SILENT VIOLENCE

Global Health, Malaria, and Child Survival in Tanzania

Vinay R. Kamat

Silent Violence

Silent Violence

Global Health, Malaria, and Child Survival in Tanzania

Vinay R. Kamat

The University of
Arizona Press
Tucson

The University of Arizona Press
www.uapress.arizona.edu

Open-access edition published 2021

ISBN-13: 978-0-8165-2952-0 (paper)
ISBN-13: 978-0-8165-4344-1 (open-access e-book)

Library of Congress Cataloging-in-Publication Data
Kamat, Vinay R.
Silent violence : global health, malaria, and child survival in Tanzania / Vinay R. Kamat.
p. cm.
Includes bibliographical references and index.
ISBN 978-0-8165-2952-0 (pbk. : alk. paper)
1. Malaria—Social aspects—Tanzania. 2. Malaria—Treatment—Tanzania. 3. Children—Diseases—Tanzania. 4. Tanzania—Social conditions. 5. Tanzania—Economic conditions. I. Title.
RA644.M2K36 2013
362.1969'362009678—dc23
2013009677

An electronic version of this book is freely available, thanks to the support of libraries working with Knowledge Unlatched. KU is a collaborative initiative designed to make high quality books Open Access for the public good. The Open Access ISBN for this book is 978-0-8165-4344-1. More information about the initiative and links to the Open Access version can be found at www.knowledgeunlatched.org.

To Kavita, Abhishek, and Aarti
for their love, patience, music, and humor

Contents

Part I: Global Discourses

Part II: Local Practices

Part III: Philanthrocapitalism

Part IV: The Way Forward

Illustrations

MAPS

FIGURES

Preface

Malaria is a complex mosquito-borne parasitic disease. It has an equally complex social history that is inextricably linked with poverty and structural inequality. The book's title "Silent Violence" is derived from Randall Packard's *The Making of a Tropical Disease* (2007) in which he demonstrates how the history of malaria is closely tied to chronic poverty, which manifests itself in violence that is often silent. In 2000, when I started my fieldwork in Tanzania, it was believed that malaria affected between 300 and 500 million people worldwide and killed more than 3 million people, 90 percent of them children, mostly in sub-Saharan Africa, each year. More than a decade later, in its 2012 Malaria Report, the World Health Organization noted that between 2000 and 2010, the global malaria-specific mortality rates fell by 26 percent. This is encouraging news. However, the rates of decline are far lower than internationally agreed targets for 2010, which called for reductions of 50 percent. Malaria continues to kill hundreds of thousands of young children, mainly in Africa, each year.

In this book I argue that global efforts to deal with malaria have achieved limited success because malaria is increasingly being cast as a bureaucratic, managerial problem and the core of the problem systematically depoliticized. As such, I illustrate how the persistence of malaria in Tanzania and elsewhere in Africa can be better explained from an anthropological perspective by framing it within a critique of neoliberal global discourses on malaria control and elimination. I explore the persistence of childhood malaria in Tanzania as a form of structural violence that emanates from historically situated structured inequality, and the resultant human suffering. I illuminate the processes that are closely tied to structural inequalities and hegemonic global discourses on malaria that are increasingly becoming biomedicine-based, technological fixes. Case studies and illness narratives in the various chapters highlight not just the social burden of malaria, but the salience of the diversity of experiences within a specific sociocultural context. My goal is to bring people's lived experience with malaria, and the local context in which malaria-related social suffering is embedded, to the attention of a global audience of both readers and policy makers. I wish to demonstrate how "top down" policies and interventions are locally and individually experienced.

Each chapter is grounded in ethnographic data focusing on a particular theme that is closely tied to the larger goal of illustrating how globally determined policies on malaria are locally experienced in Tanzania. I have included numerous ethnographically rich case studies and narratives in the different chapters. I have tried to write in a style that is easy to follow, and uncluttered by anthropological jargon. Most important, *Silent Violence* provides a theoretical argument linking the persistence of malaria in sub-Saharan Africa, particularly in Tanzania, with the politics of global health governance, as well as the "pharmaceutical nexus," driving the global antimalarials market. *Silent Violence* fills a gap in the anthropological literature on infectious disease—the lack of a detailed book-length ethnographic study on childhood malaria. The anthropological literature on malaria is growing. However, a detailed ethnographic study on malaria that traces the cultural meanings and human experiences of the illness has been missing. *Silent Violence* adds to the growing effort within anthropology in general and critical medical anthropology in particular to examine and explain the reemergence and persistence of "global killers"—infectious disease such as HIV/AIDS, tuberculosis, malaria, and cholera in relation to the larger, global political economic systems and institutional structures that perpetuate and intensify social inequalities. This book demonstrates that an anthropological account of malaria in Tanzania is at the heart of current theoretical and policy debates concerning the impact of globalization and neoliberal economic policies on local communities. It demonstrates the manner in which the implementation of neoliberal economic reforms has diminished the state's responsibility to provide health care to its citizens, making health an individual's responsibility rather than an individual's basic right.

Over the course of the last decade I have often been asked by friends, colleagues, students, and the people I interview and engage in conversation in Tanzania to learn about malaria: Will malaria be eradicated anytime soon with all the technology and unprecedented funding that we have at our disposal today? Why don't we have a vaccine for malaria yet? Why are so many children still dying of malaria when we have all the new drugs available in the market? Because there are no definitive answers to these questions, I have usually responded by saying, "I don't know, I wish I knew." This book, then, is part of an ongoing story about malaria and a medical anthropologist's quest to engage some of these questions. I hope readers will continue to learn about malaria not only as a disease, but also as an illness that entails suffering and social misery that is closely tied to global biopolitics. This book is as much about malaria as a biomedically identifiable disease and a subjectively experienced illness, as it is about the global discourses on malaria and the biopolitics of health.

