaucratic efficiency of the state (Brohman 1996). Modernization therefore was seen as a structural change process whereby the "traditional" and "backward" Third World countries developed these qualities and became more like the Western world.

Modernization theory is also characterized by the belief of mainstream Western economists during the 1950s and 60s that poverty in developing nations was due to lack of capital. Rostow theorized that once a certain level of accumulation was reached and an economy reached a particular size with a certain amount of basic infrastructure, it would take off on a growth path (Hunt 1989). Therefore, under this theory, donors emphasized arranging more investments, grants and loans to the Third World for large-scale agriculture and manufacturing projects to build up the production base of the country. This would fuel the country's "take off" to economic growth and modernization.

Health and Development under Modernization Theory

From modernization theory emerges the biomedical model of health, the cornerstone of early health and development thinking, which views the body as a machine disconnected from social environments. Under a modernist understanding, the machines were regarded solely in their capacity to work and health care was an intervention, designed to keep these body-machines productive. Health care was institutional, based on

state-led health initiatives. In the development context, Modernization saw a focus on training health personnel overseas and building large, modern health institutions in the main cities of the developing world so that the newly Western trained professionals could replicate the system of modern medicine that was found in developed countries (Phillips and Verhasselt 1994).

The first efforts of global public health emerged out of this thinking, and led to the development of single, universal health policies aimed at the "Third World", just as development approaches at this time were also universal. Local conditions, cultures and politics were not considered. Modernization invokes images of modern health care that have tended to exemplify rational, bureaucratic organization and the production line and depersonalized mechanisms which characterize the modern, western way of life. In the 1920s the Health Office of the League of Nations was established but gained strength, authority and influence when it transformed into the World Health Organization (WHO) in 1948. Their main mandate was the elimination of global infectious diseases and to standardize quarantine regulations in order to prevent the spread of infectious disease between regions (Whaley and Hashim 1995).

Modernization theory has posed great problems for developing countries who are trying to model 'modern' health systems of the West with far fewer resources. The quest for modernization has led to the sidelining of traditional medicine as a viable model for health care in the developing world. It has also opened up developing countries to undue debt burdens as they buy into this image of modern medicine. Critics of this model such as Vincente Navarro argue that health care priorities in resource strapped areas have been wrongly based on the latest technology rather than on providing widespread basic care (Navarro 1976).

Critics of this approach concede that modern medical advances have improved the health and well-being of many people. Yet this approach fails to recognize the importance of cultural and social factors in vulnerability to disease and therefore often fails to meet its desired outcomes. Furthermore, it cannot be accepted as the only solution to the global health crisis, because if for no other reason, the costs are prohibitive. There will be no end to the advances of technology, with each step increasingly more expensive (Navarro 1986). They warn that without a clear vision of what kind of health we are striving for, we may become slaves to the very technology we looked to for liberation.

2.2.2 Redistributive Approaches to Development Theory (1960s – 1980s)

When Western economists realized in the 1960s and 70s that some countries were not "taking off" as Rostow had predicted, their development strategy changed. They saw that some of their programmes actually created more poverty and that the poor were not a part of the growth in the places where it did occur. Questions of equity and distribution of resources arose. In order to deal with poverty and its ill effects such as hunger and disease, an approach was developed to meet people's basic needs which required extensive government involvement in the development process (Sparr 1994). This represented a turn from Modernization to another form of state-led development which saw an expanded role for the state beyond providing support for the private sector, but as an agent of redistribution.

The first group of theories are the capitalist theories which fall under the state-led, redistributive approach to development. Debates on development theory were taking place amongst those Western economists who, while committed to capitalism, were not

unified in their faith in open markets to fuel economic growth. Many believed that the relatively laissez-faire policies of the return to classical economics in the 1930s had led to the Great Depression. This together with international conditions favouring growth led to a replacement of laissez-faire policies with a state-led development approach in the 1940s. This was based on the assumption that the state encapsulates the public interest and thus should spearhead development on the nation's behalf. Strong state involvement in the economy was advocated by John Maynard Keynes, who theorized that government investment can spur private investment. Keynes outlined a series of regulations to direct the development of the private sector, namely Import Substitution Industrialization. In the postwar period the world economy grew at average annual rates of between 5 and 6 percent, and there did not appear to be any end in sight to this growth. Such high expectations and the pursuit of growth-with-equity led to greatly expanded welfare states. In the North, the state-led development theory, advocated by Keynes, assumes a certain rationality on the part of the state which puts the health and well-being of people at the centre of its perspective

In the South, the developing world was becoming more cohesive. Third world governments were seeking independence of action from the United States/ Europe and the USSR and created the Non-Aligned Movement as a platform to announce their independence from the Cold War. The United Nations developed UNCTAD as a platform for the member states of the Non-Aligned Movement to address trade issues. This new collective power of the developing world along with the perceived failure of modernization led to new ideas on health and development. The Non-Aligned Movement was calling for a middle way where strong, socialist states would advance populist platforms which put the well-being of their people alongside economic development as

their top mandates. Together, these two movements in the North and the South led to ideas of Basic Human Needs and Human Rights.

The second group of redistributive theories are Marxist theories. The shortcomings of the Growth and Modernization development project led to a rebirth of interest in the political economy paradigm, of Marxism and what became known as Dependency theory (Wilber and Jameson 1984). The Marxist theory of development suggests that the capitalist structures which exist and inhibit the development of Third World countries must be overthrown and replaced by a socialist society. This will in turn become a communist society over time, but the basic step must be the overthrow, violent or otherwise, of the capitalist structures.

Dependency theory emerged from Latin America under Raoul Prebisch in the 1950s, but enjoyed a heyday in the early 1970s, with the addition of other prominent development economists such as Andre Gunder Frank, Amin and Furtado. Basically, dependency theory holds that the terms of international trade are skewed in favour of the rich, central economies at the expense of the peripheral economies such that the development of the countries at the centre depends upon the underdevelopment of the countries at the periphery (Wilber and Jameson 1984). Marxist 'Dependency' theorists in the 1950s and 1960s called out for self-reliant development for peripheral economies as the only means to escape the inequity and exploitation arising from the power imbalance inherent in capitalist theory.

Marxist theories of redistribution have a common foundation in their critique of capitalism as being designed to be structurally exploitative, succeeding only through the systematic exploitation of human beings. Therefore, ill health is the natural result of the Marxist thesis of immiseration as caused by the normal functioning of the capitalist

system. This is in keeping with the theorists from the Frankfurt School, such as Horkheimer, who postulated that the economy is the first cause of poverty (Horkheimer 1974). Marxist theories allow us to examine the structure of exploitation that exist in modern society and provide a prescriptive goal of distributive justice. They identify oppressed groups and provide an explanation of the sources of the oppression. While not addressing the issue of health directly, Marxism allows us to look very seriously at health as a social condition, influenced by class.

The Marxist position on health is that medicine is part and parcel of the specific class relations and social formation of a capitalist society. Medicine's configuration is dialectically determined by the social demands of labour in the one hand and the social needs of capital on the other (Navarro 1976). Socialist nations assume the financing of all care and leave it to the medical profession to define what is needed. The main postulate that emerges from Marxist readings on health is that social legislation is generated in the reality of a struggle among classes, and primarily between the capitalist and the working classes, whose interests are intrinsically in conflict. This differs from Weberian and Parsonian sociological orthodoxy which assumes that social legislation is developed in the arena of values, such that higher classes are moved by moral instinct to provide for those in the lower classes.

Health and Development under Redistributive Theories

What we see in the 1960s and 70s with redistributive theories of development is a growing recognition of the links between health and development. This was built upon by the parallel project taking place at this time in the development field to move beyond the simple study of national income as an indicator for "development". The concept of

health as being more than the technical provision of medical intervention became more obvious in the 1960s and 70s as the links between health and other aspects of human development were made. For example, it became clear that income is not a direct predictor of well-being through the experiences of Costa Rica, Sri Lanka, Cuba and the Kerala State in India. All posted long life expectancies at birth and low levels of morbidity despite low levels of income per capita (King and Murray 2001). This lent support to the theory that well-managed, state-led health care is the cheapest and most effective means to achieve universal health.

In 1978, the World Health Organization released its "Health for All by the Year 2000" campaign through their foundational document, the Alma-Ata Declaration. It says:

> *Health, a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector* (WHO 1978).

Furthermore, human rights emerged as increasingly important in international development discourse under redistributive, state-led development theory, particularly in the areas of health and education. The legal foundations for those rights were enshrined in the *Universal Declaration of Human Rights* in 1948 and the *International Covenant on Economic, Social and Cultural Rights* in 1966 and were highlighted in the Basic Needs approach. References to the right to health were also made in the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the European Social Charter, 1961, and the African Charter on Human and Peoples' Rights in 1981. It is reported that 110 national constitutions make reference to a right to health care (Gauri 2003). Many international and bilateral development agencies have endorsed a rights-based approach to the provision of health

care in developing countries.[1] A rights-based approach to health reflects the principles of respect for the dignity and worth of each person and the universality of human rights, meaning that it should be applied equally and without discrimination to all people (CIDA 2001). The World Health Organization describes human rights as follows:

> An internationally agreed upon set of principles and norms contained in treaties, declarations and recommendations at the international and regional level. Governments have an obligation to respect, protect and fulfill human rights. In practical terms, international human rights law is about defining what governments can do to us, cannot do to us and should do for us (WHO 2001).

This new rights-based approach to health added strength to the argument of state-led development theorists who had been advocating for a strong role for the state in the development process. With the new legislation, states were obligated to address the protection and advancement of their citizens' health not just to attain a societal ideal, but to abide by the legal institution of international human rights (Evans 2002). Countries could be held to international account if an individual's human dignity were violated through state policies, practices and interventions. Although most challenges to human rights laws involve countries' failures to protect in terms of traditional security, new challenges involving the failure of standard practices of public health are emerging with global epidemics such as SARS and BSE.

The rights discourse is not an uncontested terrain. A foundation for social rights based on dignity, for example, suggests a strong guiding principle of equality compared to one based on agency, which only requires a minimum of social infrastructure as a necessity for individuals to articulate and enact a life plan. What people have a right to, whether people can hold rights without a designated person or entity bearing a duty to

[1] See for example, UNDP (2000), WHO (2002), CIDA (2001) and summary reviews by Hamm (2001) and Marks (2000).

fulfill or protect those rights, and whether or not rights exist prior to their legal establishment are all controversial topics (Sen 1999). Amartya Sen, the widely regarded development economist, writes,

> Growth of GNP or of industrial incomes can, of course, be very important as means to expanding the freedoms enjoyed by the members of the society. But freedoms depend also on other determinants, such as social and economic arrangements (for example, facilities for education and health care) as well as political and civil rights (for example, the liberty to participate in public discussion and scrutiny).

Defining health care as an essential human right means that the failure to provide or establish adequate services invites legitimate criticism but also extends the responsibility to a wide group of actors who have a duty, or what Kant would call an "imperfect obligation", to assist. It not only falls to national governments to provide health, but also to international agencies and citizens of rich countries.

Under a state-led, redistributive development approach, countries are able to develop strong public health systems for all their people, ensuring their right to health (Grenholm 1983). This theory does not view economic growth as the only solution to improve health and sees development of state-led health systems as priority, not left to the indeterminate possibility of future economic success. For example, the state of Kerala, India has health indicators similar to those of the United States, despite a per capita income 99 percent lower (UNDP 2003). Cuba's health care system delivers universal coverage with among the best health indicators in the world despite low per capita costs (Sanso-Soberats 2003). Examples such as this fuel the argument that low per capita GNP cannot in itself be held up as the sole reason for inequalities in health, or for declining access to adequate health care in those with greatest need. According to Sen and Mehrotra, low GNP is not itself a reason for the common and increasing prevalence of

diseases associated with poor environments, poor nutrition and weak reproductive rights (Sen 1999). Equally they argue that basic primary health care and medical care services can and have been implemented by countries with low per capita GNPs such as Kerala, Sri Lanka and Zimbabwe in the 1980s, and typically endorse a Basic Needs kind of approach to development (Jones 1989, Sandbrook 1985). What is required is a commitment by national governments to act as guarantors for universal, broad-based public health coverage.

For those advocates of public health prioritization, the symbolic and substantive commitment of the state to public health is an essential component of its mandate to its citizens, no matter what the economic status of the country may be. They say that health is the crux upon which all other factors contributing to well-being (economic status, education, and political freedom) are based. As such, the state's ability to fulfill its role as health provider is the basis of much of its popular credibility and legitimacy (Garfield and Williams 1989).

2.3 Market- Led Neoliberal Approaches to Health and Development (1980s to the present)

Our second approach to health and development period is the Market-led approach which in its return to classic economic theory revoked much of the role for the state that had been endorsed by State-led development theorists. Under neoliberalism, the state became an enabler of market forces rather than a director of the development process, with huge ramifications for the field of health and development, as we will see in this section.

2.3.1 Neoliberal Theory (1980s to present)

In an era of unprecedented global wealth, millions of people across the world are currently facing a health crisis which reflects the underlying economic reality of globalization, based upon neoliberal economic principles (Hilary 2002). Globalization is not new for our society which has been built upon the integration of markets and cultures for thousands of years. But the new structure of globalization that we see today is the product of a substantial body of economic theory which began in the late 18th century with the publication of Adam Smith's major work, *The Wealth of Nations*. In it he underlined the critical role of market mechanisms as the "invisible hand" which ensured that production in society was organized in the best interests of all (Martinussen 1997). This was the beginning of classical economic theory, which was resurrected by the Chicago School of Economics in the 1930s in opposition to the theory being advocated by Keynes and other advocates of State-led development. Market-led neoliberal economic theory is similar to modernization theory in that both call for an emphasis on economic growth. The difference is the role of the state. Market-led theories remove the active role of the state from the development process. The state serves only to create an enabling environment in which the free market can operate.

Market-led economics have now dominated the global landscape for twenty five years and are advocated and enforced through international institutions such as the World Trade Organization, the World Bank and its affiliated organizations, and the International Monetary Fund. There is a considerable body of literature which looks at the process of globalization which has arisen from the expansion of market-led economies, yet we will focus only on that which is pertinent to our discussion on changes in theories on health and development.

Globalization can be regarded as the process through which there is increased integration between people, societies, and nations through the rapid movement of people, goods, services, technology, finance and politics across borders. This interconnectedness is not new: trade has been a vehicle for human societies to connect for the past 15,000 years with mutual influences being absorbed along the way (Ellwood 2001). What is different now is the compression of these influences – the UNDP call it "shrinking space, shrinking time and disappearing borders" (UNDP 2002).

Some say that the real difference behind the current "globalizations" is that the new interconnectedness is governed by rules and structures, and the exploration of the past is gone. No longer do we go with our bags of salt in search for a partner with whom we can trade for glass, or beads, or spices, sharing language, technology, religion, and culture along the way. We now make the rules beforehand and the partner has to agree to our conditions and rules before we even get there. As such, there is no discovery: we know what we will find before we even get there: *markets*. The resultant homogenization is one of the most contentious issues of globalization. Cultural observers are wary of a world where diversity is exchanged for western style, music, trends and language. Social advocates warn that there can be little endogenous development when everything is reduced to a capital transaction and when property is protected more than people (McNally 2002). These ideas become very important to our future discussion on the commodification of health.

As Roddick writes, the idea of globalization as that of an interconnected world, linked through an appreciation of each other's cultures and united against injustice, is appealing (Roddick 2001). However, this is only one aspect of the changes that are occurring in our world. Advances are not being equally shared by all people, and the

distribution of the benefits of globalization is not just (Ellwood 2001, McNally 2002, Roddick 2001). The stark divisions in the world are becoming clearer as the gap between the rich and the poor becomes ever wider and dissent grows over issues of inequality, environmental destruction and commercialization of culture. The myth that the rising tide of free trade and globalization will *lift all boats* is being debunked by those who claim they only *lift yachts* (Roddick 2001).

The body of literature on globalization, health and development says that the health problem in the developing world is not due to the internal economic management of each country, but rather, is due to unequal distribution of global resources. Critics of globalization point out that poor communities, poor countries, and areas of human development provided outside markets such as education and health, have suffered in the rather ruthless drive towards satisfying the profit motives of the biggest players in the market. Ellwood calls the logic of globalization "seductive', saying that it is appealing because it is based on such a simple principle: free the market of constraints and its self-evolving dynamic will bring employment, wealth and prosperity. But despite the confidence of those who preach the neoliberal gospel, there are clear indications that people are losing their faith (Elwood 2001). The entire system is being called into question as the anti-globalization movement attempts to expose what they call the illusion of capitalism: the idea of capitalism as an engine of prosperity rather than an engine of destruction and upward redistribution (Roddick 2001). Former World Bank chief economist Joseph Stiglitz was given a Nobel Prize in 2001, acknowledging the criticism to neoclassical economics that he had levied. In his coining of the phrase 'Post-Washington Consensus', Stiglitz introduced the implications of applying the idea of systemic market failure to development. At the World Summit on Sustainable

Development in Johannesburg in September 2002, South African president Thabo Mbeki went so far as to term the international economic system 'global apartheid'.

Opposition to the current manifestations of globalization has been fierce in the South. In the opening sentence of *Open Veins of Latin America,* Galeano has written that "the division of labor among nations is that some specialize in winning and others in losing". He also writes:

> Where do people earn the Per Capita income?
> More than one poor starving soul would like to know.
> In our countries, numbers live better than people.
> How many people prosper in times of prosperity?
> How many people find their lives developed by development?
>
> (Galeano, "Those Little Numbers and People")

From all over come voices who dispute the rhetoric of the global powers who present illuminating figures of prosperity and fortune, improved livelihoods and opportunity arising from a globalized world. They say that suffering on such a grand scale can only be explained by a *political economy of brutality* and today, just as earlier in the century, the poor demand an explanation for their suffering (Farmer 2003).

> When we come to you
> Our rags are torn off us
> And you listen all over our naked body.
> As to the cause of our illness
> One glance at our rags would
> Tell you more. It is the same cause that wears out
> Our bodies and our clothes.
>
> The pain in our shoulder comes
> You say, from the damp; and this is also the reason
> For the stain on the wall of our flat.
> So tell us:
> Where does the damp come from?
>
> (Bertolt Brecht, "A Workers Speech to a Doctor")

Some theories which seek to explain the state of population health in the developing world, and Africa in particular, point to political factors, such as the colonial legacy, civil war or corrupt governments, while others point to cultural factors such as traditional practices and sexual mores. Some point to the lack of infrastructure and sanitation systems, while others point to unfair trade policies. However, the major debate concerning the explanation of poor health in the developing world revolves around the ability, or failure, of free-markets to provide good health for a population. Under this major debate come more specific arguments which look at particular features of a liberalized economy and health, such as the effects of privatization of health services on the poor, the effects of an unregulated marketplace on health service provision and the impact of the implementation of user fees on healthcare access. In this section, we will look at these debates and others which arise from the study of health and development under a market-led approach.

The neo-classical resurgence seen in the 1960s, and which gained authority as the dominant economic theory in the 1980s under Thatcher and Reagan administrations, is based on the theory of "laissez faire" economics. According to this theory, governments should stay out of the economy instead of directing economic and social development as advocated in state-led theories. Under neoliberal economic theory governments have two roles only: enforcing contracts and maintaining an enabling environment for the Market. The ultimate goal and vision of neoliberal economic theory is that of widespread economic development whereby the widening of choices available to individuals will translate into individual economic and political power. The policy prescriptions required under this theory are export-led growth, reduction in public sector spending, and privatization and deregulation of industry and public works. With these in place, the

Market will be the most effective and efficient means of distributing growth (Brohman 1996, Hunt 1989, Martinussen 1997, Wilber and Jameson 1984).

Neoclassical economic theory does not view material inequality as unjust, but rather the price that must be paid for development. The idea of "trickle-down" was popularized by Friedrich von Hayek, who argued that income inequality leads to innovation and investment, whereas income redistribution hinders these activities (Hayek 1944). The neoclassical answer to equity lies in the "trickle-down" theory, whereby the gains in economic productivity will, in the long term, trickle down to the population through the Market mechanism.

Under neoliberal economic theory, the individual, rather than the group, class or society is the relevant unit of analysis (Sparr 1994). Society consists of producers and consumers and the differences which exist between people (such as incomes and health status) ultimately reflect differences in their personal choices.

Neoliberal economic theory has been widely advocated and enforced by international financial institutions such as the World Bank and the International Monetary Fund. Based on the World Bank's 1981 Berg Report, most of the macroeconomic reforms that the IMF and Bank teams have insisted developing countries pursue are relatively uniform. The programmes, known commonly as the 'Washington Consensus,' almost always involve the following components: government budget cuts, increases in user fees for public services and privatization of state enterprises; the lifting of price controls, subsidies and other distortions of market forces; liberalization of currency controls and currency devaluation; higher interest rates and deregulation of local finance; removal of import barriers (trade tariffs and quotas); and an emphasis on promotion of exports, above all other economic priorities (World Bank 1981).

Health and Development Under Neoliberal Theory

The major explanations for the widespread experience of poor health in the developing world are economic. All claim the alleged solution to Africa's marginalization and poor human development indicators is *yet more globalization*: more trade, finance and direct investment flows. Neoliberalism's answer to the poor health in developing countries is that they have not put proper policies in place, or have not enforced those in place heavily enough, to allow growth and the "trickle-down" effect to occur. The explanation for the blight of ill-health in the developing world today is poverty, which can be alleviated through open markets. This is the prevailing view emerging from international financial institutions such as the World Bank, Inter-American Development Bank, African Development Bank and in the proposed "New Partnership for Africa's Development", known popularly as Nepad. Authors such as Castro-Leal, Mehra and Carol Graham mirror this view, claiming that in least-developed economies, public institutions are the least effective means of delivering social services while promoting commercialization of these sectors. They claim that any type of redistribution, such as publicly funded health care, involves a significant trade-off against growth. For these critics, social welfare expenditure is a luxury that only economically successful countries can afford. The shared view of these advocates of neoliberal economic principles is that Africa must develop economically before its people can achieve a standard of health comparable with the rest of the world.

The kind of approaches to health that are intrinsic to a neoliberal development model have been criticized as being flawed. For example, as was mentioned earlier, the individual is the relevant unit of analysis under neoliberal economic theory and is seen as a rational actor who would always act in their own best interest. This view of the

individual also directs the operationalization of health under neoliberal systems. It has led to health policies which stress changes in individual behaviour as the solution to improved health through the traditional public health approach based on the "health belief model" (Barnett and Whiteside 2002: p.75). This model assumes that if an individual understands the details of the disease infection and transmission process, he or she will always do what they can to avoid disease. Barnett and Whiteside show that the rational health belief model is flawed because it assumes that an informed individual will make the correct choices about practices adversely affecting his or her health, but it does not consider the many other factors which influence decision making such as gender roles, power, access to resources, autonomy and cultural beliefs and traditions. We have seen the limitations of the rational health belief model in the response to the HIV/AIDS pandemic of targeting women to increase safe sex practices, assuming that once they know the dangers they will begin to protect themselves. Because this approach does not acknowledge the power structures within the societies and cultures in which it is being advocated, it has had limited success.

Furthermore, the international trade in services, a pillar of neoliberal economic theory presents serious challenges to the universal right to health. The danger presented by the commodification of health services for trade on international markets has come to the world's attention through the conflicts around the World Trade Organization's (WTO) decisions related to health (Sen 2003). The WTO's General Agreement on Trade in Services (GATS) and Trade-Related Intellectual Property Rights (TRIPS) agreement pose threats to poor countries' health systems by opening them up to global market forces and the involvement of foreign companies in their health sectors. Private sector health care and health insurance companies from countries such as the USA are able to enter the

markets in poor countries. Also, there is increased trade in health services, with developing countries sending their own medical personnel abroad to work in foreign health systems. Furthermore, essential drugs are protected by patent laws from being produced by poor countries' generic manufacturing industries, posing a real threat to poor countries who are unable to afford the high costs set by Western pharmaceutical companies (Cheru 2002, Sen 2003).

2.3.2 Structural Adjustment Programmes and Health

The clearest example of the effect of neoliberal theory on health and development is the effect of Structural Adjustment Programmes (SAPs). For much of the South, the 1980s debt crisis halted hard-won social and economic progress and many indebted countries were forced to pursue structural adjustment, which led to a profound political-philosophical shift in their development strategies (Sparr 1994). They moved away from more autonomous, nationalistic, inward-oriented, state-interventionist and socialist models towards laissez-faire capitalism.

Starting in the 1980s, developing countries adopted neoliberal strategies under a process of Structural Adjustment, with the promise of rapid economic growth and development. There is a large body of literature which debates the benefits and drawbacks of SAPs, but for our study, we are interested in what these policies mean for health and health policy formation. Therefore, we will look at a few of the main debates on SAPs in Africa and then move on to the impact of the programme on health.

There are many arguments that support the policy framework of Structural Adjustment. It is broadly felt by advocates of the programme that developing countries' governments were too involved in directing their economies, rendering them "inefficient,

unproductive and bureaucratic messes" (Sparr 1994: p.5). Proponents of SAPs say that decreasing the role of the state to leave more room for the market improves the efficiency and effectiveness of the system. Under neoliberalism, economic policies need to focus on creating, rather than distributing wealth. The International Monetary Fund and World Bank officials assume, once again, that growth is the key target and that the poor will eventually benefit in a trickle-down fashion once long-term growth begins.

However, there are also many arguments against the programme and critics point to the widespread worsening of poverty, loss of autonomy and lack of economic growth that have been experienced under SAPs. African economists such as Bright Okagu say that Structural Adjustment policies are deficient in that they ignore the particular characteristics of an underdeveloped economy (Okagu 1989). The structures that are required for the operation of a pure market economy are absent in poor African countries, and therefore, attempts to impose pure market solutions are doomed to fail. He also writes that SAPs emphasize demand-size solutions and thereby squeeze the local economy for resources for debt payments. They do not take into account the types of products (luxury or necessity, producer or consumer) and therefore, ignore the real effects of the skewed income distribution in African countries where the poor have suffered most hardship from the indiscriminate application of adjustment policies. Furthermore, African economies end up being dominated when they are forced through SAPs to completely integrate into a global system of markets. Because of their peripheral position, Okagu claims that they have no control over the market and become even more vulnerable to fluctuations in external markets. Okagu criticizes SAPs' emphasis on increasing export capacities of primary commodities by developing countries and says

that the emphasis should instead be on food production and the construction of linkages between cash crops and domestic processing industries in order to meet local needs.

Mahmood Mamdani evaluates the failure of Structural Adjustment policies to grapple with Africa's economic difficulties. As the root of Africa's economic problems, Mamdani points to the lack of insightful assessments of African conditions in policy formation. He claims that policy makers mistake Africa's "oneness" for "sameness" and fail to recognize that Africa is a unity that is neither monolithic nor homogeneous.

Eboe Hutchful adds to the debate calling the World Bank and IMF policies inappropriate for African economies by urging a fundamental rethinking of adjustment and of the entire neoliberal development project. He is supported by UNRISD's Mkandawire who says that the currently dominant neoliberal paradigm has proven to be misleading as a guide for shaping a state-society nexus that is developmental, democratic and socially inclusive (Mkandawire 2001). He calls for an alternative paradigm, one that would question the abstract boundaries that neoliberals have constructed between 'economic', 'social' and 'political'. He claims that if financial constraints are socially and politically malleable, then it should be possible to build a socially egalitarian macroeconomic agenda- one that locates the pursuit of social objectives, such as the enhancement of social equity, at the heart of economic policy while adjusting all other policy instruments in line with those social objectives (Mkanawire and Soludo 1999, Mkandawire 2001).

Another African writer, Femi Akomolafe, claims that in addition to the social, economic and political dislocation caused by World Bank-IMF imposed reforms, the SAPs are now beginning to erode traditional African values (Akomolafe 1994). They create what he calls a 'grab and grab' mentality which undermines the responsibilities of

the extended family system. In the name of economic reform, Akomolafe says that Africa is building societies based on winners and losers.

No matter what position is taken, it is clear that Structural Adjustment is a long-term process in which developing countries have become perpetually engaged. Programmes now involve addressing social and political factors that are believed to impinge on economic performance. To the previous list of macroeconomic reforms that formed the initial core of adjustments are now an ever-expanding list of non-economic factors such as democratic reforms, good governance, and grassroots participation. It is difficult to see an end to this process. It has been described by Kari Levitt, as "short-term gain for long-term pain" (Levitt 1992).

Now let us turn our attention to the specific set of reforms which have been pursued in the health sector under Structural Adjustment and examine what is being written about the process and about the theoretical underpinnings of these reforms.

Health Sector Reform

One of the most accessible examples of neoclassical theory's handling of health lies within World Bank policy. The Bank's three-pronged health approach for governments is to: foster an enabling environment for households to improve health; improve government spending in health; and promote diversity and competition in health services (World Bank 1987). The World Bank's Health Sector Reform (HSR) policy requires national governments to make drastic cuts on health spending and turn the provision of health over to market forces such that health becomes a commodity. This opens the door for privatized health services, cost recovery in the public sector, expansion

of health NGOs as care providers and control of drug supplies by pharmaceutical companies.

Critics claim that the World Bank's health approach has disastrous effects for the health of the poor (Bond and Dor 2003, Hanson et al 2001, Wakhweya 1995, Whitehead et al 2001, Woolhandler 2003). They say that we can interpret this rhetoric into simpler terms, which have meaning for the everyday lives of the poor. For example, *'foster an enabling environment'* means requiring disadvantaged families to cover the costs of their own health. In other words, putting the burden of health costs on the shoulders of the poor through fee-for-service and cost recovery through user financing. The World Bank maintains that user fees offer financial possibilities to health providers to improve quality of services (Griffin 1992) and that revenues from user fees can be used to subsidize the poorest in a community (Shaw 1995).

The second tenet, *'improve government spending on health'* means trimming government spending by reducing services from comprehensive coverage to a narrowly selective, cost-effective approach. This essentially means an end for Primary Health Care, long held as the most effective means to ensure broad based health coverage for a population. A recent report by the World Health Organization has raised concerns about the World Bank policy which has effectively ended Primary Health Care in the developing world and has called for a return to the goal of "Health for All", which was originally adopted twenty-five years ago (WHO 2003). The report calls for strengthening health systems across the board to address the widening gap between rich and poor countries. The report represents a sharp contrast to the neoliberal model of commercialized health care which the World Bank has been pursuing and stresses the need for immediate steps to build additional state-led health care capacity.

Director-General of the WHO, Lee Jong-wook, calls the global health gaps unacceptable and says that they raise urgent questions about justice. He writes,

> Twenty-five years ago, the Declaration of Alma-Ata challenged the world to embrace the principles of primary health care as the way to overcome gross health inequalities between and within countries. 'Health for All' became the slogan for a movement. It was not just an ideal but an organizing principle: everybody needs and is entitled to the highest possible standard of health. The principles defined at that time remain indispensable for a coherent vision of global health. Turning that vision into reality calls for clarity both on the possibilities and on the obstacles that have slowed and in some cases reversed progress towards meeting the health needs of all people. This entails working with countries especially those most in need not only to confront health crises, but to construct sustainable and equitable health systems (WHO 2003: p.2).

The final concept in the World Bank's health approach is to *'promote diversity and competition'*. This means turning over to private doctors and businesses most of those government services that used to provide free or subsidised care to the poor. This implies a commodification of health and privatisation of most medical and health services which prices many medical interventions beyond the reach of the poor. Critics of privatization say that it ends up putting the brunt of financing on the sick, who are least able to pay (Sen 2003). The World Bank, on the other hand, claims that privatization increases the public's appreciation of health services and prevents overuse (Sen 1998).

By the early 1990s, governments everywhere were rapidly redrawing the boundaries between public and private in order to offload from the public purse the financial responsibility for providing services, in favour of market-led policies and provision. However, authors such as Katsuri Sen argue that these transformations are not simply premised upon a shortage of funds or an overstretching of the public purse, although this has been the proclaimed rationale. She writes that international healthcare

reforms are integral in a wider global agenda that is opening trade and creating markets in public services (Sen 2003).

Mkandawire points to the serious threats to the state-society nexus arising from the global transformation of health care provision and delivery. He says that redistributive health policies have been pivotal in building socially inclusive societies and nations in which "everyone belongs" (Mkandawire 2001). Highly redistributive health care systems embed the inequalities of society within those systems and are used as a platform for redistribution. The lesson from both European and non-European contexts is that social equity, with high levels of social welfare provision accessible to all, has been secured and retained when those services have been available to, paid for and used by, the professional and middle classes. That particular "social contract" is under threat by the international financial institution's thrust toward the privatization of services. Mkandawire warns that the emergence of a global set of health care providers serving the more privileged strata of the population constitutes a serious threat to the political economy of health care. The commodification of health may be undermining the possibility of social solidarity by freeing the middle and professional classes from an obligation to establish social welfare contracts with their working class and rural compatriots.

The World Bank has responded to the theoretical and practical attacks on its health policy. The Bank proposed exemption schemes to deal with the reports of high numbers of poor people unable to access essential services once user fees were implemented. The Bank said that the problem was that poor countries hadn't implemented the policies properly and that if done correctly, privatization and cost-

recovery policies could only improve poorer groups' access to and use of essential health services.

Nonetheless, public health advocates explain the widespread dissatisfaction with these policies in developing countries as a result of the actual, rather than the predicted, effects experienced by families and communities. They say that the World Bank's positive assumptions about market reform of the health sector have not been based in evidence and point to the severe negative effects of these policies as shown by national household surveys and participatory poverty alleviation studies. Rises in out-of-pocket costs for public and private healthcare services are creating a "medical poverty trap" by driving many families into poverty and increasing the severity of poverty for those who are already poor (Whitehead 2001).