Some of the previously published essays and data included in this book are derived from my earlier fieldwork, which I carried out in Tanzania between 2000 and 2001, and the follow-up research I conducted in the same research sites during the ensuing years. In revising the chapters based on previously published material, I have updated the references, elaborated on the context and the case studies, where appropriate, and relegated the methodological details to the notes. My interest in how single mothers deal with childhood malaria, and the manner in which the large-scale introduction of a highly subsidized new generation of antimalarials has depoliticized malaria in Tanzania, emerged during the course of my fieldwork. Indeed, I was drawn to Tanzania every year to continue with my research on malaria because of my intellectual curiosity and to keep up with the fast-changing developments in the global discourses on malaria. The recent revival of global efforts to eradicate or at least eliminate malaria from the face of the world was irresistible for me, in terms of staying in touch with the story and continuing to research and write about it. My hope is that this book will inspire a new generation of medical anthropologists to pursue the challenges of demonstrating the power of ethnography in debating and disentangling the global health issues that we feel so passionately about.

Acknowledgments

This book is a culmination of more than a decade of research and writing on malaria in Tanzania. It is also a partial record of how Tanzania's malaria program has unfolded over a decade, its pivotal moments, and the direction in which it is headed. In the summer of 1998, CARE Tanzania offered me my first opportunity to travel to Africa as a consultant on a malaria project. At the time I was a graduate student at Emory University. I thank Mary Willis who was with CARE International for facilitating the assignment, during which I had the good fortune to work in close collaboration with Professor Zaphet Minjas, a world-class malariologist. The friendship, warmth, and characteristic Tanzanian hospitality he extended to me, and his inimitable sense of humor, sealed my fate to return to Tanzania to do more research. I am grateful to the National Science Foundation, the Wenner-Gren Foundation for Anthropological Research, and the Department of Anthropology and the Institute of African Studies at Emory University for providing me with funds to return to Tanzania in 2000 for my research. I spent sixteen months learning Kiswahili and doing fieldwork in Dar es Salaam, which laid this book's foundation. Since then, I have returned regularly to Tanzania to work on different research projects funded through various grants from the University of British Columbia, the Social Sciences and Humanities Research Council of Canada, and the Wenner-Gren Foundation. During my initial fieldwork in Tanzania, I was affiliated with the Muhimbili University of Health and Allied Sciences. Professor M. T. Leshabari, who was the head of the School of Public Health, became my local supervisor and provided me with sound advice throughout my research. In the United States, Mark Nichter and Marcia Inhorn instilled in me an everlasting passion for medical anthropology, and Jane Hill got me interested in sociolinguistic anthropology. At Emory University, Peter Brown, my graduate advisor, and committee members Marcia Inhorn, Randall Packard, Daniel Sellen, and Ivan Karp, who sadly passed away in 2011, encouraged me to go to Africa to do my dissertation research. Together they set me on track and made that possible. To my mentors, both at the University of Arizona and Emory University, I will remain eternally indebted, for their support, encouragement, and honest criticisms during my graduate studies, and to this day. Peter Brown, Marcia Inhorn, and George Armelagos have supported me to the hilt. I owe them many debts of gratitude. I am also grateful to Corrine Kratz for believing in me and giving me useful advice, and to Allyson Carter, editor-in-chief, University of Arizona Press, for her trust, patience, and enthusiasm. Lenore Manderson has brought me good fortune in ways that she will never realize. If it wasn't for Lenore, I would not have become a malaria ethnographer. Thank you Lenore! I am grateful to the three anonymous scholars who reviewed my book proposal, gave constructive criticisms, and concurred that if I stayed on course, I could write this book. I appreciate their foresight and perceptive criticism. Additionally, two anonymous reviewers for the University of Arizona Press gave critical and specific advice on how I could sharpen my argument. And finally, I am most grateful to the Wenner-Gren Foundation for awarding me with a twelve-month Richard Carley Hunt Fellowship to conduct follow-up research and to bring this book to completion.

I want to thank Leigh Mcdonald, Lela Scott MacNeil, Elizabeth Grant, Scott De Herrera, Nancy Arora, Amanda Piell, Abby Mogollón, Kristen Buckles, and Lisa Stallings for all their help in preparing this manuscript. I am especially grateful to Jessica Ryan for her excellent editorial skills, and for her care and attention.

At the University of British Columbia, I have enjoyed the friendship and support of my colleagues, Gaston Gordillo, Alexia Bloch, Pat Moore, Felice Wyndham, Jennifer Kramer, Carole Blackburn, Shaylih Muehlmann, Carol Mayer, Milind Kandlikar, Ashok Kotwal, Darrin Lehman, Kirsten Bell, Shafik Dharamsi, Rosemin Kassam, Sunera Thobani, and members of the African Studies Program, especially Philippe Le Billon, Gloria Onyeoziri-Miller, Robert Miller, and Sarah Walshaw. I am immensely grateful to Professor Stephen Toope, president and chancellor of the University of British Columbia, for his trust in me. I am also grateful to my fellow medical anthropologists, Craig Janes, Kitty Corbett, Stacy Pigg, and Susan Erickson, from the Simon Fraser University, for their camaraderie and unstinted support. Jenelle Taylor, James Pfeiffer, and Rachel Chapmen of the University of Washington have been friends and a great source of scholarly inspiration. Charles Briggs has significantly influenced my thinking, research, writing, and teaching, and I owe him a big thank you for being such an inspiring scholar and a human being. My classmates from Emory—Eric Lindland, Melissa Melby, and Daniel Lende—have remained my eternal friends. I am indebted to Daniel Smith for sharing with me his book proposal "A Culture of Corruption" and for giving detailed comments on my own proposal.

The Tanzanian Commission for Science and Technology (COSTECH) and the National Institute of Medical Research (NIMR) provided the necessary research permits and ethics clearance, respectively, to conduct research in Tanzania. Special thanks go to Mzee Mashuhuri and Sylvia Francis who made it a point to process my application with alacrity.