The World Health Organization has expressed substantial concern over the quality of care provided by the proliferating private health sector in low-income countries, in particular, at the more informal end of the range of providers (Mills 2002). They also point to the poor capabilities of national governments and health ministries in these same low-income countries to monitor and regulate a varied and often unorganized private sector. They conclude that rather than pouring capital and resources into studying and organizing private health sector activities, investment should be directed towards strengthening the public health sector in poor countries. Hilary Standing and Gerald Bloom agree that the healthcare sector in low income countries increasingly resembles an unregulated marketplace rather than an organized public service (Standing 2003). They point to factors such as cost, convenience, perceived better treatment and poor quality of organized public services which make poor people great users of marketplace providers. As long as public sector salaries in these countries continue to decline, health workers

will move into the marketplace to improve their livelihoods, practicing unsupervised with no quality control as they sell drugs and recommend treatments to consumers who often have little health knowledge.

On the high-end scale of the multiplicity of health providers under a market-led approach are the organizations such as the Melinda and Bill Gates Foundation whose budget for health-related projects alone vastly outweighs that of the World Health Organization. In 1999, the Foundation had donated $6 billion for vaccines while the entire annual budget for the WHO was less than $1 billion. It is difficult to conceptualize how the World Health Organization can maintain its ability to direct countries in their efforts to protect and promote health when faced with such unregulated financial power of the private sector to also intervene in global health affairs (Poku and Whiteside 2002).

The World Bank Development Research Group has published numerous papers which address the accusations that their programmes contribute to the issue of health inequity and breach the social rights of the poor. Davidson Gwatkin, in a World Bank publication, claims that free government health services are not the best way to reach the poor and far from promoting equity, work against it (Gwatkin 2003). He calls for alternative approaches to resource allocation and purchasing based on the evidence he claims shows that overall government health services benefit the better-off more than the poor. To encourage the better-off to pick up a greater part of their own health bills, Gwatkin calls for developing nations' governments to use their authority to establish alternative, self-financed mechanisms through which they can obtain services at their own expense. He says that as long as government health services are free to everyone and used by everyone, any service use by members of an upper income group represents a government subsidy to that group, which can only be rectified through major

modification of government spending. He calls for the implementation of targeting programmes, implementation of user fees and privatized health care in the aim of improving "equity" in health.

Also writing on behalf of the World Bank, Varun Gauri argues that health care and education have been bought and sold throughout the world for at least two thousand years (Gauri 2003). He says that to refuse prices a role in allocation is foolish. Without rewards for good service, and without the information that the prices convey, providers would slack off, innovation and scientific progress in those fields would slow, and consumers would have a harder time distinguishing good from bad providers. Public health advocates challenge the traditional economic tenet in this theory which supposes that poorer groups' payment for health care is evidence of their willingness to pay. They argue that payment is not the same as ability to pay and point to the experiences of poor people, who cannot afford to pay, but still do, at great long-term cost to themselves and their families (Whitehead 2001).

Hanson et al dispute the effectiveness of policies which bring market-type incentives to the task of regulating health care. They first describe the health reform that has taken place in the UK and critique the adoption of this model by developing countries. They cite examples in Indonesia, Zambia and Uganda, where dual payment systems have had negative effects on access to services and on quality of care and conclude that the implementation of market mechanisms clearly presents dangers for equity in access to hospital services, particularly in the developing world (Hanson 2001).

This body of literature indicates that the commodification of health, a component of Structural Adjustment, pits public health advocates against free-market advocates; the former basing their arguments on the notion of health as a human right which the market

is incapable of ensuring, and the latter firmly standing on the belief that the open market is the best way to deliver goods and services to a population. We will now turn to another World Bank programme, the Poverty Reduction Strategy Papers, to see what has been written on what this process may mean for health.

2.3.3 PRSPs and Health

To explain the poverty and ill-health which define life in developing countries, advocates of market-oriented reforms point to what is called the Kuznets hypothesis which says that the initial effect of growth will be to increase inequality, this trend only being reversed when a certain minimum GNP has been reached. In the face of declining health indicators in the poorest countries of sub-Saharan Africa alongside growing criticisms of their role in impoverishing so many, the Bretton Woods Institutions seemed to advocate this theory through their development of programmes such as the "Social Dimensions of Adjustment" and "Adjustment with a Human Face". More substantive were the Bank and the IMF's modification of their core neoliberal philosophy which emerged in 1996 with the Highly Indebted Poor Countries (HIPC) initiative and then in 1999 with Poverty Reduction Strategy Papers (PRSPs), both adopted with the claim of helping the poorest during this purported time of transition.

Proponents of these strategies herald them as the most promising means of securing more effective policymaking and better partnerships between countries and donors. The World Bank and the IMF have stated that PRSPs would be the basis of all lending and debt relief (under HIPC) and point to the "widespread acceptance of the PRSP approach". According to the IMF External Relations Department:

> These (processes) are helping to promote a more open and inclusive national dialogue on the most effective policies and public actions for poverty reduction. Because it is based on the two pillars of country self-help and support from the international community, the PRSP approach promises to make development assistance more effective (IMF 2002).

Civil society groups and public health advocates say that these approaches are nothing more than a whitewashing technique which should be rejected if real change is ever to come (Bond 2003). They call for real changes to the international economic system which will roll back conditionalities, free up resources and assure the associated decommodification of essential health-related services such as water and energy that are crucial for improving Africa's health. At an African conference organized by Jubilee South to assess the PRSPs in the region, debt and development organizations, NGOs, women's organizations and church representatives concluded their debate on the implementation of PRSPs with a declaration, 'Poverty Reduction Strategy Papers: Structural Adjustment Programs in Disguise'. They raised concerns that the PRSPs were not based on real people's participation, ownership or decision-making and that there was no intention of taking civil society's perspectives seriously, but rather to keep participation to mere public relations legitimization. They also criticize the World Bank and IMF for retaining the right to veto the final PRSP programmes as the "ultimate mockery" of the threadbare claim that the PRSPs are based on 'national ownership'(Jubilee South 2001).

The general consensus in the literature emerging from health advocacy groups and the World Health Organization is that the disparity between resources being released for health care under the PRSP initiative and the resources required to provide decent health services, together with the seemingly unconcerned approach to the health crisis facing the

region, together suggest that the PRSPs under the direction of the Bretton Woods institutions do not represent an appropriate solution to the needs of the region. Health budgets are being squeezed due to macroeconomic policy constraints, not resource constraints. The Bretton Woods Institutions dictate the fiscal decisions at the higher levels of decision-making and the social service ministries are involved only at the lower levels, being forced to compete with each other for resources within a given ceiling set by the Bank and the IMF. In the context of largely unchanged allocations for health expenditure, health ministries are only left with the option of reallocating existing budgets to reflect the health sector priorities raised in the PRSPs.

In the most public damnation of these strategies, the chairman of the WHO's Commission on Macroeconomics and Health stated "Why prioritize when there isn't enough money?" In an informal address to the 4th International Conference on Priorities in Health, Professor Jeffrey Sachs maintained that the real causes of the inability of the world's poorest people to receive help for the lethal diseases that burden them did *not* include the "usual suspects": corruption, mismanagement, and wrong priorities (Wilker 2003). The reason that people suffering from AIDS, malaria and tuberculosis in the poorest countries was not that their governments were spending health care funds on tertiary care hospitals when they should have emphasized primary care or vaccinations. It was that the governments and the people did not have enough money. Even if these countries adopted the most perfect priorities, expanded their health care capacities to use health care money more effectively under the guidelines of the PRSPs, and ran their health systems in line with all principles of good governance, they still would not be able to afford the minimal set of interventions recommended by the WHO. The solution, stated Professor Sachs, was not to be found in better priority-setting or management; it is

a massive increase in health care spending in poor countries. The burden of disease will only be lifted if rich countries give more money to poor ones (Wilker 2003). Many in the health and development field were left to wonder if all of their hard work and detailed studies were akin to rearranging the deck chairs on the Titanic as the great ship sank.

The World Health Organization has raised concerns in its critique of the impact of Poverty Reduction Strategy Papers on health. In many countries, health ministries were not consulted at all, or only after a World Bank consultant had prepared an initial draft of the health component of the PRSP. The WHO insists that the degree to which ill-health results in poverty and the role that improved health can play in reducing poverty are not adequately reflected in the PRSPs:

> Ill health is typically described as a consequence of poverty, rather than a cause. Thus, many PRSPs provide data on health status by income quintile, showing that the poor are more likely to suffer from ill health, but very few calculate the impoverishing effects of ill health such as out-of-pocket medical costs, lost income, or the consequences of ill-health/ disability of the breadwinner. The gap in analysis is particularly striking as many PRSPs contain the results of a participatory poverty assessment in which poor people themselves identify ill health as a cause of poverty. As a result of this analysis, *PRSPs characterize health as an outcome of development, rather than a means of achieving it.*
>
> This reflects a traditional definition of health as a social sector, and health spending as consumption rather than investment. This suggests that within the PRSP framework health will remain under-resourced and marginalized as it has been in the past, and that opportunities to reduce poverty through improving health will be missed (WHO 2001 quoted in Bond and Dor 2003: p.8).

The Bank's track record in the health sector reflects their lack of recognition of the link between good health and development. In addition to its role in slashing public health services by means of SAPs, World Bank health projects have also, for the most part, performed badly. In an evaluation of its Health, Nutrition and Population projects between 1970 and 1997, the Bank revealed that less than fifty percent of the projects were sustainable and that in most cases, running costs were underestimated and governments'

ability to repay the loans was overestimated. In a further internal review of the 17 health projects started in 1999, the Bank revealed that 59 percent of projects failed to address the constraints the poor faced in using World Bank health projects, such as the distance to the projects, lack of drugs and payment for services (Verheul 2002).

It is important to look at the financial weight of World Bank health projects, as their operating budget, for health projects alone, is US$1.3 billion, which vastly outweights the WHO's total annual budget of US$90 million (Verheul 2002). Shortcomings are admitted in the review, but the World Bank does not take financial responsibility for its mistakes. The net result in most instances is governments saddled with debts for projects that have not added to their capacity to deliver health care to their populations (Bond 2003).

In conclusion, it appears that the PRSP framework is firmly rooted in the World Bank and IMF's narrow approach to health. They are selective in that they identify a few communicable diseases, focus on technical solutions to these diseases and divert attention and resources away from the need to strengthen health systems. They encourage public private partnerships for interventions and continue to downsize government's role in service provision. Furthermore, they continue to actively promote the privatization of health care, as evidenced by the World Bank's 2002 Private Sector Development Strategy and its drive to increase investments in private health care. Even if the rhetoric has changed, it is clear that policies have not.

2.3.4 Governance and Health

Out of the World Bank's neoliberal philosophy stems the term "good governance". It is relevant to this exploration of the literature on health and development because some

people attribute the failure of health in Africa to a lack of good governance. For example, the role of Thabo Mbeki's leadership in South Africa's HIV/AIDS crisis has been called into question. Critics have blamed him for delaying action, downplaying the crisis and fuelling the spread of infection by publicly questioning the scientific basis for the link between HIV and AIDS (Barnett and Whiteside 2002). The complex debate going on between Mbeki's ANC party and AIDS activists proves to be a fitting introduction to the discussion on governance and health and development in Africa.

As a continent, there can be no doubt that Africa is facing many problems in the economic, political, environmental, cultural and social spheres. Many Africanists and African writers are now writing about the complex situation as a "*crisis of the state*". Today's problems have deep roots, and it is crucial to recognize the political nature of the transition from colonialism to neo-colonialism in Africa, or with what Frantz Fanon described as 'false decolonisation' (Fanon 1991: p.52).

The implication for health in a "collapsed state" is clear: the destruction of infrastructure, diversion of resources away from social services, and general economic collapse lead to deterioration in primary health services (Toole and Waldman 1997). There are writers who claim that the source of the problem of poverty and disease in Africa lies within leadership priorities related to what the World Bank calls "good governance". Corrupt African governments have failed to address poverty reduction properly, have squandered national resources and have displayed a lack of "political will" in the development process. Essentially, the root of the problem lies in their failure of leadership (Schwab 2001, Englebert 2002).

Apart from the body of academic literature exists a whole world of popular literature that focuses on this theory quite exclusively. In his most recent travelogue *Dark*

Star Safari, Paul Theroux who was once a Peace Corp volunteer in Malawi in the 1960s, makes a list headed, "You Know You are in Malawi When...."

- the first seven shops you pass are coffin-makers;
- people start sentences with, "But we are suffering, sir"; and
- on the day the Minister of Finance announces his National Austerity Plan, it is revealed that thirty-eight Mercedes-Benzes have just been ordered from Germany.

(Theroux 2003)

His point is not missed – the reason for the widespread poverty and ill health in the country lies in the hands of the country's corrupt leaders.

Some find the sole accusation of corruption too narrow an explanation base for the disaster which has befallen African governments in the few decades since Independence. The combination of mismanagement, corruption and inappropriate policy advice is mirrored in the words of former Zambian president, Kenneth Kaunda. When commenting on Zambia's economic plight, he said, "*We are partly to blame, but this is the curse of being born with a copper spoon in our mouths*" (Wrong 2001, p.105). Stiglitz speaks of the changes he witnessed in Kenya, while working for the World Bank. He says that when he first went in the 1960s, the spirit of *uhuru*, the Swahili word for freedom, and *ujama*, the word for self-help, were in the air (Stiglitz 2002). Public health and community based health projects were given top priority by governments. But when he returned in the 80s, he found an economy which had been sinking for years. He writes that some of the problems such as "the seemingly rampant corruption" were of Kenya's own making. But he qualifies this by saying that the high interest rates which resulted from its following IMF advice could be rightly blamed on outsiders (p.40). Bond writes that it is not surprising that an entire generation of nationalist leaders diverted course from populist mandates, such as primary health care (Bond 2003). The problem was that as

social suffering worsened in African countries undergoing adjustment, the capacity of nation-states to increase health and education expenditures declined as social and economic policy-making was increasingly shifted from national capitals to Washington, on behalf of the financial markets.

It is not just governance in the South that has been called into question. For example, in a background paper written for the Commission on the Future of Health Care in Canada, the North-South Institute states that "in order to achieve a foreign policy projecting our values abroad, we need to include an explicit strategy of championing health as a human right on the international stage"(Blouin 2002). This includes assessments of all trade and investment agreements to ensure that they do not conflict with or undermine Canada's commitment to health as a human right, even if the effect will be felt by those far from Canada's national borders. In its assumption of a clear and defined role for donor states in the field of health and development, Canada's action extends the responsibility for health as a human right to the international stage.

Further responsibility for health and development may also be given to Western countries through the platform of "human security". Human security is a broadening form of traditional notions of security which incorporates not only threats of violence to persons, but also expanded forms of harm such as disease, hunger, pollution, fear of persecution, and disasters. The focus of the notion of "human security" is on safety and freedom from fear and want. It implies that human development requires the assurance of health and the protection of human rights. Under the concept of human security, there is a clear and definite shift in emphasis away from the security of states to the security of people (Axworthy 2001, Thomas 2001, and Mack 2002).

While material sufficiency is the crux of human security, it does not embody the whole idea. Human security includes security against economic privation, an acceptable quality of life, and a guarantee of fundamental human rights (Axworthy 2001). It is clear that the concept of human security means more than just "getting by" or surviving, but rather the full experience of living with dignity, of participating in society and having choices about one's destiny. This arises in contradiction to the neoliberal view, which sees coping, or "getting by" as sufficient and that it is the responsibility of individuals to create the conditions that would enable them to live more fully, not the responsibility of the state or donor states.

2.3.5 Conclusion

The shift from state-led to market-led development has had significant implications for the field of health and development. The transition of global health advisor from the World Health Organization to the World Bank has been accompanied by a significant shift away from the traditional concepts of social justice, rights and equity in public health provision towards markets and efficiency. Under the neoliberal market-based model, public health services and 'Health for All' are perceived as obstacles threatening public finances and the wealth of nations. As a result, public health budgets are no longer seen as a productive investment for human development and economic growth but as an unnecessary financial burden on governments. While we previously looked to the state to provide health services in the public sphere, the IMF and the World Bank have replaced the state with a multiplicity of health actors, working in the private sphere. The entire direction of global health provision has shifted.

The promise of neoliberalism and its pledge of the "magic of the Market" has not transformed into economic and social development for the developing countries of the South. They have not only missed out on the benefits of globalization but have suffered most from its negative impacts as a result of the extensive liberalization of their own economies. The greatest gains from trade liberalization have accrued to the wealthiest nations, and to the most powerful economic actors within each country. While some people within developing countries have also benefited, trade liberalization has threatened the livelihoods of the world's most vulnerable communities by exposing them to global market forces.

In response, neoliberal advocates have claimed that what we are seeing in the world today is simply the short, painful adjustment period that must be passed through before the benefits of the free market can be reaped. 'Short term pain for long term gain' is their mantra. The immiseration of the poorest cannot be seen simply as a transitional feature of globalization, or what the WTO and the World Bank call temporary 'adjustment costs' which certain groups will suffer as a result of the structural changes brought about by liberalization. Instead of the convergence and redistribution predicted by neoliberal economic models, increasing income concentration to the detriment of the poorest has emerged as an endogenous and long-term feature of liberalization.

By commodifying health care, neoliberal economic theory has threatened the well being of the world's most vulnerable members, who are unable to access the private market and must depend upon government services to provide health services. The shift from state-led to market-led development has absolved the state of its role as guarantor of the right to health for all people. Health sector reform has imposed serious cutbacks in public health care and created huge barriers to access for the poor in developing countries.

Through policies which systematically transfer responsibility for health care provision from the state to the individual, neoliberal economics have allowed the state to abandon its role in providing health services while individuals are called on to do it for themselves. Yet a bi-directional relationship exists between poverty and ill-health whereby poverty increases ill-health and ill-health increases poverty. Therefore the sickest individuals are also the poorest and vice versa. This relationship is neglected under neoliberal economic theory in which all individuals are assumed to be equal.

The implementation of health care services around such theoretical underpinnings presents grave and lethal challenges to the world's poor, especially in the face of an epidemic such as HIV/AIDS. While the AIDS epidemic in itself would pose incredible challenges to any health care system, it must be seen within the system that has allowed it to flourish and follow the fault lines of poverty and inequality. It is not the disease itself which has crippled the health of so many in Africa, it is the political economic system within which it exists. Market-led health policy is created, devoid of any notion of rights, and leaves the ultimate responsibility for health in the hands of the individual. In poor countries, massive cuts to public health expenditure have destroyed the government services that the poor have traditionally relied upon. The commodification of health, like that of so many other public goods, has created a situation where only the wealthiest members of society have the means to ensure their well-being while the poorest are left without any proper recourse except to draw on whatever resources they may have in an effort to cope with the assaults on their well-being.

How individuals deal with the responsibility for health which has been passed to them by the state becomes the topic of our next section as we turn away from the macro-structural issues surrounding health and development and look at the micro level of

development theory. First is an introduction to the shift in development theory which laid the foundation for the study of individual experience which defines the micro-level approach to development. This will take us to the study of women's issues as a separate field of social science which has opened up the household as a unit of study. This is pivotal to the field of health and development as it engages individual experiences of gender, health and poverty. It also allows for a gendered analysis of policy, which can use the principles of gender studies to predict how policy may affect women. Important to this thesis is that it can also allow gendered analysis of impact of policy which uses women's experiences to highlight the faults in policies which have already been implemented.

2.4 Gender, Health and Development

2.4.1 Gender and Development Theory

The move from macro-level studies to micro-level studies in development provided theoretical strength to support women's studies as a separate sphere of theory and praxis in social sciences, one that looks at the experience of gender as an important feature in how individuals experience the world. It involves recognition that women are systematically oppressed in society and that they typically have less power and authority than comparably situated men (Jaggar 1993). Feminist theory involves an understanding that women are placed in subordinate positions with respect to economic, political, legal and social structures and by applying Marxist theory to the position of women, seeks to explain the particular place of women in contemporary capitalism (Johnson 1990). Other feminists call for awareness that the nature and degree of women's oppression varies

significantly depending on other significant features of their lives – beyond their sex - such as race, class, age, health and ethnicity (Tong 1998).

Feminist theory views the structures of modern society as having been set up to the advantage of men, and thus contribute to women's oppression. Western health care systems are no exception, as we will see in the next section, organized to place disproportionate burdens on women as unpaid and underpaid caregivers for those who are young, ill, or infirm (Doyal 1996). Feminists see the absence of analysis at the household level, considered a private sphere by traditional social sciences, as an attempt to hide the reality faced by women around the world of intense burdens of social reproduction (Beneria and Sen 1981).

Perhaps the most significant consequence of ignoring the role of the household has been the construction of a gender-blind notion of development (Elson 1991, Brydon and Chant 1993). The patriarchal conceptual framework, which saw the world populated with individuals viewed gender as a neutral and unimportant variable, rendering women invisible and powerless (Elson 1991). Minimizing the role of the household has particularly distorted analyses of the role of women and the impact of socioeconomic change and policies on their position and status in society (Mosher 1989). Mosher calls on policy planners to take into account the triple role of women (productive, reproductive, community) and categorizes gender needs into strategic and practical needs. Strategic gender needs are those which have "feminist" outcomes, those which are emancipatory, while practical needs are those which respond to women's particular needs or problems, such as reproductive health services.

Gender analysis of development theory has opened up the household as a valuable site for study and provided gender-disaggregated data which allows for feminist study of

the differential effects of development policy on women. One area of research, feminist critiques of Structural Adjustment policies, claims that while both poor men and poor women are affected by the adjustment process, women are particularly affected (Sparr 1994). They generally have less access to financial resources, work longer hours and have less control over family assets and cash. Maggie Bangser writes that throughout debtor countries the uneven distribution of economic growth, erosion of social sector investment due to debt obligations, and impacts of SAP-related measures have disproportionately reduced poor women's well-being (Bangser 2000).

Feminist writers have pointed to the gender-blind theoretical underpinnings of structural adjustment, such as the assumption of a fully monetized, market-oriented system (Sparr 1994). Under this theory, work performed, services rendered and products made that do not have an explicit price are considered to have no economic value. Another critique is that the programmes assume that men and women are politically and economically equal and therefore do not consider the gender composition and power dynamics of the household. Studies cited by Sparr show that economic decisions are not jointly made and resources are not equally shared in most households (Sparr 1994). Sexual divisions of labour distort resource allocation such that it cannot be assumed that the person doing the labour and the person reaping the revenue derived from that labour are one and the same.

Sparr has written that structural adjustment policies have assumed that women's unpaid domestic work is infinitely flexible and free - regardless of how resources are allocated. The reality faced by poor women is evidence to the contrary: at some point women cannot find another hour in the day or work any harder to accomplish what needs to be done (Sparr 1994). While government services for women have dwindled, the

number of female-headed households in urban and rural areas has increased (UNDP 1995).

The disinvestment by the state in social welfare, a component of market-led economics, places undue burdens upon the household, with a differential impact on women (Neysmith 2000). In cutting back on state-provided services, governments implicitly rely on the quiet army of wives, mothers, daughters, grandmothers, sisters, women friends and neighbours to pick up the burden of care. Brown and Kerr report that when the provision of healthcare shifts from public institutions to the household, it falls squarely on the shoulders of women and girls, the traditional caregivers (Brown and Kerr 1997). The result is that women have less time for agricultural tasks, less time to provide for household food security, less time to spend on other income-earning opportunities, less time for childcare, and if they are young, less time for education.

2.4.2 Gender, Health and Development

In the course of their everyday lives, women and men often face similar challenges to their health. Yet significant differences exist and the most important starting point for explaining these differences is to be found in the realm of biology (Doyal 2002). A woman's capacity for reproduction makes her vulnerable to a wide range of health problems if she is not able to control her own fertility and to go through pregnancy and child-birth safely. This gives women "special needs" which must be met if they are to realize their potential for health.

However, social differences are also important in shaping male and female patterns of health and illness (Doyal 2002). Women and men are assigned specific characteristics in all cultures which include not only different responsibilities and duties

but also varying entitlements to social and economic resources. As a result, men and women living in the same communities or even households can often lead quite different lives, exposing them to different risks and offering them differential access to health and health care (WHO 1998).

With the links between health and poverty already established, gender and health studies allow us to see that a disproportionate share of the burden of global poverty rests on women's shoulders, undermining their health. For example, the UNDP reports that 70 percent of the 1.2 billion people living in poverty in the world are female. There are twice as many women as men among the world's 900 million illiterates; illiteracy having been shown to increase both poverty and disease (UNDP 1995). Gender inequalities intensify and perpetuate poverty, weakening women and girl's ability to overcome it (INSTRAW 1996). Women's health, or lack of health, is a result of their standing and position in society (UNDP 1995). To have improved health, women must gain equality. To gain equality, women must have better health. Gender must be placed alongside race and class as a key determinant of health and health care (Doyal 2002).

Feminist writers argue that it is essential that we recognize that a poor woman's health can be her only asset, one that is vital not only for her livelihood, but also for that of her family and community (Bangser 2000, Doyal 1996, and Standing 1999). It is clear that social hierarchies affect who gets ill and the consequences of such illness, including the effects of accessing or not accessing health services.

Women's health experiences have shown that access to health care can be strongly gender differentiated such that men have better access to curative care while women's care is often focused to their reproductive years (Doyal 1996). Health is dependent on health-seeking behaviour and it is poor women and girls who are least likely to seek

appropriate treatment. Low self-esteem, related to low status, can lead women to neglect their own health needs. Other factors that can limit access for women include: the overall socio-economic status of households; time constraints; the composition of households (female-headed, extended family etc.); intra-household resource allocation related to health care; and legal or social constraints on access to care (Oxaal 1998). Poor women in the developing world have heavy work burdens that may prevent access to health services. Transport costs and time to travel to health facilities, as well as long waiting times once at the facility, deter people from seeking health care.

Within households, the use of health services is differentiated by gender. Studies report that men spend more money on higher level services than women, and that parents are more likely to seek medical attention for sick boys than for girls (Tipping 1995 cited in Oxaal 1998). As well, poor education may leave women unable to make health decisions about treatable conditions. Levels of education of both men and women and maternal occupation are significant for the utilization of health services. A study in the Philippines showed an increased uptake of family planning with any kind of maternal employment (Tipping 1995 cited in Oxaal 1998). Related to access are questions of who makes the decisions for women about when and where to seek medical attention as well as women's own agency for maintaining health.

Many feminist researchers believe that the Western model of health care has been organized to place disproportionate burdens on women and rely on women's labour to subsidize government services (Neysmith 2000). They are used as unpaid and underpaid caregivers for those who are young or sick. Through cutbacks in public health services, governments have sent an unspoken message to women that it is their responsibility to

pick up the slack (Sherwin 1998). Literature which supports this view is presented next as a background to the call for a gendered approach to health and health policy.

Two main articles from the UK and the USA see women's unpaid and underpaid caregiving as a substitute for proper state health provision. In the first, Lesley Doyal, a leading feminist health researcher involved with the women's health movement in Britain, writes that women are not evenly distributed within the health labour force and that the value given to their work is reflected in their low pay, low status and poor working conditions. Doyal speaks of a growing awareness of women's unwaged and often unrecognized work in both caring for the sick and disabled at home and also in maintaining the health of their families through their daily domestic labour. In particular, Doyal writes, it has become clear that the use of women who have been socialized into seeing themselves as caregivers and who have a weaker position in the labour market has played an important part over the years in maintaining a low-cost health sector in Britain.

In a study of status of older women in the post-Reagan era in the USA, Arendell and Estes (1994) write that the 1980s were marked by an ideological revolution in which the New Right promoted a simultaneous revival of the free market and a return of the patriarchal autonomous family. They critique Reagan's ideological project and its implementation through a policy agenda designed to promote both privatization of the welfare state and the isolation of the family from society. In this article, privatization policies are seen to promote the belief that the proper and best form of health and social services are nongovernmental, and bolstered by the rhetoric of family responsibility. According to Arendell and Estes, family labour – more precisely, women's unpaid labour- is viewed as free labour. It is in the government's interest to secure as much of

this free work as possible since it relieves the government of the costs of having to provide adequate long-term care.

Feminist critiques of World Bank health policy point out that while there has been a considerable amount of effort put it to exploring the differential impact of Health Sector Reform on the poor, little gender-disaggregated data has been produced which can look at the gender considerations of health policy. Any exploration of the impact of restructuring on the health of women is constrained by the fact that until recently gender has rarely been taken seriously in the broader analysis of globalization (Doyal 2002). Globalization discourse itself has had a predominantly male focus, with most attention being paid to the public world, while the private arena of the household and family has remained largely invisible. This male bias has been perpetuated by the frequent failure to provide gender-disaggregated data and by the use of indicators which obscure gender differences and inequalities (Doyal 2002).

Nanda writes that the implications of user fees for women's utilization of health care services is great, based on selective studies in Africa (Nanda 2002). Lack of access to resources and inequitable decision-making power mean that when poor women face out-of-pocket costs such as user fees when seeking health care, the cost of care may become out of reach. The disproportionate effect of user fees on women is especially evident in the context of reproductive health, where the implementation of user fees has coincided with rising maternal mortality rates in the poorest countries of the world (Kutzin 1995).

It is recognized that a combination of biological differences and gender inequality have an impact on the health of women and men, on their health seeking behaviour and their access to health services (Jacobson 1993). This recognition has led to the

development of a gendered approach to health policy, based on an understanding of some of the key concepts that have emerged from the wider literature on gender and development (INSTRAW 1996).

Gendered Health Policy

The World Health Organization adopted the Gender and Development (GAD) approach as the cornerstone of its health and population programmes after the 1994 International Conference on Population and Development held in Cairo. Many national governments, bilateral and non-governmental organizations followed suit, incorporating GADs foundational belief that gender differences are more than just biological characteristics, but social constructions which have the potential to change in order to attain the ideal of gender equity and women's empowerment. A gendered approach to health policy was heralded as a means to more effective strategies for protecting and promoting the health of women and their families.

Gender analysis of policy is able to show that policies have a differential effect on different segments of the population, including between men and women. This process shows that policies which are essentially gender-neutral at their origin, through their neglect of the reality of women's daily lives, become tremendously discriminatory in their implementation. Gendered analysis provides a more nuanced view of a population as being comprised of people with varying levels of power and resources, which is in stark contradiction to the neoclassical view of individuals as nothing more than equal economic actors who will constantly seek to maximize their profit and advantage.

If there is a need for a gendered approach to health policy, there is also a need for clear and universal definitions in the approach taken toward women in health policy

(WHO 1998). We will review a few of the terms which will be useful later in this thesis when women's experiences are used to analyze Malawi's health policies.

The term *sex* is used to describe the genetic, physiological or biological characteristics of a person that indicate whether one is female or male. Thus, the difference between men and women is often equated with the differences between their reproductive systems. Oxaal writes that there has been a tendency to emphasize these biological differences as explanatory factors of well being and illness (Oxaal 1998).

Gender refers to women's and men's roles and responsibilities that are socially determined (WHO 1998). Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organized, not because of our biological differences. A gendered approach to health does not exclude biological factors, but considers the critical roles that social and cultural factors play in determining health status.

Gender equity refers to fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes (WHO 1998).

According to the WHO, *gender analysis* is the process that examines the differences in the roles that women and men play and the power balance in their relations. It examines how these differences determine differential exposure to risk, access to the benefits of technology, information, resources and health care, and the realization of rights (WHO 2001).

In the conceptual reorientation from sex-based approach to a gendered approach, gender relations have become the focal points of development programmes, and gender

mainstreaming has emerged as the common strategy to promote gender equality. *Gender mainstreaming* within the United Nations system has been defined by the Economic and Social Council as the process of assessing the implications for women and men of any planned action, including legislation. It involves making women's as well as men's concerns and experiences integral dimensions in the design, implementation, monitoring and evaluation of policies and programmes in all spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality (FAO 2001).

Two main approaches to thinking about gender issues in relation to health policy and practice arise from the literature on gender and health policy: *women's health needs* and *gender equality*. The former, women's health needs, is an approach to health that is concerned with the implications for women of differences in the epidemiological profile between the sexes. It highlights the specific health needs of women and girls as a consequence particularly (although not exclusively) of the biology of reproduction (Oxaal 1998). Specific, women-focused health care interventions are required as a basic right and as a means to address the imbalance of need (Standing 1999).

The second approach of gender equality has been defined by the World Health Organization as the absence of discrimination on the basis of a person's sex in opportunities and the allocation of resources or benefits or in access to services (WHO 2001). Hilary Standing has written that gender equality is the approach to health that is concerned with the role of gender relations in the production of vulnerability to ill health or disadvantage within health care systems. In particular, this approach examines the conditions which promote inequality between the sexes in relation to access and utilization of services (Standing 1997).

The approach of women's health needs has been the one most widely adopted in the mainstream international health movement. One theory used by the World Bank in their 1994 report, *New Agenda for Women's Health,* stresses the cost-effectiveness of strategies aimed at women as a means to improve infant health and reduces its view of women to little more than cost effective agents for improving household and child welfare (Oxaal 1998). This idea of improving child health through women has led to health policies that target women as mothers only yet the strict focus on maternal health means that many of the other, non-reproductive health needs of women are neglected. The concentration on reproductive issues in the mainstream discourse on women's health needs in developing countries has important implications for health policy and planning. This is particularly true today, when structural adjustment policies have lowered the priority of comprehensive primary health care and a shift to selective health programmes is occurring (Lewis and Kieffer 1994).

2.4.3 Conclusion

It is clear that gender plays a key role in the experience of health. In the context of neoliberal health reforms, three key ideas emerge from the literature. The first is that women are differentially affected by market-led reforms of the health sector. They have less access to, and control of, financial resources which are needed in order to make user fee payments or to access private health services. This has direct implication for women and family health as services are either not sought or women have sacrifice other essential inputs, such as food, in order to access health services.

Secondly is the less direct effect on women's health which occurs as nation-states withdraw from the provision of public health goods. The decline in public health

provision has led to major increases in women's domestic responsibilities as they attempt to shoulder the burden through their caring labour. For many this creates a 'time famine' with very little opportunity for rest and renewal amid the competing demands of paid and unpaid work (Doyal 1994).

Lastly, this literature points to the importance of adopting gender based analysis to all areas of policy making. In particular, a gendered approach to health policy has the potential to produce policies which are sensitive to the different circumstances and health needs of women and men such that their effects are equitable.

2.5 Livelihoods Approach to Development Theory (mid 1980s – present)

The move to the "local" as the unit of postmodern analysis came as a rejection of the meta-narratives that had pervaded the social sciences and their foundational belief that human beings could understand the world through objective, scientific knowledge. Many scholars of the middle and late 20th century no longer believe in the positivist claim to knowledge, but instead hold that the origin of knowledge is socially constructed and shaped by experience. Postmodernists argue that our understanding of reality is not a one-for-one representation of the world, but rather the result of both individual and social processes mediated by way of language, which alters, selects, and transforms our experience.

The livelihoods approach to development theory opened up for analysis all of the spaces of people's lives which had been ignored by macro-structural studies. Individual experience was given importance as a valuable source of development knowledge. Furthermore, while livelihood studies seem to hold little in common with earlier sections

which looked at market-led approaches and World Bank social policy, there is a strong connection between them because livelihood studies developed as an academic debate which attempts to theorize the shift to the individual as the unit of analysis under neoliberalism. As the state abandons its role in providing social services, individuals are called on to do it for themselves. The study of their individual efforts to manage this responsibility is the foundation of the livelihoods approach to development theory.

2.5.1 Health and Development under the Livelihoods Development Theory

Livelihoods development theory allows a more individual, micro-level examination of the development process. As such, health is viewed as an individual experience, one that involves consideration of economic status, culture, gender, race, interpersonal power relations and all of the other components that postmodernism so clearly brought to light. Under a livelihoods approach, we begin to see more individual accounts of the experience of health and ill-health. Community health becomes a real and important feature of health programming. Barriers to access of health service begin to be acknowledged. Household allocation of health resources is examined. With the livelihoods approach, there is an interest in traditional medicine; household caregiving; gendered, cultural or social barriers to health care; and household decision-making on health matters.

Two main theoretical ideas emerge from the livelihoods approaches which are important to this thesis: vulnerability and coping. They will provide the theoretical framework around which Malawian women's stories of caregiving will be arranged. Later, we will use their stories of coping as a means to analyze the health policies which have been created under the neoliberal reform of the health sector in Malawi.

Vulnerability and Coping

Out of the livelihoods approach emerge two very important concepts for this thesis. One arises out of research on famines in the 1980s and is the analytical concept of *vulnerability*. The other concept is that of *coping*. They become important because they allow us to assess the impact of the overall goal of neoliberal health policy reform which aims to transfer responsibility for care from the state to the individual. Concepts such as vulnerability and coping give us a framework to analyze the fragility of the individual in the face of this kind of policy which puts all responsibility onto them, without acknowledging their particular condition. In this section we will assess these concepts for their usefulness in the field of health and development, and furthermore, for this thesis.

Chambers points out that vulnerability is not the same as poverty. It means not a lack of want, but defencelessness, insecurity, and exposure to risk, shocks and stress (Chambers 1989). From this concept comes that of coping, or difficulty coping, with these shocks and stresses. Vulnerability thus has two sides: an external side of risks, shocks and stress to which an individual or household is subject; and an internal side which is defencelessness, meaning a lack of means to cope without damaging loss. Loss can take many forms – becoming physically weaker, economically impoverished, socially dependent, humiliated or psychologically harmed. This concept was refined and linked with deprivation, ill-health and malnutrition through the work of various scholars at the Institute of Development Studies in Sussex. In keeping with the livelihoods approach, vulnerability has been studied at the level of the household and household responses to food shortages and economic crises have been recorded with the aim of informing the policy environment so that interventions might best support household responses.

The traditional concepts of livelihood coping strategies were those in response to threat of drought and famine. This literature arose out of research during the famines of the 1980s which was concerned with why some households survived and others did not. This was extended to evaluating the effectiveness of using the prevalence of coping strategies as an early warning system to detect possible future famines and also to direct any intervention so that it would support household coping strategies and not undermine them. The basic premise of this work is that drought-stricken households have sufficient resilience (through use of social networks, fall-back resources and strategies, informed by experience and skill) to preserve a socially-acceptable livelihood (deWaal 1989).

Household Coping in Response to Health Crisis

Few studies specifically examine household coping strategies in response to a health crisis. In one study which does look at types of strategies related to health, Sauerborn et al (1996) divide the strategies according to whether they are intended to cope with *financial* or *time costs*. Some of the strategies employed to cope with the financial costs of illness include: using cash and mobilising savings; deferring expenditure such as those of school fees; the sale of assets; taking out loans; gaining wage labour; assistance from family; eating less; prostitution; begging and theft. Some of the strategies presented by Sauerborn to cope with time costs include: intra-household labour substitution; changing the capital-labour mix of production; hiring labour and rallying free community labour.

Lucas and Bloom (1999) recognize that each coping strategy, or decision taken in relation to a crisis, is to some extent a trade-off between current or future needs, between different individuals (often on the basis of age or gender), or between the sick and healthy.

This is particularly true when resources are limited due to poverty. Lucas and Bloom identify three general adaptations (or trade-offs) that poor households make when one member is sick.

Primary adaptations consist of measures to reallocate resources and deplete reserves without substantially affecting future productivity, such as running down savings, selling produce or undertaking additional paid labour to finance medical bills. If the household has access to land or other productive assets, it maintains production by requiring healthy members to work more intensely than otherwise.

Secondary adaptations are necessary when an episode of illness is more severe. The household may have to choose between neglecting the sick person and compromising its capacity to withstand future shocks. If the latter is chosen, the household may forgo expenditure on essential inputs such as food or education, borrow from commercial moneylenders or sell potentially productive assets.

The *tertiary adaptation* consists of survival measures such as migration in search of a livelihood or the reconstitution of households into less viable entities. This has become evident through the AIDS pandemic in the large number of households where the elderly are caring for young children. AIDS is placing households under enormous strain and traditional coping mechanisms may be reaching their limits (Baden 1998).

Lucas and Bloom's formulation, while making an important point recognising the complex and difficult trade-offs that the poor are forced to make, places much emphasis on the economic trade-offs without acknowledging those that occur within the socio-cultural and political arenas. The gender divisions of these coping strategies are evident. As the sick member, women may not have access to medical facilities. As household members, women and girls suffer the burden of extra labour, lost productivity, lower

nutritional intake, caregiving responsibilities, and decreased access to educational or employment opportunities.

A more general discussion of coping is presented by Moser (1996), who organizes evidence from her study into categories of assets that enable or facilitate coping strategies for the poor. She looks at key enabling assets such as labour, social and economic infrastructure, housing and household relations and says that the presence of positive assets in these categories make household coping possible.

The Use of Coping Strategies

In a very useful article, Susanna Davies (1993) questions the utility of the 'coping strategy' approach. Her concern is that coping strategies, by definition, are about success rather than failure. The concept identifies actions that enable survival, and as a result may blind policy makers into the belief that households which somehow manage to survive are actually 'coping' (Davies 1993). It is as important to define what constitutes failure to cope, and situations in which intervention is necessary, preferably before households fail to cope or collapse. Davies also makes the point that it is difficult but important to distinguish between coping strategies and normal behaviour; one household's coping strategy may in fact be another's normal behaviour.

We can ask ourselves, "What is the use of coping?" now that we have seen what is encompassed in this body of literature. There are undoubtedly some theoretical issues which must be raised. For example, although the body of literature on coping strategies is unified in its definition of coping strategies (as the actions that result from poor households trying to manage a complex but limited portfolio of economic and social resources), it is extremely disjointed as an analytical tool (Davies 1993). We will first

look at the problems which exist in the literature on coping strategies in its original context: famine and food shortages in Africa in the 1980s. We will then look at its current application to households affected by HIV/AIDS.

To begin with, it is apparent that strategies will differ greatly according to context and that brings many questions to mind. For example, can we use the strategies employed during an acute food shortage as an early warning system for a longer drought? Can one community's strategies differ from another? How can this approach account for differences within communities themselves, whose membership is diverse according to gender, age, class or social standing? If coping strategies are to be used as predictive indicators of crises, then their use by vulnerable groups must follow discernible patterns which can be monitored. Otherwise, coping strategies are no more than random responses to stresses (Gouge and Govender 2002).

Another problem that requires clarification in this body of literature is where coping ends and adapting begins. Coping seems to be presented as a short-term response to an immediate decline in food, but what about when irreversible changes occur in a livelihood system which demands a permanent change in the way food is acquired. Can this still be classified as coping, or are we now talking about 'adapting'? Coping strategies indicate that, with a little support, they can continue to provide a secure livelihood for those involved. Adaptive strategies seem to point to major changes within a livelihood system which cannot be counted on to provide security and from which people may never bounce back (Devereux 1999).

The largest and most fundamental issue with the literature on coping strategies is whether or not it holds any relevance or use for the current crisis facing southern Africa in the form of the joint catastrophes of the HIV/AIDS epidemic and regional famine. The

concept has been employed in reference to households coping with AIDS and it is in this incarnation that its failings become most obvious (Gouge and Govender 2002). As the example of the impact of HIV/AIDS on women in Malawi makes clear, households are not 'coping', in the sense that they are not successful in preserving an acceptable livelihood. In fact, they are facing destruction and a complete dissolution of their livelihoods. Families are forced to make terrible decisions which cannot be seen as coping: the break up of household structures, with members leaving to join other households; the sale of household assets; the withdrawal of children from school; not accessing medical care; and engaging in dangerous income earning activities such as prostitution. The very concept of coping distracts policy makers from the enormity of the crisis (deWaal 2003). What we see in southern Africa today is a widespread, pervasive, relentless, inevitable *failure to cope*.

The crux of this thesis is where the two approaches, the micro and the macro, come together. The literature on coping strategies reflects this juncture: the social goal under the macroeconomic system of neoliberal policy is not to flourish as individuals and families, but merely to cope, to eke out an existence, to survive. The commodification of health has transferred the duty of care from the state to the individual, in line with neoliberal economic theory, such that those unable to access the market good are forced to merely cope. In fact, this body of literature serves the kind of neoliberal policy agenda which has put overwhelming demands on poor women in developing countries in the service of profits for the rich. Thus, an economic structure which should be held accountable becomes justified, or at least, excused. Later, in Chapter Four, we will use women's stories and the coping strategies that they represent as a means to analyze the neoliberal reform of Malawi's health policies.

2.6 Summary of Theoretical Position

I have evaluated, critiqued and assessed the theoretical positions available in order to explain the problematic of the crushing burden of women's caring labour in the context of neoliberal reform of health policy in Malawi. The theoretical guide that will direct the remainder of this thesis will be that of a strong, developmental state which invests in public health care under the principles of the right to health and of health equity.

For the past twenty five years, governments throughout the developing world have been adjusting their economies and their social priorities in line with the free-market ideology of international financial institutions through Structural Adjustment programmes. Poor countries, such as Malawi, have undertaken a barrage of economic reforms as advocated by the World Bank and the International Monetary Fund which have systematically transferred responsibility from the state to the individual. This disinvestment in health provision has placed undue burdens upon the household. Health has become a commodity on the global market through the process of Health Sector Reform, one component of Structural Adjustment which aims to remodel health care under the neoliberal economic tenants of cutbacks, privatization, liberalization and cost recovery. The commodification of health, devoid of any notions of rights, requires individuals and families to provide an increasing share of health care. This can be done either via cash payments or through the in-kind contributions of caring labour.

Women are being asked to care for critically ill family members while still maintaining their household duties of childcare, water and fuel collection, cooking, washing, and crop production. For poor families, women's unpaid labour is the only asset which remains as the health crisis dismantles their livelihoods and they draw on it in

an effort to cope. This can mean even drawing on women's principal asset: her own health. Feminist literature shows that it should not be assumed that women's health needs will automatically find their way onto the policy agenda and therefore, gender analysis is required of all health policies. This research uses women's experiences of coping, or not coping, to do a gendered analysis of Malawi's health policy. This process will unveil the exploitation of women's labour in the health care sector, through policies which do not take into account women's lived experiences, the demands on their time and labour, their resource restraints or their triple roles of responsibility in the household. Neoliberal policy in the health sector treats women's labour as it is always treated in a capitalist system; as having no explicit price and therefore infinitely free and flexible.

Women's coping strategies can be used to analyze the impact of neoliberal health policy through a process of gender analysis. We will first look at the kinds of health policy which have been created in Malawi and will then use women caregiver's stories to analyze the shortcomings, gaps and outright flawed policies which have been created in Malawi under Structural Adjustment; formulated without acknowledging the real costs of exploiting women's labour as a substitute for genuine state-led health provision.

2.7 Methodology

This thesis will show that the lived experiences of women caregivers in Malawi are inextricably linked to the policy environment governing the health sector of Malawi, and to the broader neoliberal economic project which has been directing development for

the past twenty five years. The literature has shown that Health Sector Reform presents formidable obstacles to achieving good health for the poor and that women can be differentially affected due to traditional gender roles and their low social and economic position in society. This thesis aims to show how neoliberal health policy expects people to cope with the burden of care passed to them when the state abandons responsibility for public health and passes it on to individuals, in keeping with market principles. For poor households, the only recourse is to draw on the hidden domestic work of women.

I will show that individual coping or families managing to eke out a survival strategy are not enough and cannot be a substitute for a broad, collective state-led health policy which is adequately funded to provide for rising needs and to meet the right to health for all people. I will do this through a gender analysis of the impact of health policy on women's caregiving and will look to the coping strategies which women have used as a way of compensating for the failure of policy to ensure health for all.

In keeping with the overall hypothesis that while HIV/AIDS is clearly overtaxing the health care system, it is the shifts to market principles in health policy which have led to the widespread experience of crushing burdens of care for women in Malawi, this thesis follows a particular rationale of linking women's stories to policy. This is done by exploring the structural forces acting on Malawi's health sector and exposing the macroeconomic and political influences and then later, relating women's stories of individual caregiving experiences to the health policy. In Chapter Three I will show the complex political economy of health in Malawi. This involves looking at Malawi's history and the kind of health care that emerged under the various stages of political rule in the country, and under the various economic rationales. This information

was collected in the form of journal articles, books, newspaper articles, interviews and even using song lyrics. I occasionally use observations that I made over the two years (1999-2001) that I worked as a physiotherapist in Malawi and during the three months that I spent doing fieldwork in 2003. I collected all of the major health policy documents and well as those related to gender equity, which have been developed since Malawi's independence from British rule in 1964 and have drawn out the major shifts in policy direction which have taken place. Some specific features of the policies are explored and related to the broader macro-structural forces of the particular time. I also used policy analysis and critiques which were collected from various civil society organizations while in Malawi to add to the depth of analysis around the health policies presented.

In line with the hypothesis that the commodification of health, devoid of the notion of rights, involves a transfer of responsibility from the state to the individual in the provision of health care, I will show the burdens of caring labour being carried by Malawian women, the traditional caregivers in Malawian society, as a result of policy decisions. Because the resulting requirement of the transfer of responsibility from state to individual is that the individual and family must provide an increasing share of health care either via cash payments or through in-kind contributions of caring labour, I will present this through women's stories in Chapter Four, when the impact of Health Sector Reform on Malawian women is explored. Their stories are presented and linked to health and economic policies so that a clear relationship is established between their experiences and the policies which guide the health care system of Malawi. The appropriateness of these policies, implemented throughout the developing world, is called upon in the face of the evidence collected.

My role as a health care professional has guided this methodology. After working for two years in a Malawian hospital, I became convinced that women's voices were not being heard in Malawian society nor their experiences reflected in the policy decisions being made; neither in the capital city, Lilongwe, nor in Washington at the headquarters of the World Bank and the IMF. I hold a strong belief in publicly funded healthcare operating under the principle of equity and the rights-based approach to health. The methodology of this research follows these personal beliefs. Furthermore I spent three months, from July – October 2003, in the homes of people dying the most inhumane of deaths: starving; in pain; consumed with worry for their children's futures; without medical attention; without hope of recovery. How can a researcher remain objective when surrounded by so much tragedy?

Therefore, this project was qualitative in method and design. The collection of women's stories follows the undisputed move within the social sciences away from the grand narratives of history and progress and towards a more individualized accounting for everyday praxis. There is a need for a research method that enhances the place of the spoken word within social science research, which focuses on what 'real' people 'really' say. The research technique of in-depth interviewing through the collection of narratives allows for this by placing the spoken word at the centre of its praxis. The postmodern narrative form was the most appropriate for this thesis as the information that I was seeking required this method of data collection. The only way to really find out what women were experiencing, what hidden work they were doing, what stresses and vulnerabilities they were facing and what coping strategies they were resorting to, was to talk to them. To find out if they were actually coping, I had to spend time with them in

their homes and in their communities, talking and drawing out their views and experiences. Only the narrative form could expose the hidden work and efforts of women.

Narrative is defined by the Concise Oxford English Dictionary as a "tale, story, and recital of facts, especially story told in the first person". The move to micro or local narratives came as a rejection of the meta-narratives that had pervaded the social sciences and their foundational belief that human beings could understand the world through objective, scientific knowledge. Postmodernism holds that the origin of knowledge is socially constructed and shaped by experience. New research methodology emerged from this broad, interpretive, postmodern, feminist, and critical sensibility which questioned claims to universal "truths" (Denzin & Lincoln 1998). Local narratives not only allow for knowledge formation embedded in social and cultural reality, but also offer the prospect that the stories and voices of those traditionally silent such as women, the poor and persons of colour might receive a hearing.

Some writers in the field of social science and medicine are proposing that narrative is, in fact, *the very basis* of medicine. Patients come to doctors with stories. The process of getting ill, being ill, getting better or getting worse, and coping (or failing to cope) with illness can all be thought of as enacted narratives within the wider stories of people's lives (Greenhalgh 1999). We dream, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticise, construct, gossip, learn, hate and love by narrative (Hudson-Jones 1999). Through ten years of working as a health professional, it is clear to me that if we want to understand the patient then we must listen to the narrative, not just take a medical history. It offers a possibility of understanding what cannot be achieved in any other way: existential qualities such as inner hurt, despair, hope, grief, and moral pain

which often accompany, and sometimes construct, people's illnesses. Yet modern medicine, and perhaps even Western culture, has forgotten the importance of narrative, and in doing so, has lost a bridge between the very different worlds of patients and health professionals. The relentless substitution of skills deemed "scientific"- those that are eminently measurable but unavoidably reductionist – for those that are fundamentally linguistic, empathic and interpretive should be seen as anything but a successful feature of modern medicine (Greenhalgh 1999).

Out of the shift from universal to local claims to "truth" and directing this particular research effort, stems *critical social research* which argues that the purpose of research is to discover flaws and faults in society and in so doing promote actions that eliminate problems (Rubin 1995). One variety of the critical approach, feminist research, pays particular attention to the problems of dominance and submission as they affect women, using a methodology that was gentler, that listened and heard more and talked less, that humanized both the researcher and the interviewee, and that focused more on those who had little or no societal voice. Research was conducted using an open, loosely structured research methodology which Rubin calls necessary "to learn about women, to capture their words, their concepts, and the importance they place on the events in their world" (Rubin 1995).

Since research provides the knowledge base and the technology upon which health policies and health services are founded, a gender sensitive research paradigm allows women to be more visible and have their voices heard when the policies, which affect their health and their lives, are made (WHO 1998). I have found that there is little study done on the actual lives of women or the social context of women's health issues, particularly in the South. This is detrimental to women, in both the developed and the

developing world, who rely on effective health policies and systems to meet their unique health needs. This may change as qualitative methods of data collection become more popular in health research. Qualitative methods are increasingly utilized mainly because they are seen to reach the part other methods cannot – that is, the views of ordinary people in the real world. Anthropology, with its roots in a Western fascination with the 'exotic' and the associated attempts to make the strange comprehensible, is currently being seen as able to contribute useful insights to health research (Lambert 2002).

The benefit of using in-depth interviews and livelihoods research for women's health issues is that it provides a window onto social and cultural perspectives of health. If gender is viewed as the outcome of social processes which define the roles and characteristics of women, then ethnographic accounts can also provide an in-depth view of how the cultural and social norms that shape gender are constructed and how these influence women's health (Harrison 2001). It is important to understand what societal trends mean for ordinary women, and how changing macro-level dynamics contribute to women's perceptions and beliefs regarding their own health and status. Through their use of micro-level studies using in-depth qualitative research, livelihoods studies can help to uncover these views from women's own perspectives. However, as illustrated in the literature on vulnerability and coping strategies, this level of study can also paralyze an analysis by not addressing the structural forces which have created the particular sets of circumstances that women experience. Therefore, this thesis aims to go beyond a micro level approach to situate the study between structural and livelihoods approaches. This is reflected in the methodology which links women's stories to policy analysis.

The principles of qualitative research guided all aspects of this thesis. Data was collected through a variety of techniques including participant observation in hospital and

community settings; in-depth interviews with women caregivers in the hospital and household settings; a survey of Home Based Care clients' caregivers; interviews with policy makes and health administrators; and data collection through the analysis of health and gender policy documents and civil society's responses to these policies.

Throughout the duration of my fieldwork, I was present at hospitals, clinics and home based care visits in communities. As a participant observer, I interacted with staff, patients and caregivers (known as "guardians" in the Malawian health sector), explained my presence as a student researcher as well as providing information as to the nature and intended role of my research. This allowed me to establish rapport with staff, guardians and patients, some of whom I invited to participate in in-depth interviews. I kept a written record of my observations, which included the role that women played in providing care for ill family members, their comments pertaining to this role, the demands put upon them by staff and the duties which were forgone in order to carry out the required caregiving.

Twenty five in-depth interviews with caregivers were completed with caregivers purposively sampled from a group recommended by health and home based care staff. The caregivers were asked to share their perceptions and experiences within the health sector and to comment on how caregiving had affected their own lives. They were also asked about what strategies they were using in order to deal with the demands on their time and labour and how caring duties affected other aspects of their lives such as crop production, care of other family members, school attendance or income generation. The caregivers who participated ranged in age and status, in educational background and in rural and urban backgrounds. They were grandmothers, sisters, daughters, wives, aunts and mothers. Two were conducted with male caregivers. The interviews sometimes

spanned over a few days as I developed a rapport with the women and their patients. On certain days the patient was too ill and it was not appropriate to conduct an interview, so I had to return on other days. Some patients died before I managed to finish the interview. All in all, twenty five in-depth interviews with caregivers were completed in which I gathered information on their experiences with the health care system, the burdens of care that they were experiencing, the coping strategies that they were employing and their thoughts and perceptions on health care in Malawi. The break down of the interviews is as follows: 11 with caregivers at Kachere Rehabilitation Centre / Queens Central Hospital; 10 with caregivers through Home-Based Care project; and 4 with caregivers at Queens Paediatric Palliative Care Unit. The interviews were conducted by myself and an assistant, either in English or Chichewa, with consecutive translation. All interviews were tape recorded and transcribed.

A survey of caregivers' general experiences in the community was completed (in Chichewa, the local language) by 19 Community Based Counsellors through a Home Based Care project working in four Traditional Authorities in Blantyre District. The survey was prepared, translated into Chichewa, pretested, revised and then pretested again before it was finalized and distributed. A total of 38 surveys of caregivers were completed and subsequently translated into English, which although not statistically significant, provide a snapshot of the experiences of caregivers in many different communities and support the data collected in the in-depth interviews. They also add to the demographic information of the chronically ill and their caregivers in the southern region of Malawi.

I also completed eight short, topic-focused interviews with health care staff, including nurses, doctors and ward attendants with a variety of perspectives including

those working in private, government and charity settings. These interviews were completed to gather information on what is being done on the issue of women's burden of caregiving in practice and to gather the perspectives of health care staff.

Six semi-structured interviews with health and gender policy administrators were completed and data on both health and gender policy was collected and analysed as were documents, articles and reports on civil society's response to these policies. Attempts were made to meet with the Minister Responsible for HIV/AIDS and the Minister of Gender, Youth and Community Services but were not fruitful. These interviews, articles and reports served to provide data on the current debates in Malawian society on the issue of gender, health and equity. Four semi-structured interviews with academics in the field of social and economic policy were completed at the University of Malawi to provide data on what current perspectives, work and research were on issues of gender, health and equity in Malawian academia.

In order to ensure that appropriate data was being collected and that accurate conclusions have been made, ongoing organization of data, project monitoring and evaluation were included throughout the project as a component of each of the above activities. Ensuring that a wide range of informants helped to crosscheck and triangulate the data and analysis from each source. The review of literature and data collection of government documents was complemented with interviews and vice-versa. I continuously verified my assumptions and conclusions through feedback sessions with project participants and presented preliminary research findings to project participants to ensure that my findings were reliable, accurate and contextually relevant. I presented preliminary research findings to the Blantyre Home Based Care Network and recorded the responses and comments which arose in the discussion.

The final analysis of research findings was done once I returned to Canada. The information from the 38 surveys was analyzed according to demographic information (ie. age and sex of patient, age and sex of caregiver, number of people in the household, duties completed by the caregiver, duties forgone as a result of caregiving, etc.). Certain combinations of data were highlighted as significant, such as when there was a very elderly caregiver and many children in the household, or when respondents reported that a child stayed away from school in order to provide caring labour. Also, there were questions in the survey which asked for respondent's views on whether health care in Malawi had gotten better or worse and whether they felt that the government supported their health. While general trends in responses were tracked, some particular responses to these questions were noted for their significance.

The data from the in-depth interviews with caregivers was grouped according to the three categories established by the literature on the impact of disease on households: the loss of production by the sick individual; the financial costs of health care; and the time costs borne out by caregivers. The stories which comprised each category were then traced back to the health policy which had contributed to that particular problem. For example, stories where women discussed the problems they faced by the lack of availability of drugs were linked to the policies which called for decreased spending on drugs and medical supplies in Malawi. The links between women's stories and health policy could then be used to illustrate the failings of Malawi's health policy, which uses women's hidden caring labour as a substitute for comprehensive public health, to ensure the right to health for all.

Chapter 3: THE HEALTH CRISIS IN MALAWI

3.1 Introduction

While HIV/AIDS is clearly overtaxing the health care system and a poor country's capacity to meet the demands for service, it is the shifts to market principles in Malawi's health policy which have led to the widespread experience of crushing burdens of care for women in Malawi. Shifts in donor policy, including health sector reform, are aimed at replacing an overall notion of the right of access to health with policies based solely on neoliberal economic principles such that health care is now seen as yet another potential commodity on the market, joining the long march and expansion of public goods turned commodities in our global economic system. The commodification of health, devoid of the notion of rights, involves a transfer of responsibility from the state to the individual in the provision of health care. The resulting requirement is that the individual and family must provide an increasing share of health care either via cash payments or through in-kind contributions of caring labour.

This thesis aims to answer the question as to whether the experiences of excessive burdens of care by women in Malawi can be traced back to the neoliberal shift in health policy and the intrinsically-related HIV/AIDS epidemic, or are they solely the product of an unalterable biomedical process. This chapter will analyze health policy in Malawi in order to show that flawed policy is at the root of the problems that women face as caregivers. While the health crisis in Malawi is a result of the cumulative effects of many forces acting to disrupt the security and well-being of Malawians on all fronts, most of the forces have their roots in the failings of market-led approaches to health. While women

struggle to hold their families together, the government offloads more responsibility for care onto their shoulders.

The UNDP's 2003 Human Development Report places Malawi at 162 out of 175 countries (UNDP 2003). The GDP per capita, using purchasing power parity, was $570 in 2001, with only Tanzania (at $520) and Sierra Leone (at $470) posting lower. Income distribution in Malawi is amongst the most unequal on the African continent, according to the UNDP. The Human Development Report for 2003 reports 25,948 malaria cases per 100,000 people in Malawi in the year 2000. Furthermore, Malawi has one of the highest maternal mortality rates in the world, with 1120 deaths per 100,000 births (MDHS 2000). A report from the Malawi office of the UNDP reports that the magnitude of the HIV/AIDS pandemic is far misrepresented by statistics (UNDP Malawi 2003). In 1999, for example, the overall HIV sero-prevalence in adult pregnant women aged between 15 and 49 years was 24 percent, yet the report says that this only represents a fraction of the actual HIV prevalence due to under reporting and misdiagnosis. Even so, the UNDP report indicates that Malawi has one of the lowest life expectancies in the world, based on data from 2001, at 38.5 years. The only countries where the life expectancy was lower were Rwanda, Sierra Leone, Zimbabwe and Zambia.

In September 2002, international Heads of State adopted the Millennium Declaration at the United Nations' Millennium Summit which synchronises a set of time-bound, inter-related and mutually reinforcing goals and targets into a global agenda of combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. Member states have pledged to meet eight goals by 2015, such as halving the proportion of people living on less than US$1/day; halving under-5 mortality; reducing maternal mortality by three quarters; and reducing the incidence of

HIV/AIDS. A report from UNDP Malawi suggests that, according to projections for health funding and the results of the last Malawi Demographic and Health Survey (MDHS), Malawi has little chance of meeting these goals (UNDP Malawi 2003).

Malawi's health crisis exists in a real world setting of social, political, economic and cultural realms which connect, interject, amplify and diminish one another. This chapter will investigate the history of these forces in the country once known as Nyasaland in order to help explain the situation that we see today. The hypothesis stated that the adoption of macroeconomic neoliberal reforms has weakened health systems in Malawi and that in transferring responsibility from the state to the individual, health policy in Malawi increases health inequity, reserves well-being for the elite and uses women's unpaid labour as a replacement for state provided care. This chapter will explore the political economy of health policy formation through the history of what we now call Malawi. We will look at the kind of health policy created from the colonial to the current time in Malawi and investigate what these policies mean for poor Malawians so that the stage will be set for the next chapter, when the link between the stories of burdens of care of women and the flaws in neoliberal health policy will be made.

In this chapter, I will trace the issue of health and development through the three major political eras in Malawi's history: Colonial Nyasaland; Newly Independent Malawi under President Dr. Banda; and Democratic Malawi under President Muluzi. I will analyze the health policies arising during these periods and explore the resulting health outcomes for Malawi's population. This level of analysis will support my hypothesis that while HIV/AIDS is overtaxing Malawi's health care system, it cannot be seen as the sole explanation for the problems that women are facing. Women's coping, or failure to cope,

with the burdens of care passed to them by the state is firmly rooted in health policy choices made by the Malawi government under the direction of the World Bank.

A small comment on the use of quantitative health data in this chapter is necessary. Based on my experience working in a Malawian hospital together with the incomplete data sets which I have encountered doing this research, I can comment that health data collection is weak in Malawi. Attempts to find data from pre-1990s are often not very fruitful. Not only is the health infrastructure ill-equipped to support health data collection, but information gathering and research in Malawi during Banda's authoritarian rule were heavily controlled and censored. So health data is used in this chapter to set a scene and illustrate broader points, not as an end unto itself. Furthermore, epidemiology is a completely separate field of study into which this thesis does not venture. Rather, quantitative data is used as a backdrop to the larger discussion on policy issues with a full understanding that health is a complex issue and that it is terribly reductionist to say that one thing leads directly to another. That project is left to another study altogether. I recognize that improvements or declines in population health are slow processes where effects may not be evidenced immediately in the macro quantitative health statistics. Furthermore, figures from a given year are often based on data collected for a number of years leading up to that time. Results vary from agency to agency, depending on collection techniques. Consequently, quantitative health data is used in this chapter simply to paint the picture of what health looked like during different periods of Malawi's development. The more reflective and nuanced view will be explored in Chapter Four, when we look to women's stories of caregiving and see the health narratives that emerge as women struggle to care for their families in an inhospitable policy environment.

With this understanding, we will now look at the historical, political and economic context of health policy formation in Malawi. This chapter is organized into three main sections which correspond to Malawi's three political periods: Colonial Nyasaland, Independent Malawi under President Dr. Banda and Democratic Malawi under President Bakili Muluzi.

3.2 Colonial Nyasaland (1891 - 1964)

3.2.1 Introduction

The borders of Nyasaland, like all colonial frontiers created at the Berlin conference of 1884, did not follow the traditional boundaries of African populations. The success of the European invasions into their designated "spheres of interest" and the great re-orienting that ensued created a system of disunity (Davidson 1991). Keim writes that it is important to note that the processes of colonization were not the first instance of major upheaval in Africa (Keim 1995). From the seventeenth until the nineteenth century, the slave trade disrupted the lives of millions of Africans. About two-thirds of the slaves taken to the Americas were men, and this assault on the structure of the family unit surely pulled at the very fabric of traditional societies. Exposure to different religious forces also was a major factor of change throughout Africa. In Malawi, the Yao people were used by the Arab traders from the coast to supply the demand for slaves, and through this contact, adopted Islam. At the same time, David Livingstone was making his epic journey up the Zambezi, trying "to make an open path for commerce and Christ" (Livingstone 1865).

By the late nineteenth century, the wheels of colonization were well in motion, searching for new markets, raw materials and new territory in which to expand their imperialist causes. Sir Harry Johnston declared the area of Malawi a British Protectorate in 1891, after brokering a deal with the Portuguese and the Germans. The people living there found themselves under British South Africa Company rule in a land now known as Nyasaland. A steady stream of missionaries, prospectors, adventurers and settlers were soon to follow.

3.2.2 Health and Development in Colonial Nyasaland

Health care was developed in Nyasaland under a system of early mission settlements established by European missionaries responding to Livingstone's call for devoted Christian service. Representatives of the Church of Scotland were amongst the earliest missionaries to the new British Protectorate, setting up missions along traditional slave-trade routes with the hope of deterring and eliminating the trade. The Dutch Reformed Church and the Catholic White Fathers from France also set up mission sites around Nyasaland, spreading Christianity but also, like the Scottish Presbyterian missionaries, establishing schools and medical clinics.