Briefer versions of chapters 4 and 5 have appeared previously—chapter 4 as "I Thought It Was Only Ordinary Fever!: Cultural Knowledge and the Micropolitics of Childhood Febrile Illness in Tanzania," *Social Science and Medicine* 62, no. 12 (2006):2945–2959 and chapter 5 as "Dying Under the Bird's Shadow: Representations of *Degedege* and Child Survival among the Zaramo of Tanzania," *Medical Anthropology Quarterly* 22, no. 1 (2008):67–93. Sections in chapter 7 were previously published in "Cultural Interpretations of the Efficacy and Side Effects of Antimalarials in Tanzania," *Anthropology and Medicine* 16, no. 3 (2009):293–305 and "Community Response to Artemisinin-Based Combination Therapy for Childhood Malaria: A Case Study from Dar es Salaam, Tanzania," *Malaria Journal* 9 (2010):61. I am grateful to the publishers of these journals for allowing me to reuse previously published material in this book.

In Tanzania, I am indebted to a number of people who made Tanzania a second home for me. Many thanks to my hosts in Mbande village, the late Mzee Nyanza, Mama Shomvi, and Mzee Tinyango Pazi; my field assistants, Mzee Ali Mtangenange, Mwanakombo Mkanga, Mariam Mohamed, Mama Afidhi, and Mama Deo; my constant companions in Dar es Salaam, Robert Kihama and Abdhalla Njowele; and my research collaborator Daniel Nyato from the University of Dodoma. I have enjoyed my interactions with my main interlocutors in Mbande village—notably, Fatuma Mayange, Mama Bwinde, Mzee Kingwandala, and Mzee Musa. Several of the people I have mentioned in this book, written about, or used their lives as illustrative case studies, died before the book was completed. Sadly, Baba Mage, Mama Bwinde, Fatuma Mayange, Mama Ndogondogo, Biti Janja, Rehema, Hadija and Tinyango Pazi are no more, and several children whose stories I have documented are no longer alive. I will dearly miss little Mariamu and Aziza, who were very much part of my everyday life and research in Mbande village. (Where appropriate, I have used pseudonyms in the text.)

I am particularly grateful to Mama Afidhi, my neighbor and field assistant in Mbande, who was always two steps ahead of me when it came to finding people who could participate in my research and were willing to be interviewed. I do not know how to thank Wasiwasi and Shabani, two of my best friends in Mbande village, for the joy they brought to me through their teasing, joking, parody, and self-deprecating humor.

My graduate student, Maggie Woo, who did her fieldwork in Tanzania, read an earlier version of this manuscript and contributed to it with generous criticism. Rachel Houmphan, Joseph Weiss, Glen Chua, Kirsten Bell, Clare Chandler, and others read earlier versions of the materials incorporated into this book. I am especially grateful to Clare Chandler, Kirsten Bell, and Glen Chua for taking the time out of their busy schedule to read and comment on several chapters in this book.

Finally, this book would not have been possible without the unconditional support of my family and my in-laws. My wife Kavita and our children Abhishek and Aarti spent three months with me in Tanzania during my fieldwork in 2000. I have fond memories of our children playing with the goats at *mganga* Tinyango's house and chasing chickens in the front yard of my hut in Mbande. My father, a scholar, who decided to learn Kiswahili along with me at the age of eighty, inspired me to pursue excellence in education and be a good global citizen. My mother, my sisters, and my brother have contributed to my achievements in ways that cannot be measured or described. My debt of gratitude to them is eternal.

SILENT VIOLENCE

PART ONE

Global Discourses

CHAPTER ONE

The Violence of a Global Killer

Epidemics are "mirrors held up to society," revealing differences of ideology and power as well as special terrors that haunt different populations.
CHARLES BRIGGS AND CLARA MANTINI-BRIGGS 2003:8

We should think about health for health's sake. Preventing hundreds of millions of malaria cases and deaths of millions of children should be reason enough to do whatever we can to fight this disease.
RANDALL PACKARD 2009:80

One early morning in February 2001, the head nurse at the village dispensary and a young woman with a very sick child tied around her waist with a *kanga*, were engaged in a loud verbal battle on the dispensary's verandah. They were calling each other names and making insulting references to each other's *kabila* or ethnic identity. The yelling and gesturing match continued for about ten minutes. My limited communicative competence in Kiswahili[1] and familiarity with the local cultural context at the time, led me to believe that the quarrel was over the young mother's frustration with the poor quality of service offered at the dispensary, and the nurse in turn was blaming the mother for having delayed in bringing her sick child to the dispensary. The nurse, who I shall call Neema, and the young mother, Fatuma, abruptly ended their verbal match, smiled at each other, and shook hands. A dozen or so women who were at the dispensary with their sick children witnessed the drama and simultaneously burst into laughter. Nurse Neema now turned her attention to Fatuma's child.

Perplexed by the whole event, I asked Mzee Ali, my research assistant in the village,[2] who was seated next to me, to explain to me what had just transpired at the dispensary. Nurse Neema and Fatuma were not really quarreling with each other, he told me; they were in fact having a bit of fun. Nurse Neema was a Chagga and Fatuma a Mzigua; they shared a *utani/watani* relationship—a ritualized joking relationship (see

Beidelman 1986; Radcliffe-Brown 1940).[3] On that day they were enacting their customary joking relationship at the dispensary to demonstrate their familiarity with each other, and perhaps more important, to alleviate the nervous tension and frustration that mothers experience as they wait patiently—some for up to six hours—for the dispensary staff to attend to their sick children. Fatuma's nine-month-old daughter, Mariamu, was presumptively diagnosed (i.e., without a blood test) with malaria, a life-threatening mosquito-borne infectious disease,[4] and prescribed five injections of chloroquine over five days.[5]

Three weeks after this event occurred, I saw Fatuma again at the dispensary with Mariamu to deal with yet another fever episode. The routine was repeated; Mariamu was presumptively diagnosed with malaria and prescribed five more injections of chloroquine. It was the straw that broke Fatuma's patience. She broke down in front of nurse Neema saying "*nimechoka, nimechoka, nimechoka,*" meaning that she was fed up with having to deal with her child's sickness, and tired that her daughter was being prescribed the same medicine—chloroquine. Later that day, I learned from Fatuma that she was a twenty-three-year-old single mother of two young children. She did not have the resources to take her child to a private clinic or the district hospital, which was located fifteen miles away from the village. Therefore, she had no choice but to keep coming back to the village dispensary to deal with her daughter's sickness, even if it meant that she would get the same diagnosis (malaria) and the same "useless" medicine (chloroquine).