Mission hospitals introduced Western medicine in a region where traditional, herbal medicine had an established role. *The Story of Medicine and Disease in Malawi* by Michael and Elspeth King provides an interesting picture of the interplay between the ideas and principles of modern medicine brought by the mission doctors and the local culture. For example, there was a passage in the book which declared "A Big Day" at the Blantyre Mission hospital in June 1904 when 62 iron hospital beds arrived from Scotland (King 1992). The European practice of sleeping on a bed would have been very foreign,

and furthermore, Nyasaland was a heavily forested area, so if beds were truly necessary, they could have been made locally rather than shipped all the way from Scotland. According to the Kings' account of early medical work in what is now Malawi, mission doctors were heralded as brave and heroic for their efforts to improve health and sanitation amongst the "natives" of Nyasaland. They focused on basic sanitation and nutrition, the treatment of communicable diseases and rudimentary surgeries. While the mission doctors seemed quite devoted to their charges, a separate medical system was established for the white settlers and administrators of the region. The Blantyre European Hospital opened in 1897, under the Protectorate Administration, and King's book quotes Dr. Affleck Scott's description of the setting:

> The patients as they toilingly reach convalescence can enjoy the cricket matches which they overlook; and they will be by far the best people to consult for racing tips, seeing the race course lies beneath them, and the morning practice of the horses is in full view (Scott in King 1992: p.90).

Health policy under the colonial government of Malawi was based on the specialized and elite position of European mission doctors. They received assistance from their African medical assistants, who they trained. Since there were no secondary schools in Nyasaland until the 1940s, all medical training of assistants was practical in nature. Africans were not sent away for professional medical training under colonial rule until the Second World War called away most of the British medical staff practicing in Nyasaland. African hospital assistants were left to do the work of the British doctors who were transferred to the Army for war-time service (King 1992). This established the origins of the move to establish proper medical training for the 'natives'.

It is impossible to discuss colonial health policy during the 1930s and 40s without addressing the fact that the British were losing their grip on power. This requires a broad

view of the forces which were sweeping across the entire African continent. The recruitment of African military forces for battle during the First World War, in conflicts between the colonial powers themselves, raised questions of participation and rights. In 1921 the *Gold Coast Independent* wrote that if the African volunteers who suffered on the battlefields of European conflict 'were good enough to fight and die in the Empire's cause then they were good enough to have a share in the government of their countries' (Davidson 1991: p.277). The subsequent Great Depression of the 1930s left the highly dependent African economy in shambles with falling prices for primary products and cutbacks in colonial services. During these years, some African elites were studying abroad and championing the cause of African rights overseas. Early African-American leaders like W.E.B.DuBois and Marcus Garvey were raising the civil rights issue in the United States, and the message of emancipation was a powerful one. Upon their return, groups of intellectuals were forming unions to press for political reforms in the colonies. The voices calling for change were not only those of intellectuals. The Christian churches, Islamic leaders and traditional African religions were protesting in a variety of forms, from the message of *'Africa for the Africans'* to questioning the colonial belief that God wanted white people to rule over black people (Davidson: p.27). Ideas of change were spreading. A major thrust came with the deployment of African troops during World War II, sent to fight for *freedom*. Where then, was their freedom?

In an effort to hold at bay the demands for independence, Britain brokered a deal with Southern Rhodesia, by now self-ruling, that it could form a "settlers' federation" with Northern Rhodesia and Nyasaland, who each had smaller populations of white settlers. As a unified Central African Federation it hoped to hold onto power, even as West African colonies were gaining independence. The federation was seen as major setback

in the nationalist cause in Nyasaland. Southern Rhodesia, now Zimbabwe, rejected the very idea of common and equal citizenship and their influence on the struggle for independence in Nyasaland was feared. Dr. Hastings Kamuzu Banda, a medical doctor who was practicing in Britain and future leader of Malawi, opposed the union saying, "the proposed federation will not be a commonwealth, in which Europeans and Africans will be equal partners, but a slave state in which the Europeans will be the privileged masters and the Africans the unprivileged serfs" (Short 1974: p.57). Nonetheless, this federation lasted for ten years, beginning in 1953.

With respect to health and development, the Central African Federation brought a greatly increased health budget to Nyasaland through revenues from the then-rich economies of Northern and Southern Rhodesia. There was an expansion of medical training with medical students sent to Britain to receive initial training and then returned to work under the newly established Medical College in Blantyre. There ensued increased staffing of government hospitals, a steady flow of drugs and medical supplies, an extensive hospital construction programme, installation of x-ray facilities and development of rural health centres (King 1992). In 1958, the same year that Banda returned to Malawi, the Queen Elizabeth Hospital was opened in Blantyre by Queen Elizabeth herself. It was a modern medical referral facility with speciality services, a replica of the style of health care taking place in Britain.

Despite the optimism generated by the opening of Queens hospital, there were plenty of obstacles facing the European vision of health in Nyasaland during this decade of Federation. The Kings write about the "gap in understanding" between the European administrators and the African villagers which became obvious in the "well meaning" attempts to introduce immunization programmes and to control disease:

> Poor and ignorant people fled from the smallpox vaccinators when they reached a village and polio vaccines lay stored in refrigerators as parents declined it for their children. The WHO's residual spraying programme for malarial mosquitoes had to be abandoned because of lack of cooperation from the local people (King 1992: p.154).

At the same time, British colonialism on the continent was facing a state of crisis. There were guerrilla movements and large scale insurrections in some settler colonies, such as the Mau Mau uprising in Kenya. In Nyasaland, John Chilembwe led a rebellion which resulted in the decapitation of W.J. Livingstone, a colonial figure and relative of David Livingstone. His head was marched about the villages of the Shire Highlands on a pole and Chilembwe is still seen today as the founder of Malawian independence from British rule (Pike 1968). African leaders, such as Kwame Nkrumah, Jomo Kenyatta and Nnamdi Azikiwe were calling, from the forum of the Pan-African Congress, for African autonomy and national independence. Their motto became "Self-Government Now!" Their calls reached out to populations that were suffering and gained popular support: in the years since the colonial system had become well established, people's quality of life had declined. With rapid urbanization, unprecedented population growth, migrant labour and decreased domestic food production (due to the government focus on agricultural exports), a state of social and economic crisis had developed.

The colonial powers could not ignore the drive of African opinion in this post-World War II period. Nor could they ignore the pressures they faced at home to rebuild their own countries and domestic economies, in shambles after the war. The USA was now controlling the funds for European reconstruction and did not wish to finance their colonial systems as well. England began to see that concessions to demands for African self-government were unavoidable.

In Malawi, then Nyasaland, the rise of organized nationalist voices was well underway by this point. It began in 1944 with the formation of the Nyasaland African National Congress. Their cause gained strength, when in 1958, Dr. Kamuzu Banda returned home after many years abroad. He warned, "Everybody expects that I have come with self-government in my handbag, but we will have to struggle for it" (Short: p.89). Banda took leadership of the independence movement and led it through incarcerations, violent conflicts and, in 1959, the declaration of a state of emergency. It was at this point that the gains that had taken place in the Nyasaland medical system began to erode as Government doctors and medical stores were recalled to Rhodesia in anticipation of a transfer or power in Nyasaland (King 1992). Health care budgets dissolved and training programmes were shut down as the calls for self-government became louder.

3.2.3 Conclusion

Health and development during the colonial era in Nyasaland/ Malawi fit the model of the expanding imperialist empire that Britain was pursuing through the British South Africa Company. This section has shown that the model for health development was mission-based, with a separate system of modern health care established for the white settlers. Public health was focused on communicable diseases, which threatened the expansion of the colonial project both by killing the settlers and decimating the labour base in the native population. With this in mind, programmes were set up with Europeans as the specialists to bring a basic level of health and sanitation to the colony.

Under mounting pressure, Britain allowed democratic elections in Nyasaland in August of 1961. The newly formed Malawi Congress Party, headed by Banda, won most

all seats in local parliament. The settlers' federation was dissolved. Malawi achieved internal self-government by January 1963, with Dr. Banda sworn in as Prime Minister. And in July 1964, it became an independent state with the Duke of Edinburgh in attendance as flags were lowered and raised and 'Nyasaland' became 'Malawi'.

The next section will look at the newly independent Malawi, under the rule of Dr. Kamuzu Banda. Recall that this was an optimistic time in Africa's history, with newly independent nations calling for an 'African Renaissance' and a new form of development more suited to the African traditional society. Social programmes were seen as the vehicle to fuel development and to overcome the deep inequities that had been inherited from the colonial system. With a medical doctor as the head of the newly independent nation, Malawi proves to be an interesting case study for health and development during this era.

3.3 Newly Independent Malawi under Banda (1964 - 1994)

3.3.1 Introduction

In 1958, Dr. Kamuzu Banda returned home to lead the fight for Malawian independence from British rule. He was seen to be a sophisticated and modern man by the people (Short 1974). He had also taken on mythic proportions in Malawi, where stories of his "long walk" (over 1600 km) to South Africa as a young boy in search of further education and opportunity were popular. By working in South Africa's mines, he saved enough for his fare to America, where he studied medicine and qualified as a doctor in 1937. He then continued his medical studies at Edinburgh University and practiced during the war years in Britain. As the leader of the Independence movement in

Nyasaland, Banda was sworn in as Prime Minister in January, 1963 as the Federation of Rhodesia and Nyasaland was ended and Malawi achieved internal self-government. On July 6, 1964, Nyasaland became independent, known as Malawi. Banda led the country during this era of Independence in Africa, first as prime minister and then as president once Malawi became a republic in 1966.

The years immediately following Independence were not easy for Malawi, like most new African states. They all suffered from shared problems such as a lack of skilled professionals, an ineffective and ill-functioning civil service, and unrealistic public expectations of immediate wealth and prosperity. Their fellow nations of Southern Rhodesia, South Africa and South-West Africa were still engaged in bloody battle for their freedom. Collectively, the hopes of the people rested on these new administrations.

Dr. Banda's Malawi was no exception. As President-for-Life, Dr. Banda endorsed a kind of self-help development and maintained that Malawi would have to find its own answers to its own problems. The Cold War was on and newly independent African countries were facing pressure to choose sides. He broached the question of alignment, brought to the forefront of all new nations' agendas via issues of aid and assistance, as follows:

> When the West is doing what I think is the right thing - what is good for Malawi- I will align with the West. When the East is doing the right thing - what I think is good for Malawi- I'll align with the East. But when either one or the other does something wrong, which is only in their own interests and not in the interests of Malawi, then we part company (Short 1974: p.176).

Malawi, like so many other new African nations, set about the long and difficult task of reshaping and rebuilding its national life in such a way as to overcome, step by step, the

deep crisis of economic system and political structure they had inherited from the past (Davidson 1991).

3.3.2 The Political Economy Context of Banda's Malawi

The 1960s

Banda had inherited a nation with many barriers to economic growth, which was partly the reason that Independence had been granted without major bloodshed by the British. As a land locked country with limited natural resources, Malawi did not have much to offer the Empire except labour. This continued even after independence and Banda could do little to stop the out-migration of Malawi's men, who left the country to work in the mining industry in South Africa, Zambia and Zimbabwe. Banda's Malawi had limited infrastructure, low levels of health and education for most of its people and few skilled workers.

Yet despite these obstacles, Banda was diligent about creating a self-sufficient nation. Known as the 'benevolent dictator' (Short 1974), Banda led the country to internal, self-sufficient prosperity such that for some time Malawi was known as the 'breadbox of Southern Africa'. People were encouraged to stay in their home villages and farm the land, avoiding the problems of rapid urbanization that were taking place in neighbouring countries (Pike 1968).

The major emphasis of Banda's economic regime was on estate agriculture as an engine of economic growth and development, and was backed up by the 1967 Land Act which declared that all customary land was "vested in perpetuity in the President" (Chinsinga 2002). The Land Act was designed to reinforce a postcolonial agricultural strategy that distinguished estate farming from smallholder agriculture, and legally

prohibited smallholders from producing cash crops. Furthermore, the visiting tenant system ensured considerable profit margins for estate agriculture.

The 1970s

Malawi's dependence on agriculture continued to fuel the economy from Independence and throughout the 1970s. As a result, the economy was relatively encouraging during the initial fifteen years of Banda's rule. Malawi experienced high economic growth rates, a favourable balance of payments position, and increases in gross domestic investment. During these early years of Independence, Malawi's annual growth rates of real GDP averaged 6 percent and the volume of exports grew at an average rate of 4.5 percent (Kaluwa 1992). Savings as a proportion of GDP rose from the modest level of 0.3 percent in 1964 to 19.7 percent in 1979; industrial output expanded at the rate of 10 percent per annum. Domestic exports rose from US$48 million in 1970 to about US$285 million in 1979. This impressive economic performance has been attributed to the favourable policies and support by the Malawi government for rapid expansion in export-oriented agriculture and tight monetary policies which contained inflation at about eight percent per annum during the 1970s.

On the political front, Banda continued to have support at home but his relationship with apartheid leaders in South Africa drew heavy international criticism. He established diplomatic ties with the white-run government and, in 1971 he became the first head of an independent black African nation to visit South Africa. Despite the growing concerns over Banda's foreign policy and increasingly heavy-handed domestic rule, the 1970s saw Malawi enjoying relative prosperity, largely due to foreign investment. The commercially oriented estate sector was predominantly expatriate controlled and

responsible for most of the country's exports (largely tobacco and tea), while the smallholder sector was subsistence oriented. Through most of the 1970s the economy grew at about 3 percent per annum in per capita terms, largely on growth of near 5 percent in agriculture (Chilowa 1999). The strategy of generating an agricultural surplus as the prime support for development was generally accepted as working well.

Almost all accounts of the country's economy acknowledge the fact that the post-independence period can be divided into two broad phases. The first took place before 1979 when nearly every sector of the economy registered rapid growth, whilst the second one commenced around 1979 when almost every sector experienced tremendous decline followed by erratic recovery trends (Chinsinga 2002).

The impressive macroeconomic climate in Malawi began to crumble quite drastically in 1979-1980. The economic downturn persisted to the extent that in 1980, the country registered a negative growth rate for the first time since independence (Chinsinga 2002). The GDP growth decreased to 0.4 percent in 1980, plummeted to -5.2 percent in 1981 and then staggered around 3 percent in subsequent years, well below the rates which the economy had achieved in the pre-1979 phase. This economic slump was the beginning of the World Bank designed restructuring of the economy that has dominated Malawi's social and economic development for the past twenty five years.

The 1980s

The oil shock of 1979 and the escalation of the civil war in Mozambique, Malawi's traditional trade route to the sea, led the country into economic slowdown. Drought conditions of 1979-80 augmented the country's economic problems and in 1980, economic growth was negative for the first time since Independence. The government

had little choice but to seek intervention from the World Bank and International Monetary Fund (IMF) in a bid to regain the lost economic glory (Chinsinga 2002). By the following year, Malawi became the first country in the region to adopt IMF sponsored stabilisation programmes and World Bank sponsored Structural Adjustment Programmes (SAPs).

The cornerstone reforms were the removal of subsidies, the devaluation of the Malawi Kwacha, liberalisation of interest rates and the elimination of government price controls. Also, the programme called for massive cuts in social expenditure budgets, greatly reducing government inputs into health, education and sanitation. These cutbacks, or what the World Bank calls 'public expenditure rationalization', had a tremendous negative impact on the poor, who had come to depend on government services. With World Bank involvement, government expenditure continued to decline as the debt-servicing burden soared (Chilowa and Chirwa 1999).

The 1980s was a turbulent decade for Malawi, both politically and economically. With respect to the latter, the civil war in Mozambique brought 600,000 refugees and a closure of the border, Malawi's traditional trade route to the sea. The border closure forced Malawi to use South African ports which added to costs at a time when Structural Adjustment was focusing on exports such as tobacco and sugar. Agricultural growth fell to about 2.5 percent per annum in the 1980s, less than the population growth rate, with particularly poor performance in the smallholder sector.

On the political front, these years were filled with instances of heavy-handed rule. There were reports of political imprisonment, state-endorsed executions and nation-wide terror inflicted by Banda's youth league, known as the Young Pioneers, who had the notorious task of safeguarding discipline and obedience. Many were detained, tortured or

even killed for simply being related to Banda's supposed "enemies". The murders of three government ministers and a Member of Parliament by police on order from the MCP leadership in 1983 reflects the atrocities that had become commonplace under Banda. In an effort to cover up the murders, the police staged a road accident, but as evidence in the song, "*Mizimu*" by popular Malawian singer Lucius Banda, most Malawians didn't believe that it was an accident.

> There is a tree
> On Thambani Road in Mwanza
> It looks like an ordinary tree,
> But it is witness to those murders.
> In that tree, angels cried.
> The blood of a human being is strange,
> If you kill a person, no matter how you hide,
> You will be scandalized.
> ("*Mizimu*", Their Spirits, Lucius Banda 1995)

The population was losing faith in the virtue of their leader. It was during the 1980s that the systematic challenge to Kamuzu Banda's authoritarian regime began, first as clandestine meetings and mobilization of opposition to his Malawi Congress Party (MCP). During these years, the political divisions were well demarcated. On one side were the conservatives who clung to the ageing and ailing Life President, the 'Father of the Nation', who viewed multipartyism as a threat to national unity and a slight to Banda's authority. On the other side were the democrats, supported by the donors' demands for human rights observance and good governance.

Dissent was not tolerated at any level yet pressure groups began to form. The much-publicized pastoral letter written by the Catholic bishops in 1992, denouncing the violence and suppression of MCP politics and calling for multiparty elections, provided foundational support for the opposition. Violent protests against Banda's rule erupted throughout the country and Western nations suspended aid in 1992, adding to the

economic burden created by the famine that was taking place. A referendum in June 1993 confirmed that the democrats were the majority with most Malawians voting for an end to one-party rule. Parliament passed legislation establishing a multiparty democracy and abolishing the life presidency. The pressure groups developed into political parties, with the United Democratic Front (UDF) and the Alliance for Democracy (AFORD) as the leaders in the new political environment. Already a very old man by this point, Banda's grip on power was coming to an end. The one-party state was to transform into a democracy.

3.3.3 Health and Development in Banda's Malawi

As mentioned earlier, Dr. Banda supported the movement towards independent African development, and as 'Father of the Nation', he aimed to personally direct Malawi's development. I have been told about his infamous radio broadcasts, when he would instruct his nation of subsistence farmers when to plant and when to harvest. As a medical doctor, he placed great emphasis on the establishment of modern medical facilities, which became his showpieces in the urban areas of Lilongwe and Blantyre. From the beginning, he was determined to combine his medical career with his political activity. In an interview with Dr. Donal Broady, Banda discussed his efforts to start his medical clinic upon his return to Malawi in 1958,

> I was not about to let politics interfere with my plans to begin my medical practice. Nyasaland had a dearth, D-E-A-R-T-H of medical practitioners, very, very few indeed. I was determined to establish my practice and to train good competent people as I did in Ghana, particularly in my "bush" clinics. I was very pleased when I found the proper building over there in Limbe. A good strong building that was clearly visible so that sick people would not have to hunt through back streets to find the doctor. I had been anxious, if not concerned, about finding a facility before I again left for the north and now I could go to

> Nkhata Bay with my political hat on and not worry about finding a surgery (Brody 2000).

Under his watchful eye, Banda's MCP government implemented three national Health policies. At Independence, Malawi inherited a health infrastructure that was urban based and unevenly distributed (MOHP 1999a). As such, the First National Health Plan (1965 – 1969) focused on the provision of rural health facilities placed where the majority of Malawians lived. It was appropriately devoted to curative services with emphasis on the construction of facilities and on manpower development (MOHP 1964).

The Second National Health Plan (1973- 1988) was adopted by the government in 1974. The main priorities in this plan were to continue to develop basic health services; to control communicable diseases; to improve and extend hospitals and health centres; and again, to continue to develop manpower (MOHP 1973).

It was during this Second Health Plan that Dr. Banda's government endorsed the concept of Primary Health Care (PHC) as the main health service delivery strategy. This was in 1979, one year after the WHO's Alma-Alta conference called for a worldwide theme of 'Health for All by the year 2000'. In principle, PHC aims at improving health status by focusing on an affordable package of essential health services with the involvement of the population. Arising from the new commitment to Primary Health Care, a fifteen year 'mini-plan' was designed by Malawi. It aimed to strengthen maternal and child health services, increase immunization coverage and to provide health and nutrition education to families through the use of village health volunteers, all in keeping with the vision of primary health care (MOHP 1999c).

The Third National Health Plan (1986- 1995) continued its focus on Primary Health Care with particular attention given to the provision of services for mothers and

children. This included services concerned with nutrition, child spacing and a range of priority disease programmes such as malaria, acute respiratory infections and diarrhoeal diseases (MOHP 1986). This plan also continued to expand rural health services and invest in healthcare worker training.

The outcome of the three national health plans under Banda was a general improvement in all areas of public health. There was an increase in life expectancy, an increase in vaccination coverage for children and improvements in maternal and infant health. For example, infant mortality rates[2] decreased from 162 in 1980 to 128 in 1995 (UNICEF 2000). The first Child Health specialist was appointed in 1964 and by 1982, there were over a thousand under-five child health clinics (King 1992). The last case of smallpox in Malawi was in 1971, eradicated six years ahead of many other African countries. In the first ten years of Independence the staff of the Ministry increased by fifty percent and recurrent expenditure on health doubled. A National School of Nursing was established. Twelve new and enlarged hospitals were built under Banda and the number of government health staff more than tripled from 1974 to 1987. The increased attention to training meant that twenty Malawian medical students were sent to the UK each year in the 1980s, until the College of Medicine opened in Blantyre in 1991 (King 1992).

3.3.4 Conclusion

We have seen that Banda's approach to health and development was in keeping with the dominant development models for these years which looked to the state as the

[2] Infant mortality rate is the estimated annual number of deaths of infants under 12 months old in a given year per 1,000 live births in that same year.

main agent for development and the guarantor of universal access to healthcare. The three national health plans which were developed under Banda reflect a view of public health as an investment rather than a cost. It illustrates a belief that a healthy population is a precursor to economic growth which can be pursued through a model of Primary Health Care which does not need to be expensive, but must be accessible and universal in order to be effective. Recall the example from the previous chapter of Kerala state in India which has health indicators similar to those of the United States, despite a per capita income which is 99 percent lower (UNDP 2003). This is the model for health which was being pursued in Dr. Banda's Malawi. It is difficult to peg health outcomes directly to these policies, but it seems that there was a steady and widespread increase in health and well-being during these years, with access to health services expanding to reach even the rural populations. Malawi's health policies reflected international trends and WHO expertise such as the call for increased attention to maternal and child health as a building block for healthier populations. For all intents and purposes, health policy and health service delivery in Banda's Malawi were working towards universal access and the principle of 'Health for All'.

On the economic front however, Malawi's economy remained volatile and erratic through the 1990s, partly as a result of the political upheaval taking place in the country's struggle for democracy. The GDP growth rate slumped to -7.2 percent in 1992 and tumbled to -12.4 percent in 1994, related to a drought and the freezing of all non-humanitarian aid to Malawi by donor agencies (Chilowa 1999). The sad reality, as we will see in the next section, is that the situation didn't improve much even after the switch to a multiparty system of government and the return of donor aid to the country.

Things changed quite quickly after the 1994 election in Malawi. Bakili Muluzi was the clear winner of the free election, defeating Banda, who had once been his mentor. Muluzi's United Democratic Front (UDF) government, in keeping with the new constitution, established a human rights commission, freed political prisoners and closed three of the MCP's notorious torture prisons. They immediately implemented free primary school across the country as promised in their election campaign, albeit without increasing the number of teachers or educational resources. But central to this thesis, is that they also abandoned the style of health policy which had been established by the previous government in exchange for a new priority of 'Poverty Alleviation'.

In the next section, we will look at how things changed under Muluzi in the newly democratic Malawi. We will see how quickly the pace of neoliberal economic reforms took place once Muluzi established power and we will explore the impact of these reforms on the field of health and development by looking at the specific health policies which were created by his government.

3.4 Democratic Malawi under Muluzi (1994 - 2004 present)

3.4.1 Introduction

At every public event after he took power, President Muluzi used the rallying cry, "*Zinthu zatani?*" (What has happened?). The crowds, filled with hope and expectation, would reply "*Zasintha!*"(Things have changed!).

Things did change after the 1994 elections. President Bakili Muluzi, a small scale businessman, found himself at the head of government in the newly democratic Malawi. He quickly formed a coalition cabinet with members of his own party and those from

rival AFORD, led by Chakufwa Chihana. This coalition did not last but set the stage for a political scene comprised of a bewildering array of partnerships and denunciations which has persisted. Throughout all of the changes that have taken place within Malawi's party politics, one thing has remained essentially unchanged: regional divisions in the country follow ethnic lines and have given rise to political polarization (Kayambazinthu and Moyo 2002). The three administrative regions of Malawi are matched by the three main tribal affiliations and since multiparty democracy, the three major parties. The Northern region is predominantly Tumbuka and is the stronghold of the AFORD party. The Ngoni of the Central region support the MCP, while the populous Southern region, mostly Chewa, endorse the UDF. In keeping with this trend, the MCP's Banda was from the Central region while Muluzi, the leader of the UDF, is from the Southern region.

The primary change which occurred in the first months of Muluzi's presidency was the adaptation of the overall national development goal to that of 'Poverty Alleviation'. This represented a remarkable structural shift from agriculture to commerce as the desired hub of economic growth and development. Popular capitalism steadily assumed prominence under the UDF, whose leaders stemmed mostly from commerce and industry. The emphasis of this strategy was to create the conditions whereby the poor could generate their own income and therefore contribute to wealth generation (Chinsinga 2002). The programme calls on more 'bottom-up' approaches and a change in perceptions of the poor, who were no longer to be seen as helpless victims of poverty. Malawi's Poverty Alleviation programme revoked what it saw as the previous administration's view of the poor as those needing salvation by the state, through redistribution of the benefits of growth from the active sectors of the economy. Instead,

this programme regarded the poor as active participants in the economy and in *the reduction of their own poverty* (GOM 2001).

The euphoria of *zinthu zasintha* (things have changed), which characterized the 1994 democratic transformation, was built with the promises of a culture of tolerance, preservation of human dignity and respect for the rule of law. Yet the shift to multi-party democracy did not rapidly result in improvement in the quality of life for most Malawians (Chinsinga 2001). Although they could now participate in the political process, many expressed disillusionment with the state, which they claimed had not provided for their basic needs. A popular Malawian song has the verse,

> Thank you for giving me freedom,
> But freedom with hunger is never sweet.
> A slave who is full is happier than a hungry master.
> *("Ufumu wa Mbuye",* Lucius Banda 1995)

During the two years spent working as a health care provider in Malawi, a commonly heard expression was "at least under Banda, we had food to eat". Muluzi has responded to this popular sentiment by saying that he does not own a grocery and, therefore, he is not responsible (Chirambo 2002).

3.4.2 The Political Economy Context of Muluzi's Malawi

With the new leadership of the UDF and Bakili Muluzi, international donors and international financial institutions were ready to re-invest in Malawi. Poverty Alleviation was the development buzzword of the day, and a Poverty Alleviation Programme (PAP) was established by the Government under the direction of the World Bank. This was in sharp contrast to the previous administration, for the official view of Banda's regime was that as long as every Malawian was well fed, lived in a house which did not leak and had

adequate clothing, the question of poverty did not arise (Chinsinga 2002). In fact, it was virtually a taboo to consider poverty as a public problem requiring policy intervention in Banda's Malawi. This changed with the 1994 democratic transformation, as the new government adopted an overall development objective of Poverty Alleviation with the primary goal to raise the productivity of the poor.

In Malawi, poverty is taken as a condition characterized by serious deprivation of basic needs in terms of food, water, health, shelter, education, and a lack of means and opportunities to fulfill these basic needs. The government of Malawi classifies the poor as those who are not able to meet minimum nutritional requirements and essential non-food requirements equivalent to US$40/capita/annum (GOM 2001). This is the poverty line as defined by the World Bank and is an indicator of general poverty. In Malawi, 60 percent of the smallholder population, 66 percent of estate tenants and workers, and 65 percent of urban dwellers live below this poverty line (Chilowa and Chirwa 1999). A World Bank study on the incidence of poverty in Malawi, conducted in 1995, found that 30 percent of Malawians have incomes inadequate to assure basic caloric needs. The study also found that 63 percent of the poorest households (primarily in the Southern region of the country) cultivate less than 0.5 hectares, which is too small to support an average household. Upon the collection of data, the World Bank concluded that the high levels of poverty in Malawi were due to: limited employment opportunities; low physical productivity of labour and land; low levels of human capital; limited access to land and economic rents; minimal income transfers; and rapid population growth (World Bank 1995).

There are many debates on poverty in Malawi which are only unified by their lack of consensus as to what constitutes poverty in the Malawian context. The World Bank

study, for example, does not incorporate any gender analysis into the data, leaving us unclear as to the differential impact of poverty on women and men in the country. It is also not clear as to how the US$40/per capita/per annum amount was arrived at, nor does it seem appropriate to use a single poverty line for different regions which have different food preferences, costs of living, agricultural capacity as well as other factors. Ephraim Chirwa criticizes the World Bank study on the basis that it profoundly understates the incidence of poverty through its sole measurement of "expenditure on maize". When he conducted a study using instead, "proportion spent on food", he found the incidence of poverty to be 89.9 percent of the total population (Chilowa and Chirwa 1999).

The disparities in magnitude of the incidence of poverty emerge mainly as a result of the different methodologies employed in each study. Yet the one important thing to note, and which all seem to agree upon, is that the phenomenon of poverty in the country is not only an acute but also a growing problem (Chinsinga 2002). Here, again, are lyrics from a popular Malawian singer which reflect upon the worsening poverty in the country:

When I am in the streets of Blantyre and Lilongwe
All I get to see are children saying, "*Ndithandizeni bwana*" (Help me, sir)
When I get home, I sit and wonder,
Poverty alleviation is not for the poor.
I hear the cry of poor people,
Cry for food.
Hunger that was invited,
By adopting the foolish ideologies of the IMF and World Bank.
("Take Over", Lucius Banda, 1999)

Structural Adjustment Programmes

Despite pursuing World Bank endorsed structural adjustment policies for more than twenty years, Malawi has seen minimal benefits (Chilowa and Chirwa 1999). Several reviews emphasize that the SAPs have laid heavy social burdens on the

vulnerable segments of society, by not taking into account the potentially adverse effects on the poor in the short and medium terms. One example is the removal of government subsidies on fertilizer which occurred once Muluzi's administration took power. They set about reforming the government controls of the agriculture sector, which Banda had held on to, despite World Bank advice. Chilowa and Chirwa have written that the removal of fertilizer subsidies along with the floatation of the kwacha were detrimental for rural farmers, who could not cope with the 300 percent increase in price that ensued (Chilowa and Chirwa 1999). They say that SAPs have had limited effects on altering the structure of production in Malawi, with the real per capita growth rate per year averaging 3 percent prior to implementing economic reforms and decreasing to 1.7 percent during the adjustment process. Despite these results, as one of the major recipients in Africa of programme aid from both the IMF and the World Bank, Muluzi's Malawi has been held up as a model of reform and privatization.

Another example of the widespread adoption of World Bank neoliberal ideology which took place under the new democratic government was the liberalization of the Agricultural Development and Marketing Corporation (ADMARC) of Malawi. This has been detrimental for poor households in Malawi, who have traditionally depended on ADMARC for the purchase of maize. ADMARC's restructuring involved not only management reform, but also closure of its uneconomic markets and liberalization of the marketing of smallholder crops (Chinsinga 2002). The government had ensured control of rural markets under ADMARC but with liberalization, many areas of Malawi became 'uneconomic' to private traders who found it neither desirable nor profitable to travel to such remote areas. The result is that food insecurity for poor households has increased,

especially in the rural areas, such that one third of Malawi's population now depends upon food aid (Devereux 2002). Former president Banda's 'Breadbox' is no longer.

In recognition of the 'positive' steps being undertaken by the government to reform Malawi's economy, it was found to be eligible for assistance under the Enhanced Heavily Indebted Poor Countries (HIPC) initiative by the International Development Association and the International Monetary Fund in August 2000. Malawi qualified on the basis of an unsustainable stock of external debt and a track record of implementing macroeconomic and structural reforms in the 1995-99 period (IMF 2000). Malawi's debt in 1999 was $1,482 million, which was equivalent to 82 percent of the GDP and 516 percent of government revenues in that year. The government announced that qualifying for HIPC was going to allow a new focus on social programmes, yet as we will see in the next section, there has been no appreciable change in the approach to health and development under Muluzi's government. All that we see is a continuation of privatization, liberalization and decentralization which continue to have a serious effect on the well-being of the country's growing number of poor.

3.4.3 Health and Development in Muluzi's Malawi

The depiction of health throughout Sub-Saharan Africa is not generally a encouraging one. The region is beset with endemic disease, poverty and food shortages. Many explanations look to political unrest as the explanation. Yet Malawi's social indicators are even worse than the averages for the region of Sub-Saharan Africa, even without political violence. For example, the UNDP report the GNP per capita to be only $180 in Malawi but $500 for the region (UNDP 2002). Life expectancy was reported to be 39 years in Malawi versus 50 years for the region and infant mortality in Malawi

almost double the regional average. The purpose of presenting these few statistics is to say that although the health situation is grave throughout the region, what is happening in Malawi is particularly problematic.

Introduction

Health in Malawi remains poor, even with the advances made in population health and with the promises which came during the democratic transformation. Malawi's health indicators remain poor and well below the regional averages for Sub-Saharan Africa. For example, Malawi has an infant mortality rate of 104 per 1,000 live births and an under-five mortality rate of 189 per 1,000 live births. Malawi has one of the worst maternal mortality rates in the world, with 1,120 women dying per 100,000 live births, double the rate from 1992 (GOM 2002). Life expectancy has dropped from 48 years in 1990 to only 39 years in 2002. There is widespread endemic malnutrition whereby 50 percent of children under the age of five are underweight. The high fertility rate of 6.3 children per woman is one of the highest in Sub-Saharan Africa (GOM 2002). Childhood vaccination coverage has declined in Malawi, from 82 percent of children being fully vaccinated in 1992 to only 70 percent in 2000. There was also a decrease in the number of children under five being taken to a health facility for treatment when sick between 1992 and 2000 (GOM 2002). On all fronts, people are getting sicker in Malawi.

In the years since the 1994 election, Malawi has also emerged as having one of the highest HIV/AIDS rates on the continent with some reporting 31 percent HIV prevalence for women in antenatal clinics and an estimated 70,000 new AIDS cases occurring annually (CDC 2003). We will look more into the HIV/AIDS situation in Malawi later in

this section so that we can see, in particular, how government action and policy have influenced the state of the epidemic that currently exists in the country.

HIV/AIDS hit a system which was already struggling with the burden of other communicable diseases and typical public health demands. It also hit a system which was undergoing rapid transformation under World Bank directed Health Sector Reform. This programme, which we will explore in-depth later in this section, calls for major cutbacks in health expenditure, support for privatization of health service delivery and the implementation of user fees in government facilities. As we will see, these factors combined to create nothing less than a health crisis in one of the world's poorest countries. The most disturbing aspect is that despite all proof of the crisis at hand, the government and its backers continue to endorse the same style of neoliberal economic policies which have fuelled the current situation.

Health Care in Malawi since 1994

Before looking more specifically at the health policies which have been developed by President Muluzi's UDF government, we will first try to develop a picture of a health system which is quite different from our own here in Canada, but which is facing many of the same financial pressures. At the outset, there are 14,128 hospital beds in Malawi, for a population of 11 million, representing about one bed per 1000 people (MOHP 1999c). The main health providers in Malawi are the Ministry of Health and Population (MOHP), which provides 60 percent of hospital beds; the Christian Health Association of Malawi (CHAM), which provides 30 percent of hospital beds; and the other ten percent provided by private institutions, NGOs, and religious organizations. In all, there were 504 official health facilities in Malawi in 1999 and an estimated 277 informal private health clinics

(MOHP 1999c). Health care delivery is at four different levels: community rural health facilities, district hospitals, central hospitals, and specialty care facilities.

In addition to the Western model of health care, traditional medicine and practice provide much of the first line medicine for Malawians. There are approximately 1,000 traditional birth attendants scattered throughout rural areas along with some 18,000 traditional practitioners with no formal links to the Ministry of Health and Population (Ngalande-Banda and Simunkonda 2002).

Malawi's National Health Plan and other sector documents indicate that a critical factor behind the country's poor health outcomes is the serious shortage of medical personnel, particularly in rural areas. The public health care system is characterized by extremely high ratios of population to medical personnel. For example, the doctor (including clinical officers or medical assistants) to population ratio in Malawi is 1:32,000 (IMF 2000). This is compared to 1:11,000 in neighbouring Zambia and to the World Bank's "Better Health for Africa" standard of 1:9,000. Because this includes clinical officers and medical assistants in the calculation, the actual qualified medical doctor to patient ratio in Malawi is closer to 1:200,000. The nurse to population ratio is 1:4,900 in Malawi compared to the standard of 1:2,000. Health systems need staff to operate and these numbers make clear that Malawi is far from equipped to provide health care to its population.

A complex set of factors account for the health staffing shortage in Malawi. Some examples are the extremely low salaries of health workers, attrition to more lucrative jobs, sickness or death mainly from HIV/AIDS, and the training institutions' limited capacity to produce fresh graduates. Another key problem in the health care sector is the absolute dearth of drugs and medical equipment in government health facilities. For example, the

2000/01 budget allocation for drugs and medical supplies in Malawi was a mere $1.17 per capita (IMF 2000). Compare this with Canada's budget allocation of $2,524 (UNDP 2003). With only $1.17 per capita to spend on drugs and supplies, it seems unlikely that the Malawian government will be able to provide anti-retroviral drug therapy to those suffering from AIDS in the country. It has been calculated that providing anti-retroviral drug therapy to even just 10 percent of the AIDS patients in Malawi would amount to 2.4 percent of Malawi's GDP, rising to 4 percent of GDP in 2010 (Bond and Dor 2003).

Chilowa and Chirwa report that in a national survey conducted in 1999 only 17 percent of respondents said that their health facilities were adequate. Furthermore, 76 percent of respondents stated that they believed the quality of health facilities had deteriorated over the preceeding five years (1994-1999). Only 12 percent felt that quality had improved. When asked about the availability of drugs in their nearest health facility, 87 percent responded that there were none. The survey also indicated that 82 percent of households who had sick members did not seek medical attention, citing long distances and lack of money as the main reasons (Chilowa and Chirwa 1999).

It wasn't long before the gap between political rhetoric and reality was reflected in the protest songs of the hugely popular Lucius Banda. This song was released just two years after the UDF took power:

(UDF) making education free for children
But teachers remain unpaid,
You cry to see the standard of education going down, lower and lower for poor people
While sons and daughters of politicians are getting quality education abroad.
Go to the hospital,
You'll see doctors and nurses drinking coffee,
While poor patients are dying unattended to in corridors,
And the minister responsible says nothing,
Because when he is sick
He will fly to South Africa, Garden Clinic.

(*"Cease Fire"*, Lucius Banda, 1996)

1994 Health Sector Reform

When the Government adopted the overall development objective of Poverty Alleviation in 1994, the national health goal had to be revised. This was done through a system of Health Sector Reform (HSR), a three-pronged health approach developed by the World Bank for governments under Structural Adjustment. The three tenets of Health Sector Reform are as follows (Kutzin 1995):

- to foster an enabling environment for households to improve health (*user fees, cost recovery*);
- to improve government spending in health *(trimming government spending by reducing services from comprehensive coverage to a narrowly selective, cost-effective approach*);
- and to promote diversity and competition in health services (*turning over to private doctors and businesses most of those government services that used to provide free or subsidised care to the poor*).

Between the years of 1994 and 1999, Malawi was without a National Health Plan as it systematically began implementing the World Bank's plan. While the Ministry of Health and Population continued to emphasize that the ultimate objective of the reform was to improve the health status of the disadvantaged and vulnerable majority, they released policy targets which did not seem in keeping with such a lofty goal. For example, one target is stated as to "reduce the current inequity and inconsistency in cost sharing by expanding the current practice of charging user fees" (MOHP 1999c). As we saw in Chapter One, the literature on user fees shows a selective and detrimental effect on the poorest and most vulnerable in a population.

Another example is the reduction of health expenditure which took place during these early years of reform. In 1995/96, the total health expenditure in Malawi was a little over US$4.60 per capita. This placed Malawi amongst the countries with the lowest levels of health expenditure per individual in Africa (MOHP 1999b). And while the

government announced that spending on health in 1997 represented a 26 percent increase in real per capita expenditure, spending in that year was equivalent to only US$3.50 per capita, a substantial drop from the previous years.

According to the World Health Organization, US$60 is required per person per year to deliver a basic level of health care (Bond 2003). The World Bank concedes that the median per capita health budget for sub-Saharan Africa is US$6, which places Malawi at the bottom of the list. Past director-general of the WHO, Gro Harlem Brundtland, argues,

> It is clear that health systems which spend less than $60 or so per capita are not able to even deliver a reasonable minimum package of services, even through extensive internal reform. It does not matter how good the structure is – as long as you can't afford to pay your doctor and nurses proper salaries and fill the shelves with essential medicines and vaccines, a health system will not be performing at a reasonable level (Brundtland in Bond 2003).

In Sub-Saharan Africa, where donor influence and conditions of Structural Adjustment have enforced Health Sector Reform, it is taking place against a background of severe crisis in health sector budgets, weak state capacity to manage and regulate the health sector in sustainable and equitable ways, and limited civil society involvement. Public welfare services have taken the full brunt of the cut in expenditure, with state hospitals being deprived of basic drugs and other facilities. They have been left to decay while private clinics charging prices well beyond the means of the average wage-earner have flourished (Nzomo 1991).

Yet the World Bank has stated that their policies towards health spending are meant to "strengthen public expenditure management in Malawi which has long been characterized by incidents of fraud and misappropriation of public funds" (World Bank 2000). They state that poor health outcomes in Malawi "have prevailed even in the

context of favourable budgetary trends". Yet massive cuts to health budgets have taken place under the reform of the health sector. In 2000, the total health and education expenditure had decreased to US$99 million from US$148 million in 1996. As a percentage of GDP, total health and education expenditure has decreased from 8 to 5.6 percent during the same years, while the percentage of Malawi's external debt service had increased from 4.9 to 5.2 percent. To compare to health spending closer to home, health expenditure per capita in Malawi is 0.2 percent of the per capita expenditure in the United States (Bond and Dor 2003). Clearly, there have been massive cuts in the social service budgets and there can be no doubt that the decreased allocation of resources towards the health sector has led to decreased hospital services, shortages of medical supplies, and lack of maintenance of health facilities which have directly contributed to the "poor health outcomes" that the World Bank has alluded to.

There was hope that the IMF's Heavily Indebted Poor Country (HIPC) initiative might result in increased resources for health sector in Malawi. However it doesn't seem that this has been the case. Under the HIPC initiative for Malawi, 60 percent of total relief (which is estimated at US$91.4 million for the fiscal years 2001-03) was meant to be directed to health and education expenditures. As outlined by the IMF and Malawi's Poverty Reduction Strategy Paper (PRSP), Malawi will increase health expenditure in the areas of drug provision, primary health care and nurses training. Yet the World Health Organization has been critical of the HIPC debt allocation for health, stating that it just replaces government funds that would otherwise have been available to the health sector. In other words, money is removed from existing health budgets with the plan that the HIPC health funds will fill the gap and therefore, no new money is actually introduced to the health sector. Furthermore, far from providing widespread debt relief, Malawi's

HIPC initiative still requires the government to service many other major debts which do not qualify under this initiative. The implementation of the programme in Malawi hasn't provided any benefits to the country's poor, according to the Malawi Economic Justice Network (MEJN). They cite reports from the Ministry of Finance and related line ministries which indicate that "not a single Kwacha has been used from the much-publicized debt relief" (MEJN 2002).

Health Policies in Muluzi's Malawi

i. Health Policy Framework, 1995

Stimulated by the change of the development model to the Poverty Alleviation Programme, the Ministry of Health and Population of Malawi, with external consultants on contract from the World Bank, published a *Health Policy Framework* paper in 1995. It provided the policy underpinnings for all subsequent health planning and is the foundational document for Health Sector Reform in Malawi. It advocated a series of reforms to be operationalized in the health sector which were aimed at "strengthening management of health care resources at the implementation level and allowing the health sector to generate additional resources through user-fee schemes" (MOHP 1995). The productivity of the labour force was stated as the main vehicle for poverty alleviation, and it was acknowledged that productivity is dependent upon the health status of the population. This document also announced that:

> Since financial resources for health in Malawi have not kept pace with the increasing population, disease burden and awareness of rights among the population, the Ministry of Health cannot provide all desired services to all people (MOHP 1995).

This led to the development of what they call a comprehensive Essential Health Package for every citizen which is in effect, a scaled-down, less ambitious, budget version of Primary Health Care. The goal of Health for All was being abandoned as a cost too expensive for Malawi. Real government expenditure on health fell from 24.7 million kwacha in 1994 to 18.6 million in 1996 (MOHP 1999c), coinciding with Banda's loss of power and Muluzi's embrace of World Bank economic policies.

ii. Bakili Muluzi Health Initiative, 1999

The next stage of Health Sector Reform was in the appearance of the *Bakili Muluzi Health Initiative* which was released during the health policy vacuum that existed between Muluzi's adoption of HSR and the Fourth National Health Policy, which wasn't unveiled until May 1999. This policy is really very incoherent. It says that the obstacles to the overall objective of raising the level of health of the population are things such as inadequate funding of the health sector and scarcity of health sector human resources (MOHP 1999a). Yet it doesn't call for increased funding for the health sector. Instead it outlines a series of strategies to overcome the aforementioned obstacles, such as: support and empower individuals and communities to take more responsibility for their own health and to introduce cost sharing elements. This policy doesn't mention poverty nor does it mention HIV/AIDS, which in 1999, the year it was written, were clearly the major obstacles to health in the country. The Bakili Muluzi Health Initiative introduced three health activity areas, all which seem rather puzzling. The first is the provision of five essential medicines for the most common illnesses to rural areas. It seems that this should not be a new idea, however, as Chilowa and Chirwa's survey indicated, medicine is rarely available at any health facilities, rural or urban (Chilowa and Chirwa 1999). The second

area was to implement focused community based feeding programmes, which was to be done by the World Food Programme anyway. And the final, most bizarre health activity proposed under this initiative was to re-employ 2700 retired health personnel to render health services in their communities. There is no mention of whether or not these retired health workers even exist in Malawi, how they will be recruited or trained or paid, since this policy does not call for any further funding of the health sector.

iii. To the Year 2020: a Vision for the Health Sector in Malawi, 1999

Then in March 1999, the Ministry of Health and Population published another vision statement to guide development of the health sector in Malawi for the next two decades in *To the Year 2020: a Vision for the Health Sector in Malawi.* This vision seems to stem straight from Washington, DC, with its statement, "the Government has accepted the principle that it cannot provide all services free of charge" (MOHP 1999b, p.60). It does not clarify how this 'principle' was realized. However, it does assure us that "mechanisms will be put in place to exempt vulnerable groups and to ensure that nobody is denied care" (p.61) but it does not outline how this will be done.

iv. Fourth Malawi National Health Plan (1999- 2004)

After a four year vacuum during which time there was no national health plan for the country, the Fourth Malawi National Health Plan was launched in May 1999. This policy has the overall goal of raising the level of health of all Malawians and acknowledges an increasing need for quality care (MOHP 1999c). However, it says that the projections for health sector resources proved to be inadequate to sustain implementation of all priority health services. Therefore, it became imperative that

"further prioritization" be made, even among those interventions deemed to be priorities in the past, in order to *"remain in line with the financial base"*(MOHP 1999c: p.15). There is no mention of who determined the financial base, or how it can be possible to further prioritize priorities. Recalling Sachs' speech from Chapter Two, we have to question the point of so much prioritizing when the real problem is that there isn't enough money.

Another notable aspect of this policy is that it sets Home Based Care as the main policy to provide care to HIV infected individuals (MOHP 1999c: p.30). For the objective of improving general health status by strengthening, expanding and integrating relevant health services, it presents the corresponding task as *"alleviate suffering of the chronically and terminally ill patients in their home environment through family and community support"*. No mention of government support for those families and communities.

The final aspect of the Fourth Malawi National Health Policy which seemed remarkable was the section on financing. The health plan was based upon projections of financial resources, calculated based on the following assumptions: there is sustained economic growth of not less than 4 percent annually; that donors constantly increase their allocation by 15 percent annually during the plan period; and that private expenditure on health goes up by 40 percent per year. None of these assumptions seems realistic. There has not been economic growth of over 4 percent in the last 15 years and donors usually decrease their funding, not increase. The third assumption is particularly troubling because it is based on the rationale that the rise in private spending on health will be largely as a result of an increase in HIV/AIDS related illnesses. It seems problematic to base the financing of a health plan on revenue that will come from an increasingly ill

population. As people become sicker, they usually become poorer and it seems to go against all health principles to use cost recovery from them as the rationale for financing.

The four health policies that have been developed in the years since multiparty democracy in Malawi show us how quickly and decisively things can change in the field of health and development when there is a fundamental shift in policy approach. Under Muluzi's UDF government, health policy took a major turn away from the model of Primary Health Care and 'Health for All' which shaped health in Malawi under Dr. Kamuzu Banda. Since 1994, World Bank endorsed Health Sector Reform has restructured health care in Malawi in line with the main postulates of neoliberal economic policy such as privatization, liberalization and cost recovery. Whether Bakili Muluzi's UDF government could have followed another path, we do not know. We do know that as one of the world's poorest countries, Malawi is not in an advantageous position for negotiation. We might also consider that as one of the world's poorest countries, Malawi should not have to sacrifice its population health in service of an economic ideology. Nevertheless, we will now move away from looking at health policy in particular to explore more the political economy of HIV/AIDS in Malawi, which has become the single biggest threat to health and development in Malawi.

The Political Economy of HIV/AIDS in Malawi

HIV arrived in Banda's "peaceful state" in an environment that could not accommodate dissent, not even by a disease (Lwanda 2002). The Malawian educated elite joined the pan-African objections to Africa being seen as the "lenient" origin of HIV, with its culturally-endorsed promiscuity facilitating the spread. Malawians claimed that the "American Invention Depriving Sex" (AIDS) was nothing more than another ploy by

American family planning zealots. Initially, because of its "American origins" and the American NGO which used social marketing to promote condoms, AIDS was dubbed *matenda a Amerika* (the American disease) in Malawi.

The first concrete indicator of the magnitude of the problem of the "slimming disease", or *Edzi*, as it is called in Chichewa, was through USAID funded testing in 1985 which indicated that two percent of pregnant women were HIV positive. This finding emboldened local and expatriate health workers to step out of the climate of government denial to launch the National AIDS Secretariat, with assistance from the WHO. It was not until 1989 that the National AIDS Committee (NAC) was established. Yet the Banda regime, with its strict censorship laws and Dress Code, continued to bar open discussions about sex. As a consequence, AIDS research was not encouraged, at least not until there was a realization at both the state and individual level that the HIV problem could be exploited to secure scarce foreign exchange (Lwanda 2002).

Regardless of state action or inaction, the AIDS epidemic was unfolding across Malawi in the late 1980s and early 90s, so that a popular expression became *kunja kuno kwaopsya* (life is now more dangerous) as more and more people died. While Banda's government used money meant for AIDS work to ease foreign exchange shortages, the largely donor-initiated monitoring continued to show a rising sero-positivity rate at the Queen Elizabeth Central Hospital antenatal clinics. Difficulty in collecting reliable data and statistics on HIV/AIDS remains in Malawi, even today. There has been no national survey to assess the HIV prevalence rate amongst the Malawian population. The most commonly used estimate of HIV prevalence is based on women visiting antenatal clinics during their pregnancy, as they are the most frequent users of government health services. The numbers which emerged showed a rapidly increasing infection rate among pregnant

women: 8.2 percent in 1987; 18.6 percent in 1988; 21.9 percent in 1990; and 31.6 percent in 1993 (Lwanda 2002). The days of denial were over. Malawi was facing an epidemic of terrible proportions.

The 1990s saw a remarkable shift in Malawi's approach to HIV/AIDS. Under the leadership of Bakili Muluzi, the United Democratic Front (UDF) came to power in 1994 and set the fight against AIDS as a high priority. Unfortunately, the fight remained one of rhetoric only for the first four years of Muluzi's rule (1994-1998) as the UDF set about establishing itself. This era saw little advancement in research or programmes which might help stem the tide of the AIDS crisis which was taking over the country. Moreover, money was funnelled away from the National AIDS Secretariat and the Ministry of Health and used for other government activities. Adding fuel to the fire, the UDF publicly encouraging clinical officers to establish private clinics since they claimed that "the government cannot do it all" (Lwanda 2002: p.160).

Facing much criticism for his lack of concerted action towards the epidemic, in contrast to other leaders such as in Uganda who were being heralded for their astute handling of the crisis, Muluzi eventually stepped up, adopting a benign "man of the people" approach. He had been a small-scale businessman before becoming a politician and is widely reported to not have completed any further than primary school. Yet with his new honorary doctorate title, *Doctor* Muluzi began handing out money to the sick and dying, in a posture of a fatherly leader able to alleviate poverty and suffering. Inevitably, questions as to the source of the money and the long term plans for dealing with the crisis emerged. His frequent attendances at funerals led to criticisms about "too much weeping for the dead while the living suffer" (Lwanda 2002). Ben Michael, a popular reggae

singer in Malawi, sang *Tilire, tilire* (1999) whose lyrics translate, "Let's all cry! Not for the dead, their turn is over, but for ourselves!"

Eventually, the UDF had to confront the issue of HIV/AIDS and its own history of inactivity. Between 1994 and 1998, the UDF lost up to 29 of its 193 MPs to AIDS and used scarce government resources sending officials to South Africa for treatment (BBC 2004). Popular media, so controlled under Banda's authoritarian regime, was informing the public about the disease and about initiatives taking place in other countries in the region, which led to popular demand for the UDF to confront the national problem. Also instrumental in increasing the government's commitment to addressing the AIDS situation in Malawi was the visibly debilitated state of the Army and the Police.

When the 1999 Sentinel Survey reported that infection rates among pregnant women in Malawi ranged from 2.9 percent in the northern town of Kasungu to 35.5 percent in Mulanje, a tea estate region in the south, the Vice President's office admitted that "despite the severity of the HIV/AIDS epidemic, the response from the Government and the community is not commensurate with the seriousness of the problem" (Malawi National AIDS Control Programme 1999: p.107).

There have been changes in Malawi over the past five years, since my initial arrival in Malawi in September 1999. At that time, AIDS messages were few, not very explicit and coming almost exclusively from international NGOs. But during fieldwork in 2003, I noted large billboards in the main towns and border crossings which featured the image of President Bakili Muluzi, next to his message: "Malawians Change Your Behaviour Now! AIDS is killing our country!" Muluzi publicly declared in February 2004 that his own brother had died of an AIDS-related illness and the following month, one of the leading opposition members, Brown Mpinganjira announced that he had lost

half of his family to AIDS. In a report for the BBC, Mpinganjira said that his opposition party, the National Democratic Alliance (NDA) will make HIV/AIDS a campaign issue and that their campaign manifesto has deliberate policies on how to tackle the disease. He is quoted as saying, "We take the issue of HIV/AIDS very seriously because all our planning as a nation could go up in smoke if we do not arrest this pandemic" (BBC 2004).

Studies now show almost universal awareness of HIV/AIDS in Malawi (GOM 2002). People are beginning to talk openly about the challenges to individual health and to the country's development with respect to the threat of AIDS. The government launched a National Behaviour Change Initiative in 2003 to try to transform public knowledge about HIV to widespread changes in personal behaviour as a means to arrest the epidemic in Malawi.

This last section on HIV/AIDS illustrates the point that political action and policy decisions have great power over the health and well-being of a population. In the next section, we will look at another example of policy decisions which have had a lethal effect on Malawians. This is the example of the famine which hit the country in 2002-2003, which led to the deaths of thousands of people. The role of policy in creating the famine is widely accepted and thus provides a good ending to our chapter on health and an appropriate introduction to Chapter four, which will look specifically at women's caregiving stories and their links to health policy. The vignette on the 2002- 2003 famine will provide a foundation for our further exploration of the basic premise of this thesis: that people's health experiences are not separate from the economic policy decisions being made far from the villages where they live, but are directly related to the budgets and policies which guide the health care system of Malawi.

3.4.4 The 2002/03 Malawi Famine

Between February 2002 and April 2003, thousands of Malawians have died from famine, the first recorded since the "Nyasaland famine" of 1949. These deaths followed a sequence of negative food security events including a decrease in maize production by 34 percent, maize prices increasing by 325 percent, collapsing prices for livestock, the sale of the Strategic Grain Reserve and the failure of the maize import programme (Devereux 2002). All sources of food (production, purchase and transfers) failed simultaneously. Flooding cut maize production by 32 percent, from 2.5 million metric tonnes (MT) in 2000 to 1.7 million MT in 2001. This left a 300,000 MT deficit for the year 2001, with an expected deficit of 600,000 MT for 2002. Furthermore, the Strategic Grain Reserve, which held 175,000 MT of maize in August 2000, was completely sold. Recall from an earlier discussion that the government food agency ADMARC was undergoing restructuring at this time. The IMF had advised Malawi's National Food Reserve Agency to sell their buffer stocks of maize in order to repay their commercial debt. In response to heavy criticisms against the advice they gave, the IMF has maintained that they told the agency to leave 60,000 MT in stores, yet even that was sold and remains unaccounted for. The debate has not been settled as to whether the IMF or corruption in the government of Malawi was to blame for the state of disaster that befell the country (Garut 2002). Regardless, even if the remaining 60,000 MT of maize had not been sold, the act which the IMF uses to peg responsibility on government mismanagement, there would still have been a 240,000 MT deficit. Critics of the IMF say that in addition to helping create the debt that the government sought to pay off with the proceeds from the grain sale, the Fund had encouraged privatization of the National Food Reserve Agency, along with massive cuts in government spending on agriculture. Whatever the legal processes may

unearth about the specifics of the handling of the Grain Reserve, it is clear that fifteen years of agricultural reforms designed by the World Bank and IMF have failed to deliver agricultural growth and food security in Malawi.

In an analysis of the famine persisting throughout the southern African region, deWaal says that as a result of HIV, the worst-hit African countries have undergone a social breakdown that is now reaching a new level: their capacity to resist famine is fast eroding (deWaal and Tumushabe 2003). Traditional agrarian societies in Africa were well adapted to the threat of drought, and in times of famine, the victims were usually young children and the elderly. Rarely did young adults die, and women survived better than men. Thus, society's core was preserved and it could recover. Women knew what wild foods could be eaten, families scattered over wide areas and distant relatives assisted in times of food shortages.

But today, African societies are unable to call on these traditional means of resistance because AIDS attacks exactly those capacities that enable people to resist famine. AIDS kills young, productive adults, especially women, whose labour is most needed. In the rainy season, there is a critical period of planting and weeding, which if missed means a family will go hungry. Numbers of dependents no longer are restricted to children, but include sick adults, whose labour contributions are lost. Caregiving burdens are crippling families, as extended families are called on to look after critically ill people in their final weeks and the AIDS orphans they leave behind. The normal generational cycle of education and duties is completely disrupted as young people inherit debt and miss out on learning essential skills and traditional knowledge. The elderly, who had expected to be cared for in their old age, are now doing the caring and struggling with the

physical demands of subsistence farming. Poor nutrition resulting from food shortages means death for those whose bodies are already weakened by AIDS.

For certain, the link between the AIDS crisis and famine poses an overwhelming challenge for Malawi, as for all countries in the region. In agrarian societies, the HIV/AIDS epidemic is creating what deWaal calls a "new variant famine" (deWaal and Tumushabe 2003), presenting an entirely new challenge to development thinking, planning and programming. When combined with policy decisions based on financial bottom-lines rather than the well-being of a population, HIV threatens the security of an entire continent. The experience of famine in Malawi in 2002/03 illustrates the damage that can be done to the health of a population when policy is solely guided by financial concerns. Some form of grain reserve has been used in Malawi, like all African countries, for centuries as a means to deal with seasonal variations in food production. To call for the sale of Malawi's grain reserve seems unsound on its own, but becomes murderous as it was done even as preliminary warning systems declared poor harvests for that season.

3.4.5 Gender Policies in Malawi

It is now important to look briefly at the gender policies which have been developed under President Muluzi's government in order to set the scene where gender really is not acknowledged as important in policy making circles in Malawi. This will be of assistance in the lead up to the next chapter where we link women's stories back to the neoliberal health policies created under Muluzi's UDF government.

Malawi has ratified international Declarations and Conventions that deal with issues of gender in general and the plight of women in particular. The key ones include: Elimination of All Forms of Discrimination Against Women; The 1993 Vienna

Convention on Human Rights; the 1994 Cairo International Conference on Population and Development (ICPD); the 1995 Copenhagen Declaration on Social Development and finally, the 1995 Beijing Fourth World Conference on Women (FWCW). Each of these declarations and conventions advocates the improvement of the status of women. For example, the ICPD states that "*The empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself*".

The first Malawi Constitution, developed at the time of independence, did not adequately provide for the cause of women (Tsoka 1999). Furthermore, development policies from the 1960s until the 1990s only casually dealt with the development of women as a social group and advocated little more than home economics and homecraft courses for girls. Malawi's development policies, through the Policy Framework Papers (PFP) did not include any specific policies towards women until the fourth PFP in 1992 when the Women in Development (WID) approach was adopted. At this time, the government announced that improving the lot of women had become integral to Malawi's development goals and that to that end, the government had "shifted its emphasis from home economics training toward recognizing women as economic agents" (Tsoka 1999). The new Constitution of the Republic of Malawi, unveiled in 1999, provides for equality and for the rights of women. While this legal document presents the framework for a very supportive environment for women, the reality in Malawian society is quite different. As this section will show, many policies have been developed by the government of Malawi which have not translated into any practical or appreciable change in the quality of life for women in Malawi.

In March 2000, the National Gender Policy (2000- 2005) was released in which the Government of Malawi recognized that "sustainable economic and social development of the country requires full and equal participation of women, men, girls and boys". The policy is meant to guide and direct all levels of planning and implementation of development programmes with a gender perspective, with the overall goal of gender equity and equality. The problem with this policy is that there is a huge disconnect between what the government says it is aiming to do and the reality of what its macroeconomic policies are doing. The gender officer at CIDA Malawi told me that the problem was a lack of recognition of the importance of gender issues at the higher levels of policy making in the country. She said, "People here don't think that gender is a full time job".[3] Tsoka highlights the forced nature of mainstreaming gender in Malawi's government when he says that the policy makers "formulate the policy under duress to an extent that when it comes to implementation they drag their feet" (1999).

Most recently, in December 2002, the Malawi Government unveiled its new National Policy on Gender Based Violence. The main focus of the policy is on physical and psychological gender based violence and what little mention there is of economic violence uses instances of property grabbing as examples of economic violence against women. This is problematic as it is a big leap from these examples of individual economic exploitation to the systemic, institutional gender based economic violence which arises out of using women's unpaid labour, jeopardizing their health and their livelihoods, to subsidize government services.

[3] Olivia Liwewe, CIDA Malawi's gender officer, Lilongwe, Aug. 4, 2003.

These reforms and their subsequent policies have been fiercely attacked by civil society and activists in Malawi. Dr. Dixie Maluwa-Banda at Chancellor College says that there is a wide gap between any government policy in Malawi and the people:

> The language of the policy is English and academic and people are just not aware of these policies. They are far removed from understanding the policies and what they mean for ordinary people. The government creates policies which are not research based and which don't incorporate any participation of lay people.[4]

Gender and the Poverty Alleviation Programme

As outlined earlier, the Malawian government under the leadership of President Bakili Muluzi adopted the overall goal of Poverty Alleviation in 1994 after winning the national elections and unseating Kamuzu Banda. Malawi's policy framework for Poverty Alleviation identifies women as one of the most poverty-affected social groups. As such the mission of the Poverty Alleviation programme is to "transform the economic structures to ensure that they meaningfully contribute towards raising the standards of living so that people have equal access to income opportunities" (GOM 1994). This is a very economic approach which neglects the nature of women's unpaid work in Malawi.

To put some of the gender policies and strategies into context of actual budgetary spending, we can look to the 2000 CIDA Malawi report which looked at gender in the Malawi government budget. It showed that Education and Health receive the two largest allocations, yet their combined allocation is still less than the amount spent for interest on debt (CIDA Malawi 2000). For example in 2000/01, the Ministry of Health and Population got a total of just over 3 billion Malawi kwacha (MK)[5] from the recurrent and

[4] Dr. Dixie Maluwa-Banda, Chancellors College, University of Malawi, Zomba, October 8, 2003.
[5] Approximately US$30 million, given an exchange of MK100= US$1

development budgets, yet almost MK8 billion was spent on interest on debt.[6] Meanwhile, the Ministry of Gender, Youth and Community Services received only MK162 million for that same year. Only 17 percent of the MK162 million was allocated for gender development services and reproductive health services were allocated only MK1.3 million.

Gender and the Poverty Reduction Strategy Paper

The preparation of the Malawi Poverty Reduction Strategy Paper (PRSP) was conditionality for accessing resources from the Heavily Indebted Poor Countries (HIPC) initiative. The international financial institutions and donors apparently felt that the PRSP process would highlight the need to focus on poverty and by extension, on what they call "social spending for human capital development" (GOM 2001). The basis for the PRSP had been the apparent worsening poverty situation despite previous policy pronouncements and efforts towards poverty reduction. The Malawi PRSP, which is both a policy and expenditure framework, claims to put emphasis on human development and the provision of basic social services.

The PRSP may be heavily infused with the rhetoric of local ownership, participation and empowerment of the disadvantaged, but the reality is more complex, say critics. Ellis, Kutengule and Nyasulu say that the Malawi PRSP is not addressing either the rural realities or the gender realities of the country and take a sceptical view of the so-called decentralization process (2003). They say that the Malawi PRSP's goal of "creating an enabling environment for people to construct their own routes out of

[6] Approximately US$80 million, given an exchange of MK100= US$1

poverty" is based on a narrow view of poverty which does not take into account the multiple constraints confronting rural Malawians.

Another serious criticism of the Malawi PRSP stems from the closed process of actually developing it. Critics say that the Malawi PRSP was essentially complete before any participation from civil society was invited. Instances of insufficient information and denial of access to information during the design stages of the Malawi PRSP have been widely documented.[7] The Gender Empowerment working group which developed to provide insight into the Gender Strategy for the PRSP ended up having very little input (Manoukian 2002).

From the report on the Official Launch of the PRSP, it notes that there had been some debate on the importance of reducing gender inequalities as a priority target for the PRSP process. Some delegates denied the importance of reducing gender inequalities, arguing that special treatment should not be given to women. The report concludes that "it was generally agreed, however, that changing attitudes to gender relationships is more important than providing additional resources for groups of women" (GOM 2001). Again, little needs to be said; gender is clearly not a priority issue in Malawi's policy circles, beyond providing lip service to the idea in order to appease donor requirements.