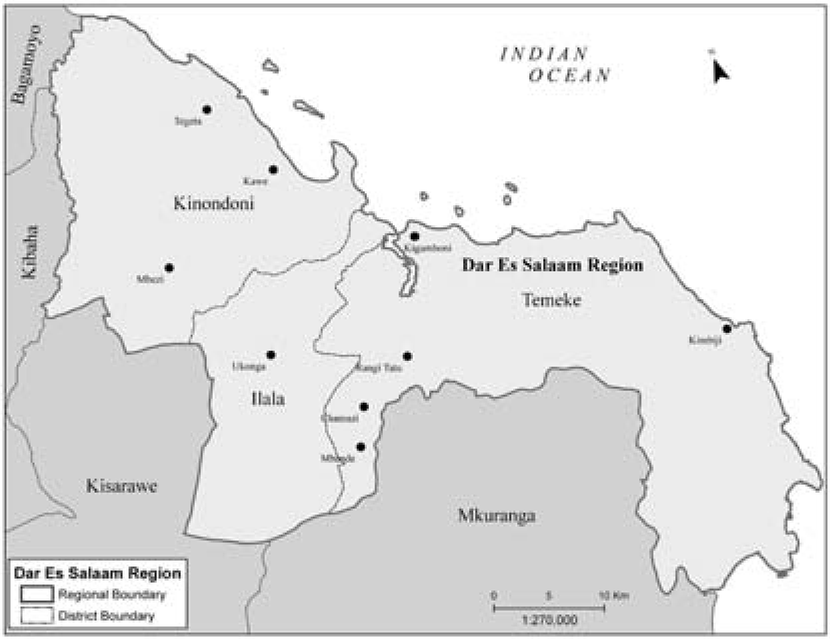
Fatuma's case is hardly unique. I followed developments in her life for nearly a decade.[6] Her life story is emblematic of what life is like for many poor mothers in rural Tanzania, especially those who are single or previously married and have to deal with their children's sickness, which includes recurring bouts of malarial fevers and malaria-related complications (see also Muela Ribera and Hausmann-Muela 2011).[7] I was made painfully aware of this on numerous occasions during interviews and in everyday conversations, when mothers would intersperse their narratives and conversations with the stock phrase "*maisha magumu—tunahangaika tu!*" ("Life is hard, we are just struggling!"). Embedded in the above vignette are elements of this book's driving questions: How do shifting global discourses on malaria control affect the everyday lives and practices of people who live in communities where malaria is endemic? How can malaria interventions be made at once responsive to the local epidemiological and cultural context and the large-scale structural conditions (poverty and inequality) that contribute to its persistence?[8] As such, some of the key issues and concerns that I pursue include: (1) the importance of the cultural context in malaria control strategies; (2) the significance of acknowledging and documenting the lived reality of the illness experience; (3) the importance of paying attention to the social and not just the biomedical burden of malaria; (4) acknowledging the uncertainty of everyday life, the absence of social safety nets, and the social suffering that is closely tied to how people in poor communities experience childhood malaria; and (5) the reasons for malaria's persistence, as not just drug resistance, but also micro- and macrolevel forces such as gender and structural inequalities. Finally, the above vignette is tied to my primary intent in writing this book—to demonstrate through an ethnographic perspective that there is more to malaria than mosquitoes, parasites, and medicines—and to illustrate my argument that the existing social, political, and economic realities or structural arrangements that influence people's vulnerability and susceptibility to disease are as much a part of the malaria story as are the innovative scientific and technological breakthroughs periodically being made to deal with the disease.[9]

Doing the Right Thing

I had originally set out to do a village ethnography focusing on the impact of neoliberal economic policies and the privatization of the health sector (health sector reforms) on the everyday lives of the people of Tanzania in the postsocialist context, and on medical decision making in particular. I started my fieldwork in earnest by interviewing elderly men and women in four villages on the outskirts of Dar es Salaam on their views regarding how their lives have been transformed since 1991 when Tanzania formally abandoned its socialist *ujamaa* agenda and embraced neoliberal economic and social policies.[10] (I discuss this topic in some detail in the next two chapters.) Over the course of my fieldwork, however, I became interested in documenting not only the everyday discourse about ordinary life (*maisha ya kawaida*), and the kinds of decisions that people make in the context of a rapidly changing sociopolitical, economic, and health environment, but also the cultural interpretations of certain illnesses or illness categories. This shift in focus was, to an extent, determined by some close encounters with death and dying in Mbande, the main village, during the early stages of my fieldwork. In addition to documenting life histories of elderly men and women, I elicited numerous illness narratives from mothers about their sick children, and their efforts "to do the right thing"

Map 1. Map of Tanzania. Credit: Alejandro Cervantes.

when confronted with their children's illness. I recorded narratives told by bereaved parents, especially those who had recently lost a child to malaria or *degedege* (see Dillip et al. 2009; Hausmann et al. 2002; Langwick 2011; Winch et a1. 1996), a culturally significant life-threatening illness, which I discuss in detail in chapter 5.[11] This book, then, is an ethnographic representation of childhood malaria in Tanzania, framed within the context of



Map 2. Map of Dar es Salaam. Credit: Alejandro Cervantes.

Tanzania's socialist past, its socialist health policy, and the recent neoliberal global discourses and practices about the way forward in malaria elimination and ultimate eradication.[12] My intention is to specifically examine how global discourses affect local understandings of malaria.