Women continue to face many threats to their well-being, and even to their survival in Malawi, yet there appears to be few positive changes on the horizon. Gender policies are being written, which are in keeping with current theories on gender and development, yet without any mechanisms to ensure implementation and no resources to back that up, they remain unknown and of little use to the majority of women in Malawi.

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[7] See Jubilee 2000's position paper on the status of PRSP and Civil Society involvement in Malawi <http://www.jubilee2000uk.org/jmi/jmi-news/malawi_prsp.htm>

Key government institutions aren't making gender issues a priority. For example it became clear in my meetings at the Malawi National AIDS Council (NAC) that while gender was recognized as a challenge, it wasn't finding its way into any meaningful action. As a result NAC, the central body for organizing all AIDS funding to the country, does not have a gender officer. They will be dispensing millions of dollars in aid for AIDS projects but will not have any qualified staff to ensure that gender considerations are taken into account.

Lastly, the macroeconomic climate which prevails in Malawi does not recognize the constraints of poverty for women, with its insistence that they find a means to pull themselves out of poverty through market activities. This structure, which towers over all other activities, poses the most formidable challenge for women in Malawi.

3.4.6 Conclusion

As a health practitioner in Malawi from September 1999 until August 2001, I was able to witness first hand the personal and devastating conditions of ill health that Malawians face. My experience serves as a kind of qualitative backdrop to the statistics that I have presented and provides me with the conviction that quantitative data do not tell the full story of suffering that is taking place in this small country. Nor do they provide an adequate account of the bewildering array of policy shifts which characterized day to day life in Malawi. Programmes and services which people had depended upon were suddenly cancelled, funding revoked, new rules instituted, all without any warning or any explanation. This section has shown the rapid pace of reform which took place in the health sector as soon as the new government of Bakili Muluzi gained power in 1994. While not the topic of this investigation, it is possible that Dr. Banda was able to protect

the health care sector, his showpiece and professional source of pride, from the forces of change while he held power. Whatever the case, the 1994 democratic transition resulted in big changes for Malawi's public health system, with changes still underway.

Health policy is being created in Malawi completely in keeping with World Bank neoliberal ideology. The majority of Malawians live in poverty and cannot afford the new commodity on the market, known as health. Their well-being has become the sacrificial lamb for a global economic project designed to make the rich even richer. Neoliberal health policy reduces life to nothing more than a coping strategy. Furthermore, gender issues rarely find their way into policy decisions, such that the differential impact of policy on women is not recognized or accounted for. Yet when the rich get richer, the poor must get poorer and the effect of this is different for men as it is for women. In a country like Malawi which has so many already living at the dead-bottom of the economic scale, there is nowhere left to fall. For them, mere survival is registered as success in the policy books.

3.5 Conclusion

This chapter which has traced health and development throughout Malawi's political and economic history provides insight as to how health policy has been formed and under what circumstances in this small African country. It has become clear that political forces have a major effect on the health care sector, as it competes with other sectors of the economy for resources. The shift from state-led to market-led development has had significant implications for Malawi's health care sector. As the leadership role for global health has transferred away from the World Health Organization to the World

Bank, there has also been a significant shift away from the traditional concepts of social justice, rights and equity in public health provision towards markets and efficiency. This is reflected in the health policies created in Malawi under World Bank directives.

Under the neoliberal market-based model, public health services and 'Health for All' are perceived as obstacles threatening public finances and the wealth of nations. As a result, public health budgets are no longer seen as a productive investment for human development and economic growth but as an unnecessary financial burden on governments. In keeping with this neoliberal ideology, Malawi made cuts in its health spending in some areas and froze spending in others. As the role of the state is curtailed, the market is freed up to generate an enabling environment for individual entrepreneurship. The problem is that the foundation of these policies is flawed. Malnourished people unable to receive health care services are in no position to improve their own well being, nor are they in a position to contribute to national economic growth.

It is not only the negative changes in policies which are of concern; it is also the lack of positive changes. As global prosperity, medical knowledge and technology advance, we should expect similar advances in the health sectors of all countries. While we previously looked to the state to provide health services in the public sphere, the IMF and the World Bank have replaced the state with a multiplicity of health actors, working in the private sphere. This is reflected in the piecemeal approach to health delivery which exists in Malawi.

The differing perspectives on health as either a cost or an investment can mean major changes in the kind of health care that exist in a country. The forces that have invoked change in Malawi's health care sector are the very same forces acting on our own, Canadian public health care system. Global capitalism and free market economics view

health as a commodity to be sold on the global market. Neoliberal economics insists that the provision of health care must be transferred from the state, where it is considered an unnecessary expense, onto the individual, who should have the means to provide for him or her self. These transactions have terrible social costs for the poor of Malawi, as we have begun to see.

While the lack of recognition of the general implications of market-based principles on health is evident in Malawi's health policy, the most startling error of omission is the lack of gender specific policy development. Women in Malawi have particular health needs as a result of their particular reproductive roles and in their gendered roles as traditional caregivers. This is not addressed in Malawi's health policy, nor does it seem that gender issues are seriously considered in any of Malawi's major development policies. The implication of this omission for women is great as we will see in the next chapter, which will further explore the social costs of the neoliberal reform of the health sector of Malawi on women. We have seen that gender issues are not afforded a high priority in Malawi's decision making circles. While policies are created which do sound quite appropriate, they do not translate into action. Furthermore, gender considerations need to move beyond the confines of gender policies and find their way into all policy decisions if they are to be effective. This has not been the case in Malawi. In the next chapter, women's stories of caregiving will be linked to the broader health policy environment so that the real-life consequences of adopting these policies can be explored. Women in Malawi are not caring for their families in a vacuum. The lived experiences of women caregivers in Malawi is inextricably linked to the policy environment governing the health sector of Malawi, and to the broader neoliberal economic project which has been directing development for the past twenty five years. It

is at the intersection of these women's livelihoods with the structural forces that guide our world that we can better understand how power, wealth and prosperity on one hand, and exploitation, misery and suffering on the other, are created in a global system.

Chapter 4: IMPACT OF HEALTH SECTOR REFORM ON WOMEN

4.1 Introduction

"Ahh, madam, can you see that here there is no peace?"[8]

There is no peace for Malawi's women, not just because of HIV/AIDS, but because the epidemic, like so many other assaults on the poor, is able to flourish in a policy environment where market priorities are given precedence over the well being of people. We saw in the last chapter that health policy under neoliberalism, has transferred responsibility from the state to the individual, putting enormous burdens of care on the traditional caregivers in society, Malawian women.

Malawi's Poverty Reduction Strategy Paper states, "The national health policy is in place, which focuses on encouraging and empowering the community and individuals to take more responsibility for their own health" (GOM 2001).

What does it mean for Malawi's women when individuals and communities are forced to "take more responsibility for their own health"? At the community level, it means that women are providing care for terminally ill AIDS patients without any support from the government. At the hospital level it means that women have to find means to pay for services and drugs. Moreover, at government hospitals and health clinics throughout Malawi, large numbers of female guardians are looking after their family members without any recognition, support or compensation, providing essential services

[8] Elderly woman caregiver, interview, Mpemba village, Aug. 14, 2003.

to the health care sector. When asked what duties guardians in the hospital are responsible for, a nurse told me:

> Guardians need to buy some firewood, some flour if they haven't brought from home, they need to buy relish each day, maybe some cooking oil, some soap for cleaning the clothes, some soap for bathing the patient. Sometimes they need to buy medicine for the patient. Sometimes they are asked to pay for things at the hospital like if the patient needs an x-ray, the technician can say that they should pay, but he is not allowed to do this and they shouldn't have to pay. But I have heard that it does happen.[9]

Another nurse outlined the duties of a hospital guardian:

> Here in Malawi, guardians are the one who must look after the patients, such as bathing the patient, feeding the patient, washing for the patient. As I have already said, the nurses cannot do these things here in Malawi, so it is the guardians who have to do a lot of work at the hospitals. They must do all of the personal care for the patient plus going to fetch some food. They do everything. Everything. And most of the guardians they are women. Sometimes the nurses even give the guardians duty-roster so that they also have to mop the floors and clean the toilets.[10]

The policy of transferring the responsibility for social service provision from the government to the individual is in keeping with current free-market ideology and is the guiding principle behind the reform of Malawi's economy, including the health sector. This line of thinking calls for open markets and small government which will provide people with entrepreneurial opportunities leading to personal wealth, allowing them to look after themselves.

In this chapter, we will use a gender analysis of Malawi's health policy to bridge the gap between the overall analysis of health policy changes in Malawi and the micro level, livelihoods analysis of the specific responses by women and their families to the demands of caring labour. By using women's stories and experiences as a means to

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[9] Nurse, semi-structured in-depth interview, Queens Central Hospital, August 19, 2003.
[10] Nurse, semi-structured in-depth interview, Queens Central Hospital, August 23, 2003

evaluate policy, we are able to see the hidden costs of downloading responsibilities to individual women and exploiting their unrecognized and unpaid domestic labour.

In the previous chapter, we investigated the political and economic climate that has prevailed in democratic Malawi under the leadership of President Bakili Muluzi and the United Democratic Front party. We also explored the process of health sector reform which was initiated by Muluzi's government and looked at the specific policy directives which emerged from that programme. We have observed that the health situation in the country is poor and has been getting worse over the past ten years. We know that the toll of HIV/AIDS on households can be very severe. In many cases, the presence of AIDS means that the household will dissolve, as parents die and children are sent to relatives for care and upbringing. A UNAIDS study in Zambia revealed that 65 percent of households in which the mother had died had dissolved (UN General Assembly 2001). But a great deal happens to a family before this dissolution occurs; HIV/AIDS strips the family of assets and income-earners, further impoverishing those already poor.

In Malawi, AIDS has led to a rapid evolution to absolute poverty for many households. Research in neighbouring Zambia shows that, in two-thirds of families where the father had died, monthly disposable income fell by more than 80 percent (UN General Assembly 2001). A similar study in Cote d'Ivoire revealed that income in affected households was half that of the average household income. This was often the result not only of the loss of income due to illness among household members, but also because other members had to divert more time and effort away from income-generating activities. In Botswana, UNAIDS predicts that per capita household income for the poorest quarter of households is expected to fall by 13 percent, while every income-earner

in this category can expect to take on four more dependents as a result of HIV/AIDS (UN General Assembly 2001).

These statistics are startling. Our natural reaction is to attribute all of the problems that have befallen Malawi to the disease. Yet, it should be becoming clear that things in Malawi could be different. Different policies could have been implemented which would have changed the course of the epidemic. For example, health experts have estimated that the world community needs to invest US$7-10 billion every year to fight HIV/AIDS, tuberculosis and malaria, which are threatening the very development of Sub-Saharan Africa. In the face of this health crisis, however, these countries continue to pay $13.5 billion a year in debt service payments to creditor countries and institutions (Cheru 2002). How would the situation I witnessed in Malawi been different if it had been able to adjust its economy to meet human needs, rather than vice versa?

This chapter will provide a deeper understanding of the link between the health policy in Malawi, which has pushed responsibility for care onto individuals, and women who are responding to the increased demands on their time and labour by employing what are called "coping strategies', but what may well indicate a failure to cope. The disastrous outcomes of developing health policy which absolves the state of responsibility to provide care and treatment in keeping with a rights-based approach to health in the midst of a health crisis will be seen through the voices of Malawian women, who shared their stories with me during three months of fieldwork in southern Malawi in 2003.

4.1.1 Introduction to Fieldwork

The primary goal of this fieldwork was to understand the cause of the intense loss that was witnessed each day while I lived in Malawi. I wanted to establish whether all of

the hardship around me was merely the impact of the epidemic or whether the causes were more profound. I wanted to explore the effects of neoliberal economic policies on women, and to uncover the horrible effects of dismantling government health care and social programmes in the midst of a health crisis. In particular, I was concerned about the effect of national "Home Based Care" policies, used extensively by governments in the region to care for the vast numbers of chronically ill AIDS patients, on women. It seemed to me that while nicely worded national gender policies had been created, macroeconomic decisions had also been made which did not take into account the demands on women's time and labour. I wanted to situate what women in Malawi were experiencing within the broader system of global health economics in order to illustrate the inequity and exploitation that this system presents for the worlds poor and vulnerable, the majority of whom are women.

I collected data in two different settings: the hospital and the community. The reason for the latter is obvious. If people are sick and dying at home, it makes sense that you should go to those homes and see what is really going on. The former demands some explanation, particularly in the foreignness of the workings of African hospitals to most Canadians' image of health care. Every patient seen at a Malawian hospital must have a "guardian". A guardian is a family member who stays with the patient full-time during the patient's hospitalization and is responsible for washing and feeding the patient. In most hospitals, they must also provide and prepare food for the patient. Having worked in a hospital, I was well aware of the demands and problems that this posed for the mostly female group of guardians. Often they were far from home, without any support, money or relief from their duties. They were often ill-treated by the hospital staff. They frequently were separated from their children and husbands. Certain medical practices

increase the time that patients and guardians are away from their homes and I met guardians who had not been home in months. For example, a new approach to tuberculosis management developed to combat the rising prevalence of drug resistance calls for the patient to stay in the hospital to receive their daily dose for fear that they would not be compliant if sent home to self-administer the medication. I knew one guardian, the mother of a boy with spinal TB, who was at least seven months pregnant but had no way to send a message home to her husband to tell him. Her son would have been discharged if she had left him without a guardian and there was no one who could take her place.

In order to do community-based research, I worked through the Southern African AIDS Training Programme (SAT)[11], funded by CIDA and the Canadian Public Health Association. I was introduced to one of their partner organizations, Word Alive Ministries International, a church-based programme which has an established Home Based Care (HBC) project.[12] Through this project, I was able to join the Home Based Care team on their daily visits to townships and rural communities in the Blantyre region.

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[11] The Southern African AIDS Training (SAT) Programme is a project of the Canadian International Development Agency (CIDA) delivered by the Canadian Public Health Association (CPHA). Since inception in 1990, SAT has supported the community response to HIV in Southern Africa by providing financial and technical assistance to many community initiatives and networks. SAT funding and skills building activities support partners in a wide range of relevant activities - HIV prevention, HIV and AIDS care and support, impact mitigation, networking and information exchange, HIV-related advocacy on gender and human rights.

[12] ICOCA program is run by the Word Alive Ministries International, a church in Blantyre, Malawi. The program began in 1992, when church members volunteered to provide pre and post-test counselling for patients receiving HIV testing at Queen Elizabeth Central Hospital (QECH). Starting in 1994, volunteers from the church started to follow patients who had been discharged from the hospital in their communities and homes. In 1996 a grant was obtained from Family Health International and 12 part-time staff were hired as the programme grew in size and scope. By 2001, the full-time staff complement reached 26 and the Canadian International Development Agency (CIDA) also joined USAID as the major donors. The main activities in the ICOCA project are voluntary counselling and testing; Home Based Care; Orphan Care and Relief and Development.

They had a comprehensive referral system in place whereby village volunteers or chiefs would identify those chronically ill community members to the HBC staff, who then followed the patient and provided whatever assistance they could.[13] The HBC team would identify cases that they thought would be appropriate for my study. They also identified community counsellors who could conduct my survey and together with the field officers, helped me to distribute and collect the surveys from those communities. Without this collaboration, the data collection would not have been so fruitful.

4.2 Gender and Caregiving in Malawi

4.2.1 Gender in Malawi

An understanding of the current economic, social and political status of women in Malawi is essential to understanding the relationship between their well-being as caregivers and the health policies which have been made under Health Sector Reform.

[13] The Home Based Care program conducts home visits to clients and caregivers, referred by hospital staff and community. They supply and replenish care kits to clients and provide basic nursing care to clients. They also train Community Based Counsellors (CBCs), who are identified by traditional authorities and chiefs, in providing care and support to the chronically ill.

The CBCs can give bedbaths, provide basic medications such as aspirin. They are supervised by the chiefs or traditional authorities in that village. The CBCs contact the head office if the client's condition drastically changes and then the HBC team visits and decides whether to take the client to hospital. Otherwise, the team visits about once a month. During their visit, the nurses can dispense medicine and food, if available. The church must pay for all food and medicine, or through donations. Nothing is provided by the government.

Clients are referred through 12 referral centres at local government (public) hospitals and clinics. Staff at the health centres identify which patients would benefit from HBC services and then direct them to their chief or CBC, who arranges for them to be included in the HBC program.

ICOCA currently has about 110 volunteers in 60 communities within Blantyre. 65 of the volunteers are female. The volunteers assist not only with the HBC project, but also facilitate discussions in the different discussion groups that exist. There are about 90 discussion groups. Three quarters (3/4) of the participants are women. The group meet to discuss cultural, social and health issues. They come to Word Alive once a month to report on their progress in the fieldwork.

My experience of living in Malawi coupled with data from studies point to the situation where the social structures in Malawi are characterized by pervasive gender discrimination. Women continue to carry the burdens of poverty and ill health in a country where they dominate the unpaid and informal labour force. This is despite Article 11 of the Constitution which states that:

> every person in Malawi is entitled to the fundamental rights and freedoms of the individual, regardless of race, place of origin, political opinions, color, creed or sex (Constitution of the Republic of Malawi 1999).

In a report on the gender dimensions of poverty in Sub-Saharan Africa, the World Bank has recognized what is termed women's "triple responsibility" (World Bank 2000c). They write that women's triple responsibility – child bearing and rearing, household management, and productive activities – and the increasing pressures on their time and energy have significant consequences for human resource development, agricultural productivity, and environmental sustainability. Fuelwood and water are becoming increasingly scarce, and more time is required to obtain them. The Bank calls for efforts aimed to reduce women's severe time constraints; lowering the barriers to women's access to land, credit and extension advice; introducing technologies usable by and beneficial to women; and upgrading women's educational standards and skills (World Bank 2000c).

It is true that women in Malawi, and throughout the world, carry a triple burden of responsibility. It is also true that the preceding report was written by the very same Bank that has enforced the dismantling of social policy in Malawi with the resulting impoverishment of multitudes of the country's women and their children. Nonetheless, the goal of this section is to develop a clearer image and understanding of the particular features of gender and caring labour in the Malawian social, cultural and political system.

We will begin with an overview and an exploration of gender roles in Malawi and then move to a more explicit look at women's caregiving role in Malawian society.

Women in Malawi hold primary responsibility for activities related to social reproduction such as child care, family health care, and provision of basic resources such as fuel wood, water, and food preparation. They also are responsible for directly productive activities such as subsistence and market-oriented cultivation, wage employment and other income generating activities (Green and Baden 1994). As many as one-third of households in Malawi are headed by women and these households are more prominent in the rural areas than in urban ones due to male migration to towns in search of wage employment. Malawi's high incidence of female headship has been related to three main factors. The first is the high number of refugee families resident in Malawi from Mozambique, Democratic Republic of the Congo and Rwanda, who are predominantly headed by women. Secondly, there seems to be a disintegration of marriages under the matrilineal systems of inheritance practiced in the central and southern regions. The explanation given by Green and Baden is that because men lack security of land tenure, productive activities on smallholdings are unappealing. Finally, labour migration opportunities outside of Malawi, primarily mining in South Africa and Zimbabwe have created female headed households (1994). The impact of HIV/AIDS affects the size and composition of households such that there is an increase in the percentage of female-headed households, including grandmother-headed and girl-child-headed households (UN Secretariat 2003).

Malawi has an agricultural economy whereby smallholder, subsistence farms comprise over 80 percent of the total cultivated land, with only 20 percent being used in the formal, commercial sector. Within the subsistence sector, approximately 70 percent

of smallholder agriculturists are female (Green and Baden 1994). Studies emphasize the fact that the bulk of agricultural labour within the subsistence smallholder sector is undertaken by women. For example, Green and Baden show that women spend over 12 hours a day working in the subsistence sector, versus approximately 4 hours a day for men (Green and Baden 1994: p.10). This included time spent on market production, subsistence farming and household duties. Divisions of labour within rural areas mean that women have an enormous work burden and that opportunities for earning income in off-farm activities are constrained by lack of time. This also points to the difficulties for women and households when they become ill or have to give care to a sick family member.

The main subsistence crops grown within the smallholder sector are indigenous varieties of maize, pulses, sorghum, millet, cassava and groundnuts. In good agricultural years, surpluses of some subsistence crops may be sold. Cash crops include hybrid maize, tobacco, cotton and groundnuts and the hoe continues to be the main means of cultivation (Green and Baden 1994).

Within the formal agriculture sector, wages are very low for women, falling even below statutory minimum levels. A study of tobacco and tea estates cited by Green and Baden found evidence of pervasive gender discrimination within this sector. Women's contracts were seasonal rather than long term; the activities for which they were employed (ie. weeding and plucking) were highly gender-segregated; and their wages were lower than those of men (Green and Baden 1994: p.17).

Women are vastly underrepresented in the formal economy outside of agriculture. For example, the female share of non-agricultural wage employment was 12 percent in

2001, as compared to 11 percent in 1990. For wage earners, using purchasing power parity, women earned $464 as compared with men's $679 in 2001 (UNDP 2003).

Despite the introduction of free primary education in 1995, the literacy rate for females was 48 percent compared to 75 percent for males, according to the 2003 Human Development Report (UNDP 2003). Many have questioned whether the programme of free primary education actually reflects any real commitment to improving the quality of life and opportunities for girls in the country.[14] Green and Baden indicate that the interaction of economic constraints and socio-cultural attitudes which "socialized females for domesticity" contributed to the high incidence of girls dropping out of school. The study also found that economic factors, such as the contribution of girls to household labour and perceptions of greater returns to investment in educating boys, strongly influenced which children in a given household attended school (Green and Baden 1994).

Multiparty elections in 1994 opened up the political process for women's participation and the potential exists for a political environment in which women's interests can be promoted and women's organizations can operate. However, women remain highly underrepresented at all levels of government, despite the new political climate. The UNDP reports that 9 percent of the total seats in Parliament were held by women in 2003, as compared with 10 percent of the total in 1990 (UNDP 2003).

Women in Malawi face incredible barriers to achieving good health. The literacy rate for women is less than 50 percent (UNDP 2003) and enrolment for girls in secondary and tertiary school is limited, with only 11 percent of the female population having ever

[14] A CIDA report on Gender in the Malawi Government budget indicates that 83 percent of the primary education budget in 1999 was for salaries, leaving very little for other inputs which are needed to ensure good quality schooling. The report also indicated that there are over 10,000 classes in Malawi which do not have classrooms, so are taking place outside (CIDA 2000).

attended secondary school (GOM 2000).[15] In Malawi, only 3 percent of births are delivered by caesarean section and the WHO regards a C-section rate of below 5 percent as a reflection of limited access to maternal health services and potentially life saving emergency obstetrical care (GOM 2000). Lastly, the maternal mortality rate for the period 1994-2000 is extraordinarily high at 1,120 maternal deaths per 100,000 live births, which represents a doubling of the rate from 1992 (GOM 2000).

We can see that women's daily lives in Malawi are filled with intense responsibilities for subsistence and domestic labour and that women largely have poor educational levels and poor health. In the next section, we will look at gender roles in Malawi and how the socially constructed role of caregiver affects the lives of women and girls.

4.2.2 Gender Roles and Caring Labour in Malawi

Women perform the bulk of caring labour in Malawi. Of the 25 in-depth interviews done with caregivers in the hospital and community settings, 84 percent (21 participants) were women and girls; 16 percent (4 participants) were men. These numbers do not vary much in the survey results, with 89 percent of the caregiving being done by women and girls, and 11 percent by men. The total combined with participants of both interviews and surveys result with 87 percent of caregivers being women and girls, and 13 percent were men. When the caregiver was a man or boy, it was usually due to the deaths of the female members of the family, such that there was no one else to provide the care. These numbers serve to situate women in Malawi as the traditional caregivers in

[15] Literacy is widely accepted as a precursor to good health, and maternal literacy has positive effects on children's health.

the household and their stories indicate that they feel strongly the need to fulfill this role and meet family expectations for caregiving.

The interviews with caregivers and health staff unearthed many perspectives on why it is usually women who are caregivers in Malawi. These included traditional gender roles, the perceived superior innate caring qualities of women, perceptions of the male as wage-earner and the historical out-migration of men to work in the regions' mines. As expressed by a young man, when asked why there are so many women guardians,[16]

> Because men are working, and so sometimes ladies have to be guardians, just because the men are at work. Also, sometimes ladies feel that they want to help more than men do. In their hearts, they feel more love and want to assist. The men, they stay for a few days and they get tired of it and so find a way to leave after a short time. They say they have to leave for work. Also, here in Malawi, we have few men and plenty of women. The men they do leave for work in other places and so it is the women who are remaining.[17]

Results of the survey challenge the traditional notion of the male as the sole breadwinner. The survey showed that not only did 94 percent of the 38 respondents report that women and girls did the domestic chores in their home, 53 percent also reported that women were the breadwinners in their household. They reported women and girls earning money through income-generating activities such as selling firewood, brewing beer, selling produce from garden and making other small businesses in the informal sector. For whatever reason and beyond the scope of this study, only 47 percent reported that men were supporting the family and named charcoal selling, business and working as drivers as the main means through which men earned income.

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[16] A "guardian" in Malawi is the family member who is required to stay at the hospital with the patient, responsible for feeding, bathing, and toileting the patient. They also provide food for the patient, in most cases. Hospitals have "guardian shelters" where they cook and sleep. A patient cannot be admitted to hospital without a guardian.

[17] Grandson, hospital-based caregiver interview, Kachere Rehabilitation Centre, August 22, 2003.

A woman guardian, looking after her mother at the hospital, said the following when asked if men can be caregivers in Malawi,

> Ahh, no. Most of the guardians, they are women. The problem is that men are not going to be guardians. I don't know why. Maybe because they need to go to work. All they want to do is buy some orange squash, bring it to the patient and then leave! They think their job is done! But women are more skilled at being guardians. I think it is because they are the ones who are always taking care of family so they know how to care for anybody. The women, they have always got love in their hearts, they love those who are sick. Unlike men. So it is better for women to be the ones to be guardians.[18]

The mother of a terminally ill 17 year old boy spoke of the caregiving burden of women and the role of fathers,

> It is difficult to manage because my sister has died and so I now have her 4 orphans and my own 3 children and plus my old mother. There is no one to help. I am the one who does everything. I am the one who helps. My husband, who knows what he does? He does nothing. I am the one. Most of the men, they are like that. They only know how to give the children to the women, but not how to help them.[19]

The survey backed up these women's statements. Only 11 percent of households named a man (8 percent named sons, 3 percent named fathers) as the primary caregiver to the sick patient. Twenty four percent of households reported that men and boys were not providing any help at all to look after the patient.

The traditional role for women as caregiver poses problems for all women as it puts demands on their time and their labour. For women in the formal economy, it presents further challenges. This quote is from a nurse who is the primary breadwinner in her family as her husband is unemployed. She expressed the pressure that she is under to provide care and her fear of the consequences of breaking tradition,

> If I am admitted at the hospital, it will be my mother who will be there for sure! My husband will just be stopping by and then going back. But if my husband is

[18] Daughter, hospital based caregiver interview, Kachere Rehabilitation Centre, September 12, 2003.
[19] Mother, hospital-based caregiver interview, Queens Paediatric Palliative Care Unit, Sept. 26, 2003

> admitted, I will not be going to work, I will be taking care of him. If you are not in the hospital when your husband is sick, his relatives will be coming and saying "Ahh, where is she?, why is she not taking care of him?" and they will make sure that you are divorced! They will say that he should have someone who will really look after him. It is difficult for women, because they are the ones expected to look after everyone.[20]

Traditional gender roles define everyday life in Malawi and women have shouldered heavy labour duties such as collecting water, firewood, cooking, cleaning and farming. Now in the context of HIV/AIDS, the duty of caregiving is added without changes to the traditional roles performed by men and women to redistribute this burden. One nurse at Queens hospital explained,

> It is difficult for women, because they are the ones expected to look after everyone. Even in the village, they can ask the girl-child to stay home from school to look after the sick person. At the village, they say that this girl will get married, so it doesn't matter if she goes to school, but the boy, he will need education so that he can support his family.
>
> Q: *What about when girls are caring for sick family members and it makes them late for school? Can their brothers help them?*
>
> Here in Malawi, there are certain chores for boys and certain ones for girls. You know, boys can't do the cooking, can't go the fetch the water, taking care of children, cleaning the house... only some certain jobs can be done by boys such as chopping the firewood. Even if the girl will be late for school and will get sent home, the boys can't help to do those things.[21]

The nurse's comments with regards to girls' education were also reflected in the survey results. Of the 16 percent (6 households) of surveyed households who reported that a child had left school in order to help care for the sick patient, two thirds reported that it was girls who stayed home from school. In the two cases where it was a boy, he was the only child in the household and was acting as primary caregiver for his sick parent.

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[20] Nurse, healthcare staff interview, Queens Central Hospital, August 22, 2003.
[21] Nurse, healthcare staff interview, Queens Central Hospital, Aug. 22, 2003.

The burden of care extends to all generations of women in Malawi. We will see in the next section on the costs of illness on the household that the labour of elderly grandmothers is increasingly called upon. In this quote, an elderly woman spoke of the effects that illness and caring labour were having on her entire household: for her as the guardian, her daughter as the patient, and her granddaughter as the wage earner and observer to the destruction of their livelihood,

> Ohh, I am an old woman. What can I do? I look after my daughter. Do you see her there? She is unable to move, her legs, there is paralysis. I try to work in the garden but I must keep coming back to check on this one (patient). There is no one to help me but for that girl. The girl, my granddaughter, she does help on school holidays. We get some money when she sells firewood. Water is near, but we must pay MK 35 [about 50 cents] per month to use, so we just visit the stream And this young girl, she has no plans [for the future]. When you ask her, she just says that life is short, how can she make plans! [22]

The attitude of the young girl, having watched her father already die and now bearing daily witness to her mother's death, is somehow understandably fatalistic. One of the volunteers at World Alive Ministries, who had been with the project since its conception in the early days of Malawi's AIDS epidemic told me,

> Once I started talking to people who were sick at the hospital, oh! so many of them, that was when I realized that this HIV/AIDS was no small problem. It was killing people before they even died.[23]

Almost invariably, the burden of caregiving rests on women as the demands for their income-earning labour, household work, child-care and care of the sick multiply. Despite the dependency on women at the household level, two studies in Cote d'Ivoire and Thailand (in the late 1990s) show that more money tends to be spent on health care for men who become ill with HIV/AIDS than on women (UN General Assembly 2001).

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[22] *Agogo* (grandmother), Home based care interview, Mpemba village Aug. 14, 2003. The household was comprised of an elderly grandmother, a sick mother and a 15 year old girl. The patient was paralyzed and bedridden.

[23] Staff member and volunteer counselor at Word Alive Ministries, informal talk, Aug. 25, 2003.

Recent estimates by the UNAIDS indicate that 28.5 million adults and children live with HIV/AIDS in Africa, with some 2.2 million Africans having died of AIDS in 2001 alone surpassing any other cause of death on the continent (UNAIDS 2002). The epidemic is spreading at an unimaginable rate in southern Africa with no indication of a ceiling on infection rates. According to UNAIDS estimates, it is projected that, between 2000 and 2020, 55 million Africans will die earlier than they would have in the absence of AIDS. By all accounts, the worst is yet to come.

Not only is women's health jeopardized in their efforts to provide care, but women are the most rapidly growing group of new infections in Malawi, where the dominant form of spreading HIV is through heterosexual sex. Statistics show that most HIV infection is occurring amongst the youth aged 15–24 years and in Malawi, the infection rate of girls outnumbers that of boys by four to six times (UNAIDS 2001). In 1999, it was estimated that almost half of the newly reported cases of HIV infection occurred in people under the age of 30, and almost 60 percent of these were in women or girls. The HIV epidemic has brought to light some cultural practices which put girls and women at risk of HIV infection. The weak position of women in society, associated with cultural practices that curtail their choices – initiation ceremonies, sugar daddies, polygamy, arranged marriages, widow inheritance – have led to high infection rates in females in the country. Sexual power and its association with dominant heterosexual masculinity, possession of money, political power and inheritance rights means that women and girls are often unable to negotiate safer sexual practices. The refusal of men to use condoms entails that women are forced into unprotected sexual practices and some of the localized responses, such as the one which advocates sex with virgins or under-age

girls as a means of killing the virus, pose clear health risks for women and girls (Lwanda 2002).

Not only are women busy providing great amounts of caring labour, but they are often sick themselves. In the survey conducted with home based care clients, 42 percent of respondents said that the guardian was not healthy. This statistic shows that while women continue to try to cope with the burden of care that is passed to them, their own health is often compromised. In the next section, we will look at the impact of ill health on households and then at the coping strategies that women are employing.

4.3 Impact of Health Sector Reform on Women

The previous chapter outlined the health policies that have been developed in Malawi since its independence. We were able to see that the policy directives took a sharp turn away from the Primary Health Care model being pursued by President Banda towards a distinctive neoliberal model of cutbacks, privatization and cost recovery with the change of government in 1994. The health sector has since seen a steady fall in resources to address an increase in the burden of disease. President Muluzi endorsed the World Bank Health Sector Reform programme as a key component in the progression of the country's Structural Adjustment plan. This programme appears to be based on some questionable assumptions. For example, it assumes that problems stem from mismanagement rather than a lack of resources and that a market-style approach will make healthcare more cost-effective and accessible. Yet the literature review in this thesis does not support these assumptions. And as we shall see in this section, nor do the experiences of the healthcare workers, caregivers and patients that I spoke to in Malawi.

Health sector reform has weakened government health services. Instead of developing their capacity to deal with the health needs of the population, the government of Malawi has implemented policies which have systematically undermined the ability of the health system to meet the needs of the country's increasingly sick and poor people. The caregivers brought up many issues. To begin, we will explore two issues, lack of transportation to health centres and lack of drugs in health centres as an introduction to this section. We will look at the issue itself and situate it using women's stories and survey results, and then trace the problem back to the relevant health policy. It is not always a flaw in the actual policy as it is written which we are interested in; sometimes it is the absence of policy which is equally erroneous. The lack of gender considerations in health policy mean that this is often the case, such that policy has a blind spot to the particular needs of women.

The guardians and patients who were participating in this research talked about the difficulty of getting transport to get to the hospital. It was either unavailable, due to poor road conditions and lack of bridges, or it was too expensive for them, even using a hired oxcart or bicycle. They reported long walking distances to health services, and some spoke of carrying their sick family member in order to seek medical advice. During one visit with the home based care team, we encountered a young mother with a very sick baby,

> The HBC nurses are trying to encourage her to walk the 10km to the Limbe Health Centre. They are telling her that her baby is sick and needs to see a doctor. The baby does look very sick, but the problem is that so does the mother. How will she manage to walk 20km? What kind of help will she receive when, and if, she gets there?[24]

[24] Fieldnotes, HBC visit, Kachere township, Aug. 12, 2003

Survey results supported this bleak scenario. When asked why they don't go to the hospital when someone is sick, 40 percent of the survey respondents said the primary reason was lack of money for transport, 9 percent said the patient was too sick to walk and 6 percent said that the nearest health centre was too far away.

The issue of barriers to access arising from lack of transportation to hospitals can be linked back to health policy. Expansion of health facilities drops out of the policy documents with the adoption of Health Sector Reform in 1994. The last mention of expanding hospitals and rural health centres was in Malawi's Third National Health Plan (1986- 1995) under President Banda. Long distances to health services pose differential problems for women. Distances can endanger their health during delivery, such that they don't receive adequate maternal health services; travel time can add to the 'time famine' which they already experience due to the multiple and time-consuming duties for which they are responsible; and it can add to transportation costs when they need to access health services, either as a patient or as a guardian. Imagine the time costs involved for the elderly woman in the following story, travelling to the hospital to deliver food to her son and his wife, who told me they had long since run out of money and food,

> The patient's mother should come next week from Chipini and she will bring more ufa flour and even money. She comes on a bicycle to Lilangwe - do you know it? - it takes about 3 hours to get there [from our village] and then she spends the night there. The following day, if she has money, she will take the minibus to town to see us in the hospital, but if she doesn't have money, she will come by bicycle. It is more than 20 km, but that is how she will travel if she doesn't have money for the bus. We hope that she will come soon because we don't have any food now. Sometimes some other guardians they do share their relish with me. Or I beg from them.[25]

Aside from not extending hospital services to rural areas, Malawi's health policy makes no provisions for the current situation where distances to hospitals can be great. Nowhere

[25] Wife, Hospital based caregiver interview, Kachere Rehabilitation Centre, Aug. 13, 2003.

in any of Malawi's policies is there the vision of a medical transportation system, or even reimbursement system, which would overcome the barrier of transportation costs for the poor, or for the guardians whose unpaid work is so vital to the survival of Malawi's health system.

The second example that was a frequent topic of conversation during my time in Malawi was the lack of drugs in the hospitals. Patients, guardians and friends all reported that it was sometimes more convenient to just buy drugs from local vendors and shops, rather than go to distant health clinics, where service and drug supplies were not guaranteed. A study by Kadzandira and Mvula reported on this same issue, saying that the use of vendors or shops was increasing because of their convenience in terms of distance, relative low cost, lack of waiting time, politeness of the vendors and availability of drugs compared to government health clinics (2001). The survey results for this thesis show 23 percent of respondents citing lack of drugs at hospitals as the main reason why they do not go to the hospital when somebody is sick in their household. A cleaner at the hospital explained,

> Sometimes, if I am not too sick, if it is not serious, just a headache or malaria, I just buy some medicine at the grocery instead of going to the hospital. But when it is continuing I go to the health centre.[26]

I visited the Blantyre market to see the drug vendors in action. There were tables of colourful pills lined in neat rows and divided into little plastic packets, manned by engaging, knowledgeable young men. They showed me all of the drugs, told me what they were for (malaria, heart palpitations, high blood pressure, oral thrush). Disturbingly, they also had tuberculosis medication and anti-retro viral drugs but just laughed when I

[26] Cleaner, healthcare staff interview, Kachere Rehabilitation Centre, Aug. 22, 2003.

asked what would happen to the patients at the hospital if all of the drugs were at the market.

The lack of drugs in health centres is largely the result of two interrelated government policies: the lack of government spending on drugs and the low wages of public health workers in Malawi. Recall that the IMF budget allocation for drugs and medical supplies was a mere $1.17 per capita for the budget year 2000/01 (IMF 2000). Under the financing formula set for Malawi's Health Sector Reform, the ceiling for this expense is pegged at $1.25 per capita (MOHP 1999c), so there is little hope that hospital pharmacies will find their shelves fully stocked as long as the budget is determined by the World Bank and the IMF. There is also little hope that the extreme cutbacks in government spending will result in improved wages for public workers. The general feeling in most of the interviews was that health staff have no choice but to take whatever medicines are available and sell them,

> The problem is salaries. People steal the medicine and sell it at the market because they need to make money. Their salaries from the government are just too low. Even the guards who are brought in to protect the medicine have too low salaries and so can be easily bought off.[27]

Low wages in the public sector are a feature of neoliberal economic reform. Nurses that I worked with in Malawi told me many stories of "the good days" under Banda when nurses could live in nice houses and could perhaps even afford to own cars. This was far from the reality of the Malawi I know, where nurses in the public sector earn less than US$100 per month.

The lack of drugs in hospitals, and the proliferation of unlicensed and untrained drug vendors, poses risks for all Malawians. But as the main caregivers in society,

[27] Guardian, casual interview, Queens hospital, August 26, 2003.

women suffer when drugs aren't available. For example, women's caring labour is increased when their patient's nausea, vomiting and diarrhoea are not controlled. They have to do more cleaning, more bathing and more washing. Women spend precious time and precious money seeking out other sources of medical assistance through traditional medicine or private clinics when government clinics do not have medicine. We will return to the issue of the impact of drug expenses on households in the next section and will look further into the issue of how financial inputs for health can have a differential impact on women.

The general picture of social policy in Malawi is that coverage of social protection programmes and social services are very low and sparsely scattered (Kadzandira and Mvula 2001). Access to the formal health sector is low and hampered by long distances to the nearest centres, drug and staff shortages, poor behaviour of staff, negligence, segregatory treatment, insufficient medical equipment, lack of communication facilities, poor road network, non-availability of public transport and impassable rivers during the rainy season. In places where paying clinics are available, they are unaffordable for most people.

The scene has been set and it is appropriately grim. Yet there is another side to be acknowledged in our study of the impact of health sector reform on women caregivers in Malawi and it is the positive, communal, sharing effort that exists in communities all across Malawi. While the situation is dire, people have managed to support one another. The 2002 Southern African AIDS Training programme country report for Malawi provides this very picture.

> Long before the advent of life-sustaining therapies for people living with HIV, communities in Africa started to organize themselves for mutual support. While international organizations were searching for strategies to 'win the war against

> AIDS', communities throughout Africa realized that it was imperative to organize community support to prevent the epidemic from tearing apart the fabric of their society. The emergence of community support groups throughout Africa was as important a development as the discovery of anti-retroviral therapies (SAT 2002).

From this notion of community and collective response, we will turn to an examination of the impact of disease on households. This section will continue to show how the extreme burdens of care that women are shouldering can be traced back to health policy transformation under neoliberalism. The argument that the scope of the current health crisis in Malawi can be best understood through the lens of women's everyday lives is advanced through their stories, which illustrate the hidden costs of using women's labour as a replacement for comprehensive, state-led health systems.

4.3.1 Impact on Households

Literature on poverty and health, through livelihoods studies, advises us to examine the impact of ill-health through the economic and social costs of illness on households. People in low-income communities rely on their families to a great extent, since they have fewer ties to other structures of power in society, upon which middle and elite families can rely (Singerman 1995). I will use Singerman's definition of the household as "a group that ensures its maintenance and reproduction by generating and disposing of collective income". As a collective institution, the members of the household negotiate and renegotiate their roles and positions, according to the changing circumstances within and outside the household.

The literature on the impact of disease on households organizes the economic costs of ill health on households into three major categories: the loss of production by sick individual; the financial costs of health care; and time costs borne out by caregivers

(Standing 1999, Oxaal and Cook 1998, and Brown and Kerr 1997). I will use this formulation to organize the data from the interviews and the surveys done in Malawi so that we can easily track the burden of disease on households. This sets up the framework through which we can trace the problems that women are experiencing not just back to HIV/AIDS, but back to health policy, which is now based solely on neoliberal economic principles. In commodifying health care, the government of Malawi has transferred responsibility from the state to the individual such that individuals and families must provide an increasing share of health care provision, either by cash payments or via in-kind contributions like caring labour. In this section, we will see the effects of these policies on the household through the experiences of women, the traditional caregivers in Malawian society and will trace their stories of coping (or not) back to the actual health policies.

The Loss of Production by Sick Individuals

The first category, *the loss of production by sick individuals*, is based on the economic concept of production such that a very sick or disabled person will be less productive than a healthy one. The states of diminished capacity can vary greatly, but all result in the reduced output of sick individuals.

I visited the home of a very sick mother of four little children. She had a large, infected Karposi's sarcoma on her foot and could not walk. They lived in a hut that looked as if it had once been prosperous: plenty of fruit trees, chicken houses and a large area for gardening. They lived a subsistence life, but she was unable to farm due to her illness. She told me this:

> There are so many problems now. It used to be that I could do the gardening, together with my husband, and we would have enough to eat. But these days, my husband is gone and I cannot manage to do gardening. My first born, he cannot do enough to provide us with food to eat. We have been selling our ducks and chickens and eggs, but we can't manage to eat good food these days. There is too little money.[28]

The loss of the household's income due to the illness of the breadwinner was reported by 14 percent of those surveyed. One survey indicated that the family had spent more than K30,000 (approximately US$300) on medical expenses, but were unable to go to private clinics once the patient got too ill to continue working. For wage earners, the loss of production means a loss of financial resources in the household. But for subsistence farmers, their inability to work can mean hunger for the entire family, as is evident from my fieldnotes taken during a visit with a young woman, her small children and her elderly mother in a rural village,

> The patient's mother comes everyday to wash and cook for her. She can no longer manage to do these things on her own. The *agogo* (grandmother) stays nearby, with a 3 year old grandchild, an orphan. Since the patient can no longer do any farming, the *agogo* tries to do it all alone, but never manages to get it done. They can't produce enough food to feed themselves. They always have to buy more. There is another garden that the patient's husband used to cultivate but she is too weak to do it. The *agogo* says she doesn't know what they will do.[29]

This sad scenario is replicated all over Malawi. Seventy nine percent of the households surveyed reported a decrease in food in the household since the patient fell sick. In many cases, grandmothers are trying to do the labour-intensive work of subsistence farming on their own. Kofi Annan has said that the combination of famine and AIDS is threatening the backbone of Africa – the women who keep African societies going and whose work makes up the economic foundation of rural communities. He says that development depends on building successful partnerships with the African farmer and *her husband.*

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[28] Patient, Home Based Care interview, Chileka district, Aug. 20, 2003.
[29] Field notes, Chileka September 1, 2003.

Yet, millions of women in Africa are today facing two simultaneous catastrophes: famine and AIDS. HIV infection is spreading dramatically and disproportionately among women in Africa. A United Nations report that was released in December 2002 shows that women now make up 50 percent of those infected with HIV worldwide, and that in Africa, that figure is 58 percent. As Annan has made clear, today AIDS has a woman's face.

In famines before the AIDS crisis, women were more resilient than men. They had better survival rates and more effective coping strategies. They were they ones who found alternative foods and shared their survival techniques with younger women. But today, AIDS is not only destroying the health of Africa's women, but also the skills, networks and experiences that traditionally enabled families to survive times of food shortages. Women look after their sick husbands, decreasing the time that they can spend planting, harvesting and marketing crops and when he dies, customary and land ownership laws can leave her destitute. Annan has said, in reference to AIDS and famine in Africa, that "if we want to save Africa from two catastrophes, we would do well to focus on saving Africa's women" (Annan 2002).

Elderly women who rely on their children to sustain them in their old-age have found this support disappear as the younger generation get sick and eventually die. An elderly woman who I interviewed chronicled a family disaster when she told me about the loss of her children and her support system,

> There are 12 of us living in that small house. There is me and my three daughters. All of their husbands have died, so they have come back to live with me. They have 6 children amongst them. The other 2 children are those orphans from my other two daughters who have died, along with their husbands. I have only one son, the one who is now sick and is the patient here. My husband he died a long time ago, and so I have always depended on my son, but now he can't help me. Now he is too sick. There is no peace at all.[30]

[30] Elderly grandmother, hospital based caregiver interview, Kachere Rehabilitation Centre, Aug. 28, 2003.

One of the surveys indicated a situation where a forty-six year old man was being cared for by his elderly mother. His wife and children "went away while the husband was getting sick" so that it was just the man and the *Agogo* (grandmother) who were left. She did not know her age, but we can assume that she is elderly. Her son was too sick to work, so she reported having to brew *kachasu* (alcoholic drink) and sell groundnuts in order to earn money.

What can these women's stories tell us about health policy? Most obviously we can see that the lack of a formal social safety net in Malawi is a great threat to the most vulnerable members of society, particularly the elderly, women and children. By implementing policy which requires individuals to care for themselves in a market-oriented system, the government neglects the well being of those people, such as subsistence farmers, who live outside of the market system. Without their health, their only productive asset, women in the subsistence sector cannot contribute their physical labour and therefore, cannot assure an adequate food supply for themselves or their families. Health policy in Malawi neglects this largely female sector of the population in its market-oriented solutions to health rationalization. Without effective policies to deal with the rising needs for food aid and material assistance for orphans, widows and the elderly, the government of Malawi has neglected the right to health for many of its people and passed the responsibility on to women, who are the main subsistence agriculturalists in the country.

Their stories also speak to the absence of a plan to distribute anti-retroviral drugs in Malawi and the government's overall lack of effective policies to deal with the HIV/AIDS crisis in the country. Without life sustaining drugs, HIV infected people are rendered so weak and sick as to be unable to participate in household duties, passing the

burden of their lost production onto other family members. We have seen the effects of this on women and children in this section. Anti-retroviral drugs would keep HIV-infected individuals healthier for a longer period of time, boosting their productivity which would have positive effects on the entire household. Yet these policies do not exist in Malawi.

Lost production by the sick individual was the first category in the categorization of the economic costs of ill health on the households. The women's stories illustrated the impact of lost production in a system based solely on the economic ideal of productive capacity. With no system for redistribution or social welfare, those who are unable to "produce" and their dependents face uncertain futures.

The Financial Costs of Health Care

The second category of economic costs of ill health on households is *the financial costs of health care.* This include expenses for user fees, "informal" payments levied by employees of public health services, the costs of drugs and transportation and the time spent away from home for both patient and hospital guardian. These expenses have created huge barriers to access for the poor, and subsequently, very ill people are not being taken to health care facilities but instead are being cared for by their families. The effects of hospital user fees in the case study of Zambia were that the poor were unable to access modern healthcare and were simply "dying at home" (Brown and Kerr 1997). An excerpt from my fieldnotes written during an interview with a family in a rural community highlighted the terrible choices for poor families who are limited by the financial costs of accessing health care services,

> The patient is very ill. He is lying on a mat on the floor, unable to speak or turn his head. He is covered in blankets and appears extremely emaciated and his breathing is very laboured. His wife, the main guardian, appears to be very ill. She is thin, pale, has thin hair, and very big sores on her mouth and nose. The patient has PCP pneumonia, the kind that goes hand in hand with AIDS. Last month they walked 20 km to access a government hospital and were given medication. But since then he has gotten sicker and the wife says they were desperate. They couldn't afford transport for him, because he was too weak to walk, so the wife went to the private clinic here in Chileka and begged for some medicine. Without seeing the patient, they gave her some, it cost MK250 [US$2.50]. This medicine has run out, but they don't have any money to go back to the private clinic or to take the patient to the government health center. So they don't know what to do. It seems like he is going to die very soon.[31]

Many households in Malawi are unable to access health facilities due to the cost of utilization and transportation, and so instead use traditional medicine during times of illness (Lwanda 2002). Studies of user fees in Ghana have shown a correlated general decline in health status in rural areas whereby those seeking medical treatment, especially women, are presenting more complex, chronic and terminal ailments (Brown and Kerr 1997).

The household survey results showed that 95 percent of households surveyed had spent money on some form of health services as a result of their patient's illness. They cited costs for transportation, treatment and drugs as their main expenses. The reports of how much was spent were startling. The average reported amount spent on health was K9230.[32] When the average annual earning in Malawi is only $270, the obstacles to gathering such sums must be great. While it is not the topic of this study, it would be important to find out what expenses are forgone and what extreme measures are taken in order to gather these funds. Surely, households make painful decisions when they choose between buying food, paying school fees and purchasing health care (Devereaux 1999).

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[31] Field notes, Chileka village, Sept. 1, 2003.
[32] Approximately US$92, based on MK100=US$1

The lack of availability of free drugs was an issue that was brought up again and again during my fieldwork in Malawi. Many people, obviously unclear on my role as a researcher, would ask me to tell the government to send more drugs to their clinics. Of the 63 percent of survey respondents who said that health care had gotten worse in Malawi over the previous twenty years, 65 percent cited the lack of free, government provided drugs as their principle reason. One survey said that government health care was better in the past because drugs were available in the health centres, unlike now. Expenses for health services pose differential barriers to access for women and girls, who often are not in control of household resources. The mother of a very sick little girl, unable to sit or stand on her own, asked me:

> What am I to do? The father, he is the one with money yet he thinks all is fine. But I know that this baby is sick, I am the one who is spending all day with her. But I need the money from him to take the child to the hospital.
>
> But maybe it is not worth it. The last time it went it was so costly and they just gave malaria treatment without even examining the child. And then I went back to the Limbe clinic and they just gave iron tablets. Not even Panadol, and the baby, she was in pain. The nurse just told me to go buy on my own.[33]

I also interviewed a 16 year old HIV-positive girl with tuberculosis, whose TB medication had run out. She was coughing throughout the interview and looked very frail and thin. Tuberculosis treatment is free at all government hospitals throughout Malawi, but she didn't have K100 [US$1] for transportation to the hospital, and it was too far to walk. Her mother said that they had been waiting for three weeks for the father to bring some money so that she could go, but that he had failed. They were certain that the money would be available at month-end [workers are paid once a month in Malawi], yet it was only the 12th of the month when I met them, and the patient's medication was

[33] Mother, Home Based Care interview, Kachere township, Aug. 12, 2003.

already 3 weeks past due.[34] By "further prioritizing" health priorities, essential services such as tuberculosis programmes are only available at the district level, meaning that people have to travel great distances to access them. While the drugs are free once they get there, transportation and time costs pose insurmountable obstacles to accessing the services. Local community level health centres able to provide comprehensive health care would serve women's health needs much better, but this is not addressed in any of Malawi's health policies since 1994. Furthermore, in declaring that "the Government has accepted the principle that it cannot provide all services free of charge" (MOHP 1999b: p.60), health policy has remained blind to the differential effects of financial inputs for health on women.

Health policy in Malawi does not address the unequal control over resources that exists along gender lines within most Malawian households. While the *Vision 2020* health policy document recognizes a greater need for involving both genders in all spheres of development, including the health sector, it notes that despite the adoption of specific gender initiatives, operational mechanisms for their implementation are yet to be developed. "One of the main stumbling blocks is cultural resistance, especially among male policy makers" (MOHP 1999b: p.55).

Women's lack of control over financial resources is not considered in either the formal demand for payment in the form of hospital user fees, or in the "informal" payments that are often levied by health workers. In a study of the health sector in neighbouring Mozambique, Lubkemann writes that "It is no secret that "informal costs" – meaning corruption- constitute the most significant portion of out-of-pocket health costs

[34] Information from interview with 16 year old female patient and her mother, Kachere township, August 12, 2003.

borne by the average health service user" (Lubkemann 2001). Loss of income, additional care-related expenses, reduced ability of caregivers to work and mounting medical fees and funeral expenses collectively push affected households deeper into poverty. According to a study in Cote d'Ivoire, healthcare expenditure rose by up to 400 percent when a family member had AIDS. The hardship does not end there. Studies in Thailand and Tanzania show that the financial burden of death can be far greater than that of illness. Households there have reported spending up to 50 percent more on funerals than on medical care. Traditions in many societies, including Malawi's, require that relatives and community members gather (sometimes for several days) at the home of the deceased to mourn and support the bereaved.

Throughout my time in Malawi, guardians and patients described the incredible obstacle of payment for medical services. Even the smallest financial requirements are too much for some. Patients described how they were required to bring notebooks with them when visiting their health clinics because of lack of stationary. This was presenting a barrier to access – people were not going to the clinic because they did not have a notebook, nor did they have the resources to buy one. User fees present huge obstacles to the poor. While I did not gather data to this effect, Kadzandira and Mvula report complaints about the procedures used to settle health care costs such as detaining patients and confiscating their valuable assets like bicycles and livestock until the bills were settled (2001). They also report instances where people were not allowed to collect the remains of their dead relatives if they had not paid the medical costs which arose before the relative died.

The lack of government policies to address the rising health needs of its people in the face of a deadly epidemic stared out at me during my interviews with women

caregivers. Sometimes, the immediate solution to their problems seemed so obvious, such as subsidized transportation to hospital facilities. With so many mothers sick and dying, it seems unbelievable that the government has not established comprehensive policies to provide food aid for them and their children. I will never forget the image of a small baby, too malnourished to even cry, for want of baby formula. There was a woman lying outside on a mat under a tree with her elderly mother and sisters sitting beside her. The tiny baby was wrapped in cloth next to her,

> The patient cannot manage to breast feed as she is too weak and sick. There is no milk. The husband has been trying to buy formula, but it is expensive and they can't manage to buy it. The baby is very small and lethargic, just lying outdoors on a mat, beside its mother. She doesn't open her eyes at all or move around. About one week ago they carried the patient and the baby to the local health center and were told to go to [far away] Queens hospital. But the family has no money for transportation or medication, so they haven't taken her.[35]

The patient had died by my next visit, two weeks later.

This section has shown that the financial costs of ill-health to households are great, with a differential impact on women, who are often do not have the power to control financial resources within the family. Even my female nursing colleagues from when I worked as a physiotherapist in Blantyre told me that they had to hide away money from their pay and destroy their pay stubs so that their husbands would not take control of all of their earnings. Clearly, it cannot be assumed that the one doing the labour and the one reaping the benefits are one in the same. Nor can it be assumed that access to health care is equal along gender lines when financial requirements are introduced.

[35] Field notes, Chileka village, Sept. 1, 2003.

The Opportunity Cost of Caregiving

The third element of costs of health shocks to households is *the opportunity cost of caregiving*. This category includes the time that caregivers spend away from other productive labour. This research of caregiving in Malawi is in keeping with UNAIDS case studies in Uganda and South Africa which found that the burden of care of sick family members is borne predominantly by women and girls (UNAIDS 2000). In the survey, 76 percent of respondents reported that looking after the patient prevented people in the household from farming. Studies on the impact of HIV/AIDS on households document reduced levels of household food consumption, leading to malnutrition, when one member is sick (UN Secretariat 2003). The survey results mirrored this, with 79 percent of households responding that they had less food since the patient got sick. It was not clear as to whether this was entirely due to time constraints on caregivers or also was related to lost production by the patient. Nonetheless, 92 percent of respondents said that looking after the patient kept them from doing other jobs. They cited cooking, bathing and feeding the patient as duties that interfered with their other activities.

Many of the older women who I interviewed spoke of the poor treatment of the elderly in a system so overburdened. While the elderly are often the guardians for others, they said that they are not looked after if they get sick themselves. They cited a popular expression in Malawi which says that *fertilizer is not applied to wilting maize.*

Some respondents said that the time costs of caring fluctuated, according to how sick the patient was. Seventeen percent noted that the time spent with the patient at home was less of a burden then when they had to go to the hospital. This was reported to be a very time-consuming journey. One woman reported,

> We don't get good care at our local (government) health centre. They can leave you to wait in line all day while they are just going up and down. Finally, at 2 pm, if you ask if they are going to see you, they shout at you so much. They shout, "Do you want to go home with wrong medicine and die?" We tell them that we live far away and need to get home before dark, but still they do shout at us.[36]

One of the nurses at the government hospital spoke of the differential effect of the time costs of ill health for the poor. She said,

> Mainly, it is the poor people who are not looked after. For me, if I get sick, I can just go to the private hospital, I can just find some money. But for a poor person, when he is sick he just goes to Queens and stays in the line and then maybe at 4pm, after being there since early morning, he finally sees the doctor. And so it is bad for the poor people, at least we can chose to go to a private hospital.[37]

One of the guardians at the hospital expressed frustration at the many roles she was required to play within the family and how her caregiving duties kept her away from her productive activities, which so many others were dependent upon,

> The duty fell to me, because I am the oldest daughter. My brother is the one who has appointed me to do the job. But the problem is that I have just too many things to do. I am running up and down and just sinking money as my business suffers while I am the guardian. I requested that my brother should reconsider because the family depends on my earnings for so many things. As well, the money for my business, I have borrowed from Malawi Rural Finance. So I asked my brother, if I am the guardian, how will I meet my monthly payments? And my children they go to private school, and who will pay the fees if I am unable to do my business? [38]

Caregiving takes the carer away from other productive activities, such as paid employment, agricultural work, trading in the informal sector or education. Standing (1999) argues that prolonged financial constraints on public health services put a high burden of care on unpaid female household members.[39] While the current livelihoods

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[36] Cleaner, healthcare staff interview, Kachere Rehabilitation Centre, Aug. 22, 2003.
[37] Nurse, interview, Queens Central Hospital, Aug. 23, 2003.
[38] Daughter, hospital caregiver interview, Kachere Rehabilitation Centre, September 12, 2003.
[39] Oxaal and Cook write that 75 percent of health care takes place at household or community level, and is predominantly supplied by women. Women form a high proportion of informal and community-based

literature indicates that women are coping, I found evidence to the contrary. This is the voice of an elderly woman who came to town to visit and found that her 13 year old granddaughter was acting as the hospital guardian for her sick father. The *Agogo* didn't know that her son was so sick, but reports that he has been chronically ill for over two years and is now paralyzed from the waist down. Here is some of her story,

> When I came to visit I discovered that [my granddaughter] was being guardian. I felt too sad that this small girl was doing such things so I decided that the best thing was for me to stay. I didn't know that the patient was admitted when I came from Balaka, I have just found him like this.
>
> *Q: Why was [your granddaughter] being the guardian? Why not the patient's wife?*
>
> Maybe the wife is tired of all the work. Maybe she is tired of the patient. Maybe she wants somebody else who can earn money, not this sick husband.
>
> *Q: What is the patient's wife doing now that you are here?*
>
> She is at home. She used to be the guardian but the problems got worse last Sunday. The wife she came from Ndirande with food for the patient, but it was 2 o'clock in the afternoon and he told her it was too late, that he couldn't accept this food. So, the wife, she said that she would take this food and not bring any more to him. So that was Sunday and now it is Thursday and we have not seen her. She is not coming.

The incredible stress and strain that this man's illness was putting on the women in his family became more evident as I learned more. He had always worked as a driver and so the family had enjoyed the security of a steady job in the formal sector. When he first became ill two years earlier, he lost his job and the wife had to cook *mandazi* (doughnuts) and brew *kachasu* (alcohol) to earn income. He became paralyzed and since they didn't have a wheelchair, she had to carry him everywhere. The Sunday lunch scene of her late arrival at the hospital, a far distance from where they live, points to a culmination of the

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health providers (e.g. community health workers, traditional birth attendants) as well as lower-level professional or ancillary staff in formal health services (1998).

stress and heavy burden of care that she had carried for so long. This situation was also not good for either the elderly grandmother, who already was caring for a number of orphans, or for the granddaughter. Here is more from the *Agogo*'s sad tale,

> This morning, I asked the patient, my son, if he can allow me to go to Ndirande to talk with his wife. But he said no, I shouldn't go. He said we should just leave her. She should do what she wants. She is tired.
>
> If the wife doesn't want to look after him, it is better for her just to leave. That is the best thing. If this happens, I will take him back to [my home]. But the problem is that the patient, he says he doesn't want to go. Life in the village is too difficult and he wants to stay in the city. But if the wife won't care for him, what can I do?
>
> And [my granddaughter], that girl, she is too devoted to her father. She wants to look after him. But how can she go to school and look after him as well? She must continue with school. If she can't go to school, if she leaves so that she can look after her father, it will just be as if we have killed her.
>
> Ahh, too many problems....[40]

The time costs of women's caring labour creates situations where they are forced to chose about what activities get done: school or caring; business or caring; food production or caring. They are sick and tired, yet continue to shoulder the burden of care that has been passed to them. It is clear that health policy in Malawi has only exacerbated these choices by drawing on women's hidden work as a replacement for broad, collective state-led health policy. In the next section, we will look at the coping strategies that women are using to deal with the demands on their time and labour to show that under current policy conditions in Malawi, women are not coping.

[40] Elderly grandmother, hospital based caregiver interview, Kachere Rehabilitation Centre, Aug. 28, 2003.

4.3.2 Coping Strategies

The last section illustrated that the sickness of a family member constitutes a dire emergency because the event is a financial, emotional, and physical drain on the household. In the absence of disease, cash income and subsistence activity barely keep the average Malawian household afloat (Devereux 1999). The sudden and immediate financial demands, time costs and emotional strain posed by ill health causes a jolt to the household. In rural Malawi, family members survive by helping each other and their friends when times are difficult (Mtika 2003). As Devereux shows in his study of informal safety nets in Malawi, households lacking the resources to solve a problem can turn to unrelated community members for assistance and emotional support. While both kinship and communal ties are important elements in safeguarding the welfare of families in Malawi, this research shows that both are reaching their limits.

Devereaux has highlighted the range of informal safety nets which Malawians rely upon during times of insecurity. Conceptually, informal safety nets are one manifestation of 'social capital' or the 'moral economy', which involve drawing on social networks such as extended family, friends, neighbours and wealthy patrons for assistance in times of need. Informal safety net transfers are non-market transactions which range from remittances of food or cash within families, to meal-sharing between neighbours or interest-free loans between friends and gifts to beggars (Devereaux 1999). Yet much of this help comes from prime-age adults; the population that is most likely to be ill from AIDS related diseases in Malawi. These adults are central in both intergenerational transfers (upwards to parents and downwards to children) and in lateral transfers (exchanges with brothers, sisters and friends) (Mtika 2003).

It is reasonable to expect that poor health compromises transfers and that the spread of AIDS will exacerbate the needs of families for external intervention as their traditional informal safety nets disintegrate. The survey conducted amongst 38 households backs this up and suggests a disintegration of what could be considered coping strategies, in the sense that these strategies enable the household to preserve an acceptable livelihood. To restate some of the survey results which indicate a pervasive, widespread failure to cope in Malawi:

- 16 percent of surveyed households reported that children have withdrawn from school in order to provide caring labour;
- 11 percent indicated that the household had reconstituted itself in the face of illness such that some members had moved out;
- 76 percent of households reported that looking after the patient prevented them from farming while 92 percent said that caregiving prevented them from doing other jobs;
- 79 percent said that the household had less food as a result of the patient's illness;
- 42 percent of the guardians were reported to be ill.

People in both the surveys and the interviews reported relying on charity, borrowing and begging as means to cope with the financial and time costs of sickness in their families. Almost half of the survey respondents reported selling food from their gardens as a way to earn money for health care expenses, with obvious dangers for household nutrition. A teenage guardian, trying to balance looking after her dying mother and her education, was chastised by the HBC team on a visit for the new hair extensions she was sporting. They were suspicious of her reports that a "well-wisher" had given her

money for her hair extensions and her school fees and accused her of being involved with a sugar-daddy. Households that had suffered repeated losses were most vulnerable as they had already used up their savings, called upon all of their relatives and exhausted all other sources of assistance.

It is not just HIV/AIDS but flawed policy which transfers the responsibility for health care provision from the state to the individual, such that families must either have the means to access the commodified health market, or must provide health care themselves. When poor families are unable to do the former, they resort to the latter and are forced to draw heavily upon women's domestic labour as a means of health provision. Clearly, it would be fraudulent to call these women's stories examples of coping.

4.3.3 Home Based Care Policies

> *Home based care is an abuse of human rights because it's just a way of sending patients from the hospital without treatment. Patients in home based care die quickly because they know that the hospital has given up on them.*[41]

In an informal interview with an international consultant from Oxfam, specializing in HIV/AIDS mainstreaming, her reply to my question about Malawi's health policy was, "Health policy? What health policy? I am an optimistic person generally, but there is no reason to be optimistic here".[42] During interviews with doctors working in the public health system it became clear that the popular policy to deal with the chronically ill was to prescribe "Home Based Care". Medical staff describes this as sending the patient home to their family to die. Little or no instruction on care are provided, nor are medical supplies due to the incredible resource shortages in the government health system.

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[41] HBC project employee, backing up a complaint that HBC is used by hospital personnel as a 'dumping ground' for HIV+ patients (Marum et al 2000).
[42] Dolar Vassani, informal discussion, Blantyre, Aug. 2, 2003.

"There is nothing we can do for them – no medicine, no treatment, no room on our wards – it is better for them to go home."[43]

The health policy designed to guide Malawi's health sector for the next twenty years, *To the Year 2020: A Vision for the Health Sector in Malawi*, mentions that while the concept of organized home based care is new in Malawi, the practice of caring for patients with chronic and incurable diseases in the home by families and communities is an "integral part of Malawi's culture" (MOHP 1999b: p.89). The policy says that major factors (including the dramatic rise in the population, the unabated growth of the disease burden as the economy performs below expectation and the concurrent and interrelated epidemics of TB and HIV) have made it mandatory for the health sector to look at home based care as a "viable service delivery mechanism". The policy concludes, "Even if hospitalization were the most appropriate response to this situation, most hospitals could not cope with the situation since they are already operating at between 150 and 200 percent occupancy rates".