A Brief History of Malaria in Tanzania and Dar es Salaam

As one of the world's poorest countries, with a population of 46 million in 2011, a per capita gross domestic product (GDP) of $457, and a per capita income of $280 per year (Makundi et al. 2007; Sanders 2008), Tanzania represents a country where the intricate, bi-directional link between poverty and malaria is strikingly evident.[13] Widespread poverty coupled with an inadequate health-care infrastructure often translates into excessive childhood illnesses, especially malaria-related deaths, high morbidity and mortality rates, as well as an exceedingly high incidence of life-threatening infectious diseases (Setel 1999; UNICEF 2007). In 2009, for example, the under-age-five mortality rate was estimated at 108 deaths per 1,000 live births and the maternal mortality rate was 550 deaths per 100,000 live births.[14] In terms of sheer numbers, it is malaria rather than HIV/AIDS that is the biggest killer disease in the country.[15]

Tanzania is holoendemic for malaria; that is, malaria is a perennial problem in the country; more than 90 percent of its population is susceptible to malaria (Mboera, Makundi, and Kitua 2007). It is endemic in almost all parts of the country, accounting for 30–40 percent of the disease burden (admissions and outpatient attendance), with approximately 11.5 million clinical cases in 2008. Each year, it kills between 60,000 and 80,000 people, most of them children below the age of five. The annual incidence rate is 400–500 per 1,000 people and this number doubles for children less than five years of age (Makundi et al. 2007).[16] The annual mortality rate is 141–650 per 100,000 people, increasing to 300–1,600 for children 0–4 years of age (Caldas de Castro et al. 2004). Malaria is also a major contributor to maternal deaths and low birth weights among children. It is believed that malaria costs the Tanzanian government an estimated US$240 million every year in lost GDP (Makundi et al. 2007).

Tanzania's National Malaria Control Policy strategic plan is aimed at improving malaria case management, promoting the use of insecticide-treated bednets (ITNs) on a national scale, prevention of malaria during pregnancy, and prevention and control of malaria epidemics. Other strategies include Intermittent Preventive Treatment in Pregnancy (IPTp) and Integrated Management of Childhood Illnesses, which constitute an important part of the Tanzania national package of essential health interventions (Makundi et al. 2007). However, given the rapidly changing global funding structure in the realm of HIV/AIDS, tuberculosis, and malaria control, Tanzania's malaria control program has also witnessed some significant changes. Malaria control intervention strategies in Tanzania, and in most of East Africa, are increasingly becoming technocentric and, in effect, overwhelmingly biomedically based. I am not suggesting here that the existing intervention strategies have been altogether ineffective or counterproductive. Rather, in the long run, these strategies will have a limited impact on both vulnerability to malaria and vulnerabilities caused by malaria. Many malaria historians have already reminded us that the history of malaria control is in large measure a history of the rise and fall of technology-based interventions. Randall Packard (2007), for example, provides an exquisite history of the initial spectacular successes and subsequent failures of an array of biomedical weapons and technologies that were mobilized in the "war against malaria" in the 1950s and the 1960s.

Dar es Salaam, the setting for most of my research, is the third-fastest-growing city in Africa. With a major port on the Indian Ocean, it is Tanzania's commercial capital and the largest major urban center in the country.[17] The city comprises three independently governed municipalities: Kinondoni, Ilala, and Temeke. The current population is estimated at 3 million and with a growth rate of 4.39 percent per year, the metropolitan area population is expected to reach 5.12 million people by 2020.

The Dar es Salaam region is characterized by a hot and humid tropical climate and two rainy seasons: the main rainy season is from March to June and a shorter, less intense rainy season is from October to December. As previously noted, malaria is endemic and transmission occurs throughout the year, although it is more intense in the peri-urban and rural areas of Dar es Salaam where I conducted most of my research, than in the urban areas. *Plasmodium falciparum* is the predominant malaria parasite, accounting for 90 percent of all cases. The mosquito species Anopheles *gambiae* and Anopheles *Funestus* primarily transmit the disease. During the last twenty years or so, a number of major public health interventions have been implemented in the Dar es Salaam region to control malaria. However, malaria remains the single most common clinical diagnosis at health facilities in the municipalities of this region (see Kachur et al. 2006; Wang et al. 2006).[18]

Malaria as a Disease and an Illness

Medical anthropologists commonly make a conceptual distinction between disease, illness, and sickness to highlight the experiential aspects of being unwell from the pathology or disorder as defined by a medical system.[19] I emphasize that malaria should be examined not only as a "disease" that can be dealt with through biomedical interventions, but also as an "illness" that reflects the social, economic, and political conditions that undergird people's everyday lives.[20] The point bears emphasis: an ethnographic study of childhood malaria is de facto a study of the social, cultural, and economic conditions that predispose certain populations to becoming more vulnerable to suffering from malaria and related complications. Malaria is first and foremost a disease of poverty and structural inequalities.[21] In other words, from an anthropological perspective, a study of malaria is de facto a study of poverty and social suffering, not only at the local level in poor communities, but also at the national and international level. In chapter 6, for example, I focus attention on single mothers in the villages where I conducted fieldwork and highlight their stories of poverty, marital disruption, betrayal, neglect, hardship, travails, struggles, resilience, and their hopes in relation to raising their children, many of whom periodically suffer from malaria and its related complications. Thus, we must shift our attention away from the existing technology-oriented interventions to deal with malaria (e.g., insecticide-treated bednets, antimalarials, vaccines, genetically altered mosquitoes) that dominate both the academic literature on malaria and media reports, and refocus it on the underlying social basis of the illness (see Feierman 1985; Feierman and Janzen 1992; Helitzer-Allen, Kendall, and Wirima 1993). As Leeanne Stratton et al. have cogently argued in their analysis that malaria is a global killer:

> An exclusive focus on controlling malaria either through lessening exposure (e.g., use of mosquito nets) or treating the disease (e.g., administering medicine) may provide a more realistic and immediate solution than more integrated approaches, partly due to the infeasibility of radical systems reform in the short-term. However, while such strategies may provide tangible health benefits, given the vast scale of poverty in the most malaria endemic regions, the efforts will be less effective in the long run at reducing total health burden than approaches aimed at underlying causes of differential vulnerability. (2008:885)

While medical anthropologists and historians of medicine have long recognized the significance of understanding the social basis of emerging and re-emerging infectious diseases (Armelagos et al. 2005; Briggs and Mantini-Briggs 2003; Briggs and Nichter 2009; Farmer 1999; Packard et al. 2004), it is only recently that some nonanthropologists have more boldly articulated their appreciation of the cultural analysis approach to the study of malaria. Again, to quote Leeanne Stratton et al.:

> A necessary component of malaria-related needs assessment is ethnographic narratives of people's lived experiences with the disease. These narratives are crucial to understanding how the disease fits into people's interpretive frameworks and the ways in which competing needs are prioritized and met. Few ethnographic data on malaria illness experiences and risk perception exist. . . . Opportunities to document the experiences and shifting perspectives of local communities will arise with newly formed antimalaria global partnerships. (2008:857)

Accordingly, this book is about the lived experiences of people in malaria endemic areas and an examination of how shifting global discourses on malaria affect local understandings and practices. I draw on research conducted over a decade in the same region to provide an ethnographic representation of childhood malaria and its cultural meanings, manifestations, and ramifications for the people of Tanzania and the global health community. I emphasize "local" understanding of childhood fevers and analyze certain health-related cultural practices and their meanings. Needless to say, the cultural meanings that people give to certain illnesses or illness categories are not static, and in most cases, as research has demonstrated, they do change. For example, following the introduction of highly effective antimalarials, and better access to good quality health-care facilities, researchers found that people's ideas and practices related to childhood malaria have changed dramatically. In Tanzania, researchers have provided evidence to suggest that ideas and practices pertaining to *degedege*, the locally recognized "folk" illness, believed to be caused by a spirit attack, have changed significantly in the course of intensive health interventions. While the preferred course of action to deal with *degedege* traditionally has involved seeking the help of a *mganga*, recent studies have found that parents who believed that their children were suffering from *degedege* brought them first to a biomedical health-care facility (see Hausmann et al. 2002; Hetzel et al. 2007).

This book, then, is at once an analysis of the persistence of malaria in East Africa, and particularly in Tanzania, from a historical and ethnographic perspective, and an ethnographic representation of how global discourses and practices surrounding the way forward in malaria control or malaria elimination have affected the people of Tanzania, especially those who live in malaria-endemic areas. In doing so, I draw on recent scholarship on global health governance and neoliberal economic and health policies and their impact on local communities (Janes 2004; Janes and Corbett 2009; Pfeiffer and Chapman 2010). As with several medical anthropologists, I am concerned with larger issues of human suffering and how these are brought about by conjuncture of specific social and political relations (Farmer 1999; Green 2006; Moore 1999). Consistent with the scholarly work in critical medical anthropology that seeks to link wider social, economic, and political forces to local experiences of sickness and suffering—"suffering as experienced by subjects in 'local moral worlds' and asking what is at stake for them" (Kleinman and Kleinman 1991; see also Briggs and Mantini-Briggs 2003; Farmer 1999; Whyte 1997), I draw attention to the importance of the larger socioeconomic and political matrix in which malaria-related suffering is embedded. By exploring the persistence of childhood malaria in resource-poor communities as a form of structural violence that derives from historically situated structured inequality,[22] and the resultant human suffering, I illuminate the processes that are closely tied to structural inequalities, and hegemonic global discourses on malaria control that are increasingly becoming biomedicine-based, technological fixes. In addition to exploring the quotidian, everyday aspects of childhood malaria, such as symptom recognition and treatment-seeking behavior, this book is grounded in current anthropological theorizing on globalization, neoliberalism, social inequalities, and global health (Adams, Novotny, and Leslie 2008; Burawoy 2000; Comaroff and Comaroff 2001; Farmer 2003; Janes and Corbett 2009; Ong 2006; Ong and Collier 2005; Tsing 2005).[23]

Shifting Global Discourses since World War II

In 1955, the Eighth World Health Assembly (WHA) convened in Mexico City and formally launched the Global Malaria Eradication Program (GMEP). The mandate was clear: to follow a military style operation plan (preparation → attack → consolidation → and maintenance) with the final goal of eradicating malaria within three years. As the malaria historian Randall Packard (1998) has suggested, the decision to implement one of the most daring, yet controversial, programs spearheaded by the World Heath Organization (WHO) to eradicate malaria was based more on political expediency and less on solid epidemiological evidence. Key malariologists at that time argued that "there was no other logical choice" but to go ahead and implement the eradication program, without any further delay.

> Eradication had to be executed before the central weapon against malaria was no longer viable. The director general concluded that "there is . . . no other logical choice: malaria eradication is clearly indicated, presents a unique opportunity and should be implemented as rapidly as possible. Time is of the essence." The global strategy for the eradication of malaria was thus a race against time in which the WHO was gambling that malaria could be eliminated before vector resistance precluded this possibility. (Packard 2007:155)

The program relied on vector control, mainly indoor residual spraying, and systematic detection and treatment of cases. The twin pronged attack on malaria-transmitting mosquitoes and malarial parasites using the residual insecticide dichlorodiphenyltrichlorethane (DDT) and the antimalarial drug chloroquine was seen as the best strategy to eradicate malaria globally.

> Ultimately malaria eradication was buoyed by a growing faith in the ability of Western science and technology to transform underdeveloped countries. This faith was part of what has been called "the culture of development." The attitude of "know how and show how" emerged out of World War II and the myriad of technical innovations, from antibiotics to nuclear weapons, that the war had produced. (Packard 2007:156)

The initial impact of the GMEP was spectacular, particularly in South Asia.[24] However, for reasons that continue to perplex many malaria historians and malaria researchers today, Africa, the most malarious continent, was left out of the GMEP. Proponents of the GMEP put forth three main reasons for precluding Africa. First, the infrastructure necessary to implement the programs at the local level (spraying and distribution of chloroquine) was simply not in place. Second, key malariologists argued that implementing the program in Africa would mean interrupting naturally acquired immunity in the African adult and that would certainly be a catastrophe because the full implications of long-term shifts in mortality were not known. A later re-introduction of malaria would result in epidemics and high mortalities. They argued that unless there was a solid commitment of economic funds and political will to sustained antimalaria effort, it was unwise, and even immoral, to design an eradication intervention (see for details Dobson et al. 2000; Brown 1997). Third, most of the malariologists agreed that "time was of the essence," in that the eradication program had to be implemented, even it if meant excluding Africa, before the parasites developed resistance to chloroquine, and the mosquitoes developed resistance to DDT. By 1969, however, because of administrative, financial, and technical issues, including the rapid spread of insecticide and drug resistance, WHO concluded that it would be a futile exercise to continue with the GMEP. Thus, the dreams of the GMEP were short-lived, and the program died out in 1969, along with the hopes of achieving global eradication, and was reconfigured as the Global Malaria Control Program (GMCP) (Mills, Lubell, and Hanson 2008). The after-effects of the "immunity-related catastrophe" hypothesis that resulted in the exclusion of Africa from the GMEP, are being felt even today. "Today, the 'catastrophe' for Africa remains not a loss of immunity over the previous half century but the persistent and tremendous burden of malaria morbidity and mortality which, with the problem of increasing drug and insecticide-resistance, has risen to alarming and worrying proportions" (Dobson et al. 2000:164).[25]