As policy, home based care is a planned and organized effort with the overall goal to strengthen and support the existing capacity of the family and the community to care for their sick members, according to the WHO. The National AIDS Control Programme says that home based care offers the affected families an opportunity to receive comprehensive care to meet the patient's and family's different needs (VanMulken 2000). In principle, home based care is the care of chronically ill patients in their home, using family and community strengths. It is meant to be an ongoing process with medical, counselling, spiritual and psychological support as essential tools, which the health

[43] Doctor at the admissions clinic, informal discussion, Queens Central Hospital, August 19, 2003.

worker, the family and the community can utilize while providing the care. The experience on the ground is quite different.

A discussion with a nurse on the general medicine unit at Queens hospital illustrates the pressure on the medical system arising from so many sick people:

> For these AIDS patients, if they have already been discharged from the hospital, then there is no need to take the patient back, because they will be told just to go home with Home Based Care. It is true, that there is nothing that can be done at the hospital.
>
> If all of those sick patients from the villages came to the hospitals, oh! There would be so many patients! The nurses would run away![44]

Home Based Care can be seen as a popular health policy which enables to system to "cope" with the demands of the health sector arising from a serious health crisis due to the related ravages of HIV/AIDS and famine in the context of severe budget cuts. The health care sector in Malawi is unable to cope with the demand for its services due to an increase in the number of AIDS patients. It has been estimated that since the epidemic started, overall demand for health care has increased by 50 percent. It has further been estimated that presently over 70 percent of hospital beds in Malawi are occupied by people with HIV related conditions (Marum et al 2000).

Certainly, there are many reasons why people want keep their sick family members at home. It keeps people in their communities and allows for the social network of support that this affords, rather than being far away in a health centre. For the relatives, it reduces the conflict of activities that occurs when a patient is hospitalized and someone must go and act as guardian. One hundred percent of the surveyed households said that home based care helped their family by allowing them to do their domestic work while looking after the patient,

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[44] Nurse, Semi-structured, in-depth health care staff interview, Queens Central Hospital, August 22, 2003.

> Home Based Care is good because the money spent on food is minimal, compared with when the patient is in the hospital, and we have lots of time to chat with our patient and people from the community come to visit our patient easily.[45]

But we must also see this policy for what it is: a shifting of the burden of care from the government to the household, where under the traditional gender roles of Malawi, women will shoulder the burden. Caring labour will be added to the already heavy workload of women. CIDA Malawi's gender officer advocates against home based care programmes due to "the burdens women will continue to face unless it gets modified in their favour and puts in effective strategies for involving men in the actual caregiving business."[46]

An elderly woman whose daughter is chronically ill as a result of HIV/AIDS expressed the burden when asked how she was managing,

> Ahh, it is difficult. I have to collect water, wash the clothes, cook the food and it is too difficult to get farming done while doing all of these things, plus looking after the patient, her son and that child (orphan) who stays with me. There is no one who can help me these days. I am alone with these problems.[47]

What can a researcher say to a nine year old girl, caring for her dying mother and twin seven year old brothers, alone with such a burden of care?

> I do all of the housechores, such as drawing water, cooking, sweeping, washing plates and clothes. I do all of these things even when I am sick myself. I try to get it all done before I go to school in the morning. I wake up at 5 am and then it takes a long time to walk to school. Sometimes I am punctual, but sometimes I am late and the teacher sends me back. The problem is that when I get to school I am tired and I can't concentrate. And even when I am sick, I have so many chores to do and so then I feel more sick. My mother encourages me to go to school each and every day, she says that if I feel too sick, I can always come back home. It's good when I get to school on time because that is the time in the day when I can rest.[48]

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[45] HBC survey #16, Maira Village, Makhetha
[46] Olivia Liwewe, interview in Lilongwe, August 4, 2003.
[47] Mother, Home Based Care interview, Sept. 1, 2003.
[48] Nine year old caregiver, Home Based Care interview, Aug. 20, 2003.

Many charitable projects have sprung up in Malawi which aim to help families who are caring for chronically ill patients at home. One of these projects was the Intervention, Counselling and Care (ICOCA) project, run by Word Alive Ministries International. Like other Home Based Care projects in Malawi, it employs staff including nurses and AIDS counsellors and involves community volunteers who visit families who have been identified by community resource workers as needing help caring for sick people. The ICOCA project was able to supply basic drugs to their clients through donations from their church members. They were also trying to secure funding for food aid and orphan support through international donors. However, they were overburdened with proposal writing and other administrative duties of reporting that were required by the numerous donors who funded their projects. The home based care team often had to cancel their visits to the community in order to meet a pressing deadline arising from donor demands.

In an assessment of home based care services in Malawi completed in March 2000, Marum et al found that most programmes were operating without adequate medical backup or supplies, that volunteers lacked training and that most patients had multiple unmet needs such as pain medication, oral rehydration therapy, bedclothes, soap and help with household tasks. They noted the absence of care plans for patients and the lack of outpatient centres able to provide specialized medical care for AIDS patients.

In interviews with the managing directors and field staff of various home based care projects, the most often mentioned goal of HBC was to "mobilize the household to deal with their problems'. But what this research showed time and again was that the households had mobilized all that they could – they had spent all of their savings, sold all

of their belongings, eaten all of their food, called upon all the favours or charity available to them – and still could not manage.

Dr. Stephany, representing the College of Medicine at the Blantyre HBC Network meeting, supported this view when he said that the role of government health programmes is solely to provide basic drugs, not to deal with nutritional issues. In the meeting, he stated, "If households don't have enough food, they should mobilize themselves through some kind of income generating activities."[49]

Taking a rights based approach would open the door to many questions about the ethics of promoting home based care as health policy without backing it up with resources. A rights based approach would unveil the multiple levels of exploitation that are inherent in such policy, in its current implementation. Not only are the basic rights of women caregivers jeopardized in this system, the use of so-called volunteers by major donors must be addressed. Donors with substantial budgetary capacities are relying on village volunteers to do all of the leg work for their projects. For example, I met a village volunteer in one of the Blantyre townships who was involved with Word Alive's programme, a reproductive health programme run by the College of Medicine as well as a World Food feeding programme for orphan children. He volunteered full time for these endeavours and had a lot of responsibilities, yet the only incentives that he receives are from Word Alive. From them, he gets K290 (about US$3) a month and an umbrella for the rainy season. He says,

> I am just used to doing it because I am so moved by other people's suffering and I do not know what else to do. At least I can help somehow in this way. It is within me to help. God will take care of my problems.[50]

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[49] Blantyre Home Based Care Network Meeting, Salvation Army, Ndirande, Sept. 25, 2003.
[50] Village volunteer, August 12, 2003.

In an interview with the World Food Programme's HIV/AIDS programme officer, I was told that they did not provide food assistance for carers or for project volunteers as it would "kill the volunteer spirit and create dependency".[51]

It seems that the approach taken for home based care as policy in Malawi is not in keeping with the principles behind the concept of home based care. Without any backup of services or resources, without trained community staff members, and without any real capacity to provide the medical, psychological and social service care required by their clients, home based care programmes in Malawi do little. While the intentions and altruist motivations of the staff and volunteers are commendable, the problem is in the financial backing of these programmes. They are piecemeal and unorganized, cropping up wherever different church or charity groups manage to respond to the community's need. There are few referral mechanisms in place between government and the HBC projects which exist. Furthermore, the government has done little to direct the process or to send resources their way.

4.3.4 Who is Responsible?

The question of who should provide the support that so many Malawians obviously need is hotly debated within the country. At one religious meeting at Word Alive Ministries, a very active church in the field of HIV counselling and Home Based Care, a visiting preacher from Ghana said to the congregation, "Whose role is it to build hospitals? Not churches! The Ministry of Health! So we churches have to stop doing their work for them, and concentrate on our work – saving souls!"

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[51] Gertrude Kara, WFP HIV/AIDS programme officer, Interview, Lilongwe, August 5, 2003.

In the household survey, 90 percent of respondents reported using government health services, but only 51 percent said that they received adequate treatment there. They cited overcrowding, lack of drugs and poor quality of services as the main reasons. When asked if the quality of government services had gotten better or worse over the past twenty years, only 11 percent of those surveyed said that it had gotten better. Twenty-six reported that it was sufficient and 63 percent indicated that they felt it had gotten worse. Despite these overall results, respondents used examples such as improved family planning services, improved access to safe water, widespread vaccination programmes and decreased levels of diseases such as cholera to show that the government was doing some things right. The ball is in the government's court. In both the interviews and the survey, Malawians reported a strong preference for using government services. When asked to explain this, one nurse told me,

> Sometimes when you go to Queens [government hospital], you are helped. But other times you wait, and wait and wait and still are not helped. So you just hope that you will get good service, because sometimes you do.[52]

Her colleague backed up this idea of hope,

> Sometimes you get very good treatment there, you wonder, wow, can this be true? And if you have a very big problem they can refer you to a specialist. You just are hopeful, especially if someone is seriously sick.[53]

Different responses came with the question of what the government could do to make things better. Most guardians said that food was the main problem, and that the government should provide food for sick people and their families. The cleaner at Kachere Rehabilitation Centre had many ideas for how health care could be better

[52] Nurse, healthcare staff interview, Queens Central Hospital, August 22, 2003.
[53] Nurse, healthcare staff interview, Queens Central Hospital, August 22, 2003.

provided by the Government of Malawi, including better donor support and putting a ceiling on private health clinics,

> Now in ten years, the population in Malawi is going high, so the government is trying to help us but we are so many people. Our government, it has no gold, it is only begging from outside the country. So, the government is failing to assist us. When this government started working, they tried to help with health, especially in the villages, but shortage of medicines means that they are failing to take care of people, but it is not their intention. Concerning medication, they need donations. They are trying, but health workers have small salaries and so they are forced to steal the medicines and to sell them.
>
> *Q: What should the government do to make health care better in Malawi?*
>
> To make it better, they should open more nursing schools, ones which are for free; make short courses for patient attendants and ward aids; have more security over the medicines; and they should ban some private clinics because all of the clinical officers are working there at the private clinics and they need to come back here to the hospitals; and they should limit the number of private clinics because we have enough and don't need more small ones. And they need to get medicine for HIV/AIDS. As of now, only rich people are getting it, and poor people are just dying
>
> *Q: What is wrong with having so many private hospitals?*
>
> In the past, I can say under Kamuzu Banda, even Government Ministers were admitted to Queens, but now they all go to the private hospitals. Back then, there were no private hospitals and everyone could go to Queens, there were lots of medications at the hospital, and even poor people got good treatment. But now, anyone who has money goes for private.[54]

Others had less exact ideas about the way forward. When asked what could be done to support poor families who have a sick family member, a nurse at Queens hospital said,

> Ahh, nothing can be done. I can't take my salary and give to them. People will always be poor. They just have to find a way to get some money. Nobody can give them money.
>
> *Q: What can the government do to help?*
>
> There is nothing they can do. There are a lot of sick people in the villages, too many to help. You can't give them food, because if you do, everyone will want to

[54] Cleaner, healthcare staff interview, Kachere Rehabilitation Centre, Aug. 22, 2003.

be sick. They won't look after the sick one properly because they will want him to stay sick so that they can get some bags of maize.[55]

She is not the only one with such a view on poverty. When the Electoral Commission released a report in August 2003 which stated that poverty is the main cause for political violence in Malawi, the government responded by saying that poverty can only be alleviated if Malawians "work harder".[56] This focus on individual effort fits in nicely with neoliberal economic thought which maintains that those who don't succeed must not be trying. It releases responsibility from an economic system which impoverishes so many for the wealth of a few and puts it on to individual actors, who aren't working *hard enough.*

4.3.5 Conclusion

Women's stories from the midst of Malawi's health crisis have illustrated the dire situation facing families in the country. HIV/AIDS is clearly a factor, yet this research shows that the underlying problem is with the economic system which is driving the reform of the health sector. Yet little has been written on this issue. Even the UNAIDS has not really unequivocally denounced the kind of pressures and reforms that the World Bank is putting on Southern health care systems. Instead they say that social protection programmes that support people, households and communities hard hit by the epidemic make a huge difference. In a document on *Caring for Carers*, they advocate remedial income generating projects as the solution to the crushing demands that caring labour is putting on women in the heart of the pandemic. The article says:

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[55] Nurse, healthcare staff interview, Queens Central Hospital, August 22, 2003.
[56] The Daily Times, August 23, 2003.

> Given the heavy burden the epidemic places on women as caretakers and breadwinners, new safety nets are needed. Microcredit schemes that take account of womens special needs can be important tools that also help make local social relations more equitable. Microfinance programmes, such as the African Microenterprise AIDS Initiative, have provided opportunities for women to operate business ventures and to fashion relatively autonomous livelihoods. This helps them to generate enough household income to organize their work schedules around HIV-related care demands (UNAIDS 2000).

Based on the findings from this research, the UNAIDS approach seems destined to do little more than add to women's burdens. It might have some merit for some women in higher income countries or who have substantial support at home. But for the poor women of Malawi, there is no time off from their "work schedules", nor is there an abundance of untapped economic opportunities waiting for them during this time off. People work all day in the informal sector just to eke out a few kwacha for basic food. It is therefore unlikely that women working for an hour a day, during their "break" from all of their other activities of caring and social reproduction, will be able to "fashion relatively autonomous livelihoods".

This kind of policy, just like the health policy in Malawi, misses the broader point that women are doing all that they can. No more "solutions", in the form of greater burdens, should be passed to them. The real solution lies in proper social policy that takes into account the lived experiences of everyday people, both men and women. In the following section, I will present an image of what this policy might look like in Malawi.

4.4 Conclusion

Throughout my research, I heard the expression "*Kunja kuno kwaopsya*" (Life is now more dangerous). Indeed, it does seem to be.

On top of the logistical problems intrinsic in the formulation of home based care in Malawi come the questions about its very foundations. In transferring care and responsibility over to the household, the government is releasing itself from ownership of duty for the well-being of its citizens. This poses enormous problems for women, who must pick up this burden of care and find the means to manage all of the demands on their time, labour and resources. It also poses big problems for the world, as states absolve themselves from the business of caring for their people and focus their attention and resources on caring for the market.

When only "productive" activities are considered in the economic equation of global markets, poor women who work in the subsistence sector are overlooked. They continue to shoulder the burdens passed from state to household through the adjustment of national economic policies. Free market ideology has never claimed to be able to take care of people, pointing to the potential of liberalization and privatization of third world markets to provide people with the opportunity to care for themselves. This has not been the case. The failings of neoliberal economics in the developing world, enforced through Structural Adjustment programmes, stare back at us from all corners of the planet as the rich amass wealth and the poor fall deeper into ill-health and insecurity. The failure of the healthcare system in Malawi to meet the needs of poor women is linked to the larger failure of the global economic system to meet the needs and expectations of all of those who had hoped for a more equitable, less brutal world.

This brings us to the question of what would good health policy would look like in Malawi. Broadly, it would not count people's mere ability to cope as a success. Instead, it would focus on allowing people to flourish, to meet their potential as true citizens and to experience the fullness of living that good health brings. In the context of HIV/AIDS,

this means an immediate and enormous investment in the health care system. A universal, comprehensive system of state-led health care would overcome the current patchwork of services provided by NGOs, churches and private dealers. It would mean a steady and reliable supply of medicines to a health delivery system which caters to both the urban and the rural populations. This would include free anti-retroviral drugs for everyone infected, hospice care centres in communities and respite services for caregivers.

Good health policy in Malawi would recognize that there is a value in HBC programmes but that they must be backed up with resources such as manpower, medicine, food aid, educational support and material resources such as medical supplies, gloves, bed sheets, blankets and mattresses. Programmes must be designed to help women with the burdens of domestic work while allowing them to keep their patient at home, if that is where they want to be. Families have to be supported. Home based care has to be organized so that all communities are reached and must be staffed with trained workers who are able to run health education programmes, counselling, training for caregivers and the dispensing of medical services. Furthermore, national public education programmes are needed to challenge the traditional gender roles so that men can be more involved in the provision of caring labour.

Finally, vast resources need to be pumped into education, so that children can have the foundation they need to have hope for a better future. Hope is the only way to fuel behaviour change. The government of Malawi has missed what young people in every town in Malawi are saying: if I am going to die soon anyway, why not have fun along the way? Poverty and disease have taken away the hope of the people of Malawi. Nothing could be more dangerous for development.

Chapter 5: DISCUSSION AND CONCLUSION

The next decade will see a major attack on the very foundations of African societies with a very real possibility that development will be reversed. Women are standing at the front line of this crisis. In this thesis, we examined the issue of health policy, women and caregiving in the context of HIV/AIDS and health sector reform. We did this at three levels: first, we explored the theoretical issues surrounding gender, health and development; next, we looked at the forces directing health policy formulation in Malawi; and finally, we investigated the impact of neoliberal health sector reform on women caregivers in Malawi.

This project has filled some of the gap which exists in both the academic and policy arenas by addressing the impact of the joint calamities of crumbling government healthcare and HIV/AIDS on women's daily lives. The final package of women's narratives alongside the analysis of the gender and health policies being pursued by the government of Malawi links the everyday lives of women with the broader macroeconomic processes that govern global health. The women's stories and personal experiences indicate a system which is putting crushing demands on its poorest and most vulnerable members, without consideration for the wide ranging ill effects this will have on them as individuals or on the broader society. It was shown that the problems women caregivers in Malawi are facing cannot be solely explained by the biomedical process of HIV/AIDS. Rather, their extreme burdens of caring labour were better understood by analyzing the health policies in the country, which follow market principles, as opposed to principles of the right to health. The answers were not always provided in the policy itself; often it was through error of omission. Under the kind of policies that have been

created since the adoption of Health Sector Reform in 1994, Malawians' human needs have had to adjust to economic principles, rather than the other way around. Moreover, the specific needs of women are even further off of the policy radar, such that gender issues rarely find their way into policy at all.

This thesis has given rise to some conclusions which are more specific to the particulars of the case study in Malawi and some which are broad, and speak to the global development problematic. Most have already been made throughout the thesis, but will be restated here and followed by a few, general policy recommendations arising from this research.

Women in Malawi are experiencing excessive burdens of care which can better be traced back to the neoliberal shift in health policy and the intrinsically related HIV/AIDS epidemic, rather than solely to the results of a biomedical process. While women anywhere would suffer in the face of so much disease, poor health policies in Malawi have created an enabling environment in which HIV has been able to thrive. The spread of HIV/AIDS in Malawi is not unalterable, nor can it be halted through individual behaviour change alone. The directions of politics, economic priorities and overall development models have direct effects on the health of people of any country. The Government of Malawi, while not without World Bank and IMF guidance, has chosen to follow a certain development path based on market principles. The Poverty Alleviation Programme has led to widespread suffering for most Malawians, yet it is still pursued. It is time to recognize that a population of impoverished, sick people are in no position to perform their roles as 'economic actors' in order to fuel a country's development. Good health is a precursor to development.

The situation facing women in Malawi is linked to a lack of recognition of their specific gendered needs in the health policy environment. Policies have been created which explicitly call on women's unpaid labour to compensate for insufficient government health services while also creating further barriers to women's access to health services. This research clearly established a link between the policy directives in Malawi's health sector and the daily experiences of hardship for women. By passing the responsibility for health care provision on to individuals, the government has absolved itself of any moral or financial responsibility to its people. Families are given two choices: either they find the financial means to access the market-oriented health care system, or they do without. In doing without, poor families must draw on women's hidden labour within the household in their efforts to manage the burden of care for which they are held responsible. In a desperate attempt to preserve their livelihood, this can mean even drawing on women's one principal asset: her health. Women in Malawi are sick and they are tired, yet they plod on while the government pays mere lip service to their suffering. Failure to cope is seen only as an individual failure of effort, not as a broader reflection of fundamentally flawed government policies. We all should be concerned about the findings of this research, whether or not we know anything about Malawi in particular, because the same forces of change are knocking on the door to our health care system. Women who struggle to care for their families in Malawi do so under the same system as women in Canada: a system which does not measure their unpaid work and therefore, produces policies which do not value their labour. Health policy must be created to support the health and well-being of all members of society. Gender-sensitive policy analysis must be carried out if health policy is to meet the needs of women and support their right to health.

Policy means nothing if it is not implemented. Gender issues are not seen to be a priority in Malawi and women's social, health and educational statuses leave them unable to make demands on their government to change. While Malawi has created some appropriate gender policies they cannot lead to any changes while alongside macro-level policies which systematically exploit the poorest and most vulnerable members of society, of whom women number greatly.

This research has shown that the livelihoods approach to development theory has opened up some very important social areas for analysis, yet it alone cannot bring substantial change on the macro level. For example, in the critique of the concept of coping strategies, the assumption that women in developing countries are able to develop strategies which enable them to cope with the continued assaults on their livelihoods misses the reality that there does exist some point in which women cannot find another hour in the day or work any harder to accomplish what needs to be done. As the women's stories demonstrated, even if they could work any harder, they do not have the skills and resources required to solve the problems they face. As caregivers, they can provide comfort care, but they cannot contribute to improved health outcomes.

Livelihoods studies, when combined with an analysis of the influence of the structural forces acting upon a social, political or economic system, can expand our understanding of the development problematic. In other words, we can learn what is really going on. A sole emphasis on either the micro level of livelihoods studies or the macro level of structuralism will not provide us with a meaningful analysis of the development issue and therefore, cannot be used to guide our response. As this research demonstrated, we can best advance our knowledge of development by looking at the intersection of policy and people's everyday lives.

The neoliberal free-market style of economics advocated by the World Bank and the International Monetary Fund is flawed. It is flawed in the field of health and development in its view of health as a commodity and its failure to recognize that good health must be the basis for economic growth, not the outcome. Furthermore, it is flawed as the model for our world when it gives overriding precedence to the needs of capital at the expense of the needs of the people.

The challenges to creating social policy in a global system of profit-driven economics are universal. It will take a great shift in thinking and a shift in priorities if we want the direction of development to change in a positive way. The well-being of people must become the first priority of governments, donors, international financial institutions, and every other actor who plays a role in what is becoming a human disaster. The responsibility for this disaster lies in many hands, and cannot be transferred to the women of Africa, who have borne enough.

Based on these conclusions, it is clear that the best way to deal with development in Malawi is to invest massively in health and education under the direction of the Malawi government. What follows are a few general policy recommendations:

1. Return to 'Health for All' model of Primary Health Care

There is much to be done in improving the health of the people of Malawi. The first step is to acknowledge that these levels of ill health are unacceptable and that there is an international responsibility to intervene. Serious consideration must be given to the economic reforms which have contributed to increasing the levels of disease and sickness in Malawi. The realities of market forces make it difficult for the government to fulfil its commitment to improve the health of all Malawians. In fact, the government seems to

have little autonomy over their economic decisions. It is time to evaluate the role of international financial institutions in the development process. The 'Health for All' concept must now be revisited with a firm commitment to improving the health of all Malawians, men and women.

2. Supporting the government as the main agent for health service delivery:

As the state releases itself from the duty of social service provision, non-government organizations (NGOs) are picking up the pieces of the so-called social safety net. The taking over of health service delivery by other actors in the wake of government retrenchment has created a sort of "patchwork" of health provision in Malawi. The pieces of the safety net which are picked up by NGOs do not provide a cohesive system of healthcare provision and furthermore, the true situation of collapse is masked by the piecemeal nature of services.

The development project must make a commitment to the health of the people of Malawi. All actors in Malawi's development, including government, financial institutions and donors, must recognize that good health of both men and women is the foundation for any social or economic development for the nation. NGOs must stop working unilaterally as health providers in Malawi and instead, focus on mobilizing the capacity of government health services. The unrelenting pressure to cut public health expenditure must end. The Malawi Ministry of Health must be supported in their efforts to create meaningful and achievable health policies that follow a state-led development path, committed to meeting the needs and rights of its population.

3. Implement a Gendered Approach to Health Care

As the indicators for women's health allude to, it cannot be assumed that women's health needs will automatically be considered in health decisions. Therefore, a gendered approach to health care policy, planning and provision must be implemented through a coordinated effort negotiated between governments and the pool of aid donors. Better information about the determinants and the impacts of disease that highlights the relationship between gender, poverty and illness are required. The particular health needs of women must be incorporated into health sector reforms with attention given to reducing barriers to women's use of health services as the poorest members of communities. Furthermore, health sector planning will need to address the specific needs of women and girls in the face of the health issues arising from the HIV/AIDS pandemic. Statistical analyses which reflect the informal care burdens being borne by women and girls are urgently required, which provide analysis of household resource allocation. This must all be done while ensuring women's effective participation in the decision-making process.

In conclusion, this research has shown the damaging effects on women caregivers in Malawi when health policy is created which replaces the overall notion of the right to access to health with policies based only on market principles. While this thesis looked at the particular set of political, economic and social conditions of Malawi, its message is global: the commodification of health has not brought about positive health outcomes anywhere in the world. The most effective and financially efficient way to achieve good population health is through state-led Primary Health Care programmes, as evidenced in Kerala State, Sri Lanka and Cuba. The U.S. model of market-led health care has not led to improvements in the global health arena and furthermore, has created tremendous

obstacles to creating the conditions which could lead to better health in poor countries. Market-based health policies pose particular threats to the well being of women, who have particular health needs arising from their reproductive role, but who also face highly gendered obstacles to good health as a result of their low social and economic standing in society.

The current situation where the World Bank has the financial and political power to direct global health poses a real threat to the health and well being of the majority of the world's people. The World Health Organization must regain their leadership position in global health affairs if we are to see any positive change. The neoliberal explanation for lived examples of systemic market-failure is always the same: market-based policies haven't been implemented long enough or enforced hard enough. The solution is always for more of the same. The crisis which has befallen Malawi's women is yet another example of the failings of the global economic system. It isn't working now and it won't work in the future. A fundamental restructuring of our global priorities is urgently needed.

APPENDIX A

Data Collection Tools for Fieldwork

Appendix 1: Word Alive International, ICOCA Home Based Care and Orphan Care Programmes – Community Based Counsellors Survey (English)

Appendix 2: Word Alive International, ICOCA Home Based Care and Orphan Care Programmes – Community Based Counsellors Survey (Chichewa)

Appendix 3: Interview Guidelines for Guardian Interviews at Kachere Rehabilitation Centre and Queens Elizabeth Central Hospital
(Hospital based Caregiving Interviews)

Appendix 4: Interview Guidelines for Caregiver Interviews through Word Alive Ministries ICOCA Home Based Care Project
(Community Based Caregiving Interviews)

Appendix 1.

Word Alive International, ICOCA Home Based Care and Orphan Care Programmes - CBC Survey

return to HBC team on next visit

Background Information

1. How old is the patient? _____
2. Is the patient a man or woman? _____
3. How old is the guardian? _____
4. What is the relationship of the guardian to the patient? _____
5. How long has the patient been sick? _____
6. How many people live in the household? _____
7. How many adults? _____ How many children? _____
8. Who earns money for the household? _____
9. How is the money earned? _____
10. Who does the household chores (cooking, washing, collecting water)? _____

    _____
11. Has any child stayed home from school to look after the patient? _____
12. Has anyone moved out of the household because the patient is sick? _____
13. Does looking after the patient prevent people in the house from farming? _____
14. Please describe how looking after the patient prevents people in the house from doing other jobs? _____
15. Does the household have as much food as before the patient got sick? _____
16. Is the guardian healthy? _____

17. How are men or boys in the household helping to look after the sick patient? _____

_____

Health Care Information

1. What have you had to spend money on because of the patient's illness? _____

_____

2. How did you get the money to pay for these things? _____

_____

3. What hospital do you go to when the patient or others are sick? _____

_____

4. Do you feel that you receive good service and quality care at this hospital? _____
5. Why or why not? _____

_____

6. If you don't go to the hospital when someone is sick, why not? _____

_____

7. What do you have to spend money on when you go to the hospital? _____

_____

8. Do you think that the government provided healthcare in Malawi has gotten better or worse in the past 20 years? _____
9. How? _____

_____

10. Do you feel that the government supports your family's health? _____

_____

11. How does the Home Based Care programme help your family? _____

Appendix 2.

Word Alive International, ICOCA Home Based Care and Orphan Care Programmes - CBC Survey

return to HBC team on next visit

1. Wodwalayo ndi wamkulu bwanji? _____
2. Wodwalayo ndi mwamuna kapena m'mkazi? _____
3. Woyang'anira wodwalayo ndi wamkulu bwanji? _____
4. Pali chibale chanji pakati pawodwazikayo ndi wodwala? _____
5. Wodwalayo wadwala nthawi yaitali bwanji? _____
6. Mumakhala anthu angati munyambamo? _____
7. Mumakhala akulu angati? _____ Nanga ana? _____

8. Ndani amapedza ndalama dzogwiritsa ntchito panyumba? _____
9. Nanga amadzipedza munjira yanji? _____
10. Nanga ndidani amagwira ntchito zapannyumba monga kuphika, kuchapa, kutunga madzi? _____
11. Pali mwana yemwe sapita kusukulu chifukwa choyang'anira wodwala? _____
12. Pali m'modzi yemwe awatuluka munyumbamo chifukwa choipidwa ndi wodwalayo?

    _____
13. Kuyang'anira wodwala kumakupangitsani kulephera kupita kumunda kukalima?____
14. Talongosolani zifukwa zina zomwe zimapangitsa kuti mutsagwire ntchito zapakhomo chifukwa choyang'anira wodwala? _____
15. Mumakhala ndichakudya chambiri kusiyana ndi poyamba musanakhale ndi wodwalayo? _____
16. Wodwazikayo ndi wa thanzi? _____
17. Ndi amuna ndi zibambo kapena anyamata angati omwe amathandiza kuyang'anira wodwalayo? _____

Health Care Information

1. Mwaonongapo ndalama dzingati chifukwa cha wodwalayo? _____

   _____

2. Mumapedza bwanji ndalama zolipilira pazofunika? _____

   _____

3. Ndi chipatala chiti chimene mumapita ndi wodwalayo kapena inu mukadwala?_____

   _____

4. Mukuganiza kuti kuchipatalachi mumalandirayo chithandizo ndi chitsamaliro choyenelera? _____

5. Nanga ndi chifukwa ninji? _____

6. Ndichifukwa chanji simupita kuchipatala ngatiwina wainu adwala? _____

   _____

7. Ndi ndalama zingati zomwe mungawononge mutapita kuchipatala? _____

   _____

8. Mukuganiza kuti zaka makumi awiri zapitazi boma lakupatsani chitsamaliro chazaumoyo chopsa kapena ai? _____

9. Nanga mwanjira yanji? _____

   _____

10. Mukuganiza kuti boma likukupatsani chitsamaliro cha zaumoyo m'mabanja anu? ___

    _____

11. Chisamaliro cha kunyumba chimathandiza bwanji mabanja anu? _____

    _____

Appendix 3.

Interview Guidelines for Guardian Interviews at Kachere Rehabilitation Centre and Queen Elizabeth Central Hospital (Hospital Based Caregiving Interviews)

Background Information

18. How old is the patient?
19. Is the patient a man or woman?
20. How old is the guardian?
21. What is the relationship of the guardian to the patient?
22. How long has the patient been sick?
23. How many people live in the household?
24. How is money earned for the household?
25. Who earns this money?

Critical Information

1. Have you spent money because of the patient's illness? Yes or No
2. On what: _ transport
   _ medicine
   _ hospital charges
3. How did you get the money to pay for this?
   _ borrow
   _ savings
   _ sell things we own
   _ work extra jobs (who worked and in what capacity?)
4. Have any children had to stay away from school to look after the patient?
5. Has any child not gone to school because of lack of school fees because the patient is sick?
6. Has anyone moved out of the household because the patient is sick?
7. What hospital do you go to when the patient is sick?
8. If you don't go to the hospital, why?
   _ transport money
   _ no money for other fees
   _ hospital has no medicine
   _ they don't help at the hospital / bad service
   _ no time
9. How many hours a day does it take to look after the patient?
10. Does looking after the patient keep you from producing food?
11. Is the guardian healthy?
12. Are men in the family helping to look after the sick patient?

At Kachere, demands on guardians:

1. What do you have to do to care for patient here at Kachere?
2. What activities would you be doing at home if you weren't here?
3. How do you support yourself and patient while at Kachere?
4. What do you need to buy while you and patient are here?
5. How do you get the money to do it?
6. How did the family decide that it should be you who is guardian?

Appendix 4.

Interview Guidelines for Caregiver Interviews through Word Alive Ministries ICOCA Home Based Care Project (Community Based Caregiving Interviews)

Background Information

26. How old is the patient?
27. Is the patient a man or woman?
28. How old is the guardian?
29. What is the relationship of the guardian to the patient?
30. How long has the patient been sick?
31. How many people live in the household?
32. How is money earned for the household?
33. Who earns this money?

Critical Information

13. Have you spent money because of the patient's illness? Yes or No
14. On what: _ transport
    _ medicine
    _ hospital charges
15. How did you get the money to pay for this?
    _ borrow
    _ savings
    _ sell things we own
    _ work extra jobs (who worked and in what capacity?)
16. Have any children had to stay home from school to look after the patient?
17. Has any child not gone to school because of lack of school fees because the patient is sick?
18. Has anyone moved out of the household because the patient is sick?
19. What hospital do you go to when the patient is sick?
20. If you don't go to the hospital, why?
    _ transport money
    _ no money for other fees
    _ hospital has no medicine
    _ they don't help at the hospital / bad service
    _ no time
21. How many hours a day does it take to look after the patient?
22. Is the guardian healthy?
23. Are men in the family helping to look after the sick patient?

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