From the mid-sixties, the term *eradication* was an anathema, brought up in conversations among international health specialists only in euphemistic terms or in historical discourse. While the HIV/AIDS epidemic in the 1980s became the focus of world attention, malaria as a global health problem receded into the background. Yet, an estimated 3 million people, 90 percent of them children under the age of five, were dying each year, mainly in Africa.[26] The shocking malaria morbidity and mortality figures on the African continent led twenty-eight heads of African states to meet in Abuja, Nigeria, in April 2000. They announced the Abuja Declaration, with the goal of ensuring that by 2005 at least 60 percent of those suffering from malaria would have access to affordable, appropriate, and timely treatment, and that the number of malaria-related deaths would be halved by 2010.[27] In 2002, however, only 20 percent of Tanzanian children with malarial symptoms obtained appropriate treatment within twenty-four hours, in contrast to a target of 60 percent set by African Heads of State. The WHO-led Roll Back Malaria program (RBM) was based on the goal of achieving these targets by emphasizing prompt and presumptive treatment of fevers in young children living in P. *falciparum*–endemic areas of Africa with effective antimalarials. The World Bank played a crucial role in supporting the RBM program; it had “the ability to direct massive funds toward malaria control. The funding of RBM interventions reflected a new emphasis on individual responsibility for health care and for the financing of malaria control measures” (Packard 2007:221). In 2007, the RBM partnership was discredited for having failed to achieve its stated goal. However, it was soon presented to the world in a different avatar, in a radically expanded funding environment. Some of the key donor initiatives that have contributed to the dramatic scale up of malaria control interventions include the Global Fund to Fight AIDS, TB and Malaria (GFATM), the World Bank Malaria Booster Programme (WBMBP), and the U.S. President’s Malaria Initiative (PMI). Anne Mills et al., however, note that “while bringing dramatically expanded resources for malaria control, this proliferation of global initiatives has placed new demands on programme managers in terms of coordination, reporting and accountability requirements” (2008:8).

In the Tanzanian context, the shifting global discourses on malaria control and funding patterns have had a decisive influence on how the government has rearticulated its malaria treatment policies. For one, it has increasingly calibrated its national malaria control programs to meet with global concerns, global initiatives, and global (donor) funding opportunities, as the more reasonable way forward in malaria control, rather than addressing concerns emanating from community-based studies that called for a more integrated approach focusing on poverty reduction (Muela Ribera and Hausmann-Muela 2011).

In retrospect, for malaria historians, the dynamics surrounding the RBM program and its deliberations were akin to those closely tied to the GMEP of the 1950s. As malaria historians Mary Dobson et al. (2000:5) have put it, "old strategies have been given new cloaks of approval." In other words, the fundamental emphasis on technology-based intervention in the 1950s to deal with malaria continues today: the large scale distribution of ITNs, diagnosis using rapid tests, treatment using artemisinin-based combination therapy (ACT),[28] and prevention/treatment of high-risk target groups such as pregnant women are seen as the way forward in malaria control, and ultimately its elimination. The goal of developing an effective vaccine against malaria is seen as one of the grand challenges in global health—a goal that has remained elusive for decades (Desowitz 1991; Turnbull 1989; Breman et al. 2004). The complexity of the malaria parasite is one of the foremost reasons why it has been so difficult to develop an effective vaccine against malaria.[29]

Malaria Elimination

According to what is now a well-known story, on October 17, 2007, at an invitation-only malaria conference held in Seattle, Washington, Bill and Melinda Gates surprised many malaria experts by announcing that their Foundation's goal was malaria eradication (Das and Horton 2010:1515).[30] They urged those who had assembled at the conference to take up the challenge to once and for all eradicate malaria from planet Earth. Margaret Chan, the WHO's director-general, immediately endorsed their challenge. In November 2007, the Roll Back Malaria Partnership endorsed the creation of a global malaria business plan to guide collective eradication efforts.[31] According to Richard Feachem et al. (2010:1566), a three-part strategy to eradicate malaria has been developed and is now widely endorsed. This strategy involves: (1) aggressive control in highly endemic countries, to achieve low transmission and mortality in countries that have the highest burden of disease and death; (2) progressive elimination of malaria from the endemic margins to shrink the malaria map; and (3) research into vaccines and improved drugs, diagnostics, insecticides, and other interventions, and into delivery methods that reach all at-risk populations.

Currently, Africa has become a testing ground for a range of interventions to control, eliminate, and ultimately eradicate malaria. Amid claims of success stories in Zanzibar, Rwanda, and Ethiopia, questions have been raised concerning the thorny issue of the generalizability of these highly focused, complex interventions aimed at "shrinking the malaria map" (see Feachem and the Malarial Elimination Group 2009). Skeptics have urged cautious optimism regarding the push toward malaria elimination. For example, the editors of the journal *The Lancet* cautioned readers that "pursuing malaria elimination will change priorities around treatment, chemoprevention, vector control, and vaccines . . . [that] elimination will be no easy task, will take a long time, and is potentially more costly than control" (Das and Horton 2010:1515).[32] More pointedly, they emphasized that "the quest for elimination must not distract existing good malaria control work. The danger of the Gates' call for a new era of elimination is that their immense funding power and influence . . . could cause damaging swings in funding and political priorities. . . . Good intentions could cause adverse and unanticipated harms" (Das and Horton 2010:1516). On a similar note, the malariologist Kevin Marsh cautioned those involved in malaria work that while it might be tempting to use external quick fixes, "such an approach would be fundamentally misguided" (Marsh 2010:1627; see also Feachem and Sabot 2008). Notwithstanding the renewed enthusiasm and funding geared toward dealing with malaria, there is also renewed concern among malaria researchers about the best way forward toward achieving the goal of malaria elimination.

As mentioned earlier, one of the goals of this book is to examine how global discourses and practices, including funding patterns and political priorities, affect communities that are most seriously affected by malaria. Notably, malaria is no longer categorized as a "tropical" disease; it is described as a "global killer" disease that is on par with other exceptional life-threatening infectious diseases such as HIV/AIDS and tuberculosis. Consequently, global discourses and practices pertaining to malaria control have dramatically shifted over the last few years, with unprecedented levels of funding and concerted efforts, all geared to once and for all "eradicating" or at least "eliminating" the scourge from this planet (Das and Horton 2010; Roll Back Malaria 2008; Snow et al. 2010).

Amid the renewed enthusiasm to deal with malaria directly by adopting a critical path method and removing technological roadblocks, the grim reality remains: despite billions of dollars spent to control malaria worldwide,[33] the disease affects millions of people annually and is responsible for the deaths of hundreds of thousands of children each year, mostly in Africa (Packard 2007; Stratton et al. 2008). Malaria is responsible for approximately 20 percent of all deaths among children less than five years of age in sub-Saharan Africa; malaria-related illnesses account for approximately

30 percent of all outpatient clinic visits within malaria-endemic countries of the sub-Saharan Africa region (Roll Back Malaria 2008). How, then, might one explain the persistence of malaria, particularly in sub-Saharan Africa, despite the fact that billions of dollars have been spent to deal with it?[34] Part of the explanation lies in the very approach that funding agencies and donors have adopted to deal with the problem—an approach that is based on technical fixes that are more individualized and less community-based—an approach that is increasingly vertical, intervention-specific, and invariably donor funded.

Neoliberalism, Responsibilization, and Decision Making

The current hegemonic global discourse on malaria control (or elimination) is couched in the fundamentals of a neoliberal approach, with its emphasis on individual responsibility rather than on advocating systemic changes, as the preferred mode of solving problems. The influence of neoliberalism, with its emphasis on promotion of free markets, free financial flows, privatization, small government, and economic deregulation, in international economic and health policy, has been well documented. While there is a rich literature on the impact of structural adjustment programs (SAPs) on health-care services in general (Chapman 2011; Foley 2010; Turshen 1999),[35] studies that demonstrate the "causal" link between SAPs or neoliberal economic and health policies and the persistence of malaria in Africa in particular have been elusive. This is because of, among other things, the very nature of malarial infection, which, unlike HIV/AIDS and tuberculosis, is in most cases, acute and not amenable to longitudinal case follow-up. Nonetheless, scholars such as C. Manfredi (1999) have elaborated on the mechanisms by which rising malaria rates in sub-Saharan Africa throughout the late twentieth century could be attributed to structural adjustment reforms:

> The devolution of the health sector led to a greater individual responsibility for malaria treatment and follow-up; rising income disparity and greater absolute poverty reinforced the tendency to self-medicate, while rising health-care costs delayed treatment-seeking for serious cases of malaria; economic deprivation led to environmental degradation and diverted the resources necessary to address environmental risk factors for malaria; and worsening women's health, resulting from the uneven allocation of household resources in scarce times, worsened child and infant health. While the relative significance of each pathway to malaria's rise

> in sub-Saharan Africa under structural adjustment is unknown, socioeconomic impoverishment probably undermined antimalaria efforts. Ultimately, the adverse population health consequences of structural adjustment reforms can be attributed to the failure of the international financing institutions to appreciate the links between development and health. (Manfredi 1999:389–390)

Neoliberalism, which generally refers to the ideology that advocates the dominance of a competition-driven market model, is predicated on the assumption that individuals in society are autonomous, self-reflexive, agentive actors (rationally constituted person) and that they are rational producers and consumers whose decisions are motivated primarily by economic or material concerns unencumbered by economic and social context in which they make their decisions (Farmer 2003; Harvey 2005; Wardlow 2006). Throughout this book, however, I use illustrative case studies and narratives to show how the social actions of individuals are often structurally constrained by certain "externally imposed institutional arrangements, or capitalist economic structures" (Wardlow 2006)—gendered structural arrangements—and how these often determine aspects of why people do what they do in their everyday lives. For example, in chapter 6, I provide illustrative examples to show how existing structural arrangements and gender inequalities are responsible for why the burden of child care and children's health disproportionately rests on single mothers. And in chapter 8, I show why, despite the availability of highly efficacious antimalarials and treatment in the private health sector, a large percentage of the people in Tanzania are unable to access these drugs (and resort to cheap, poor quality antimalarials) and services, by the very nature of their structural position (i.e., their poverty and marginalized status within the overall social structure). This is not to say that individuals, including the very poor, are not agentive actors in all contexts. I argue, however, that in many cases people's agency—actions that strengthen or oppose overt forms of domination—is often overestimated or exaggerated in contexts that are structurally constrained (Farmer 1999; Muela Ribera and Hausmann-Muela 2011).[36]

The process of privatization (a.k.a. marketization), which is at the core of neoliberal economics, refers to changes in the ownership of an enterprise, liberalization, deregulation, and a transfer of goods or services from the public to private sector. Typically, under this privatization arrangement, the government is expected to liberalize protected markets and encourage competition. It is assumed that this will increase efficiency, improve the quality of goods and services produced, and decrease unit costs. As Robert Nordyke and John Peabody (2002:940) note, the term *privatization* is subject to ambiguity and interpretation, especially in post-socialist contexts. When used in developed market economies, privatization typically denotes the transfer of public assets to private ownership. In a broadly defined sense, the term has additionally been used to describe any program from the limited introduction of market forces in particular industries to the total transformation of formerly planned economies. In their review of the literature on privatization in the context of developing countries, health economists Sara Bennett, Barbara McPhake, and Anne Mills (1997:5) make a distinction between incremental privatization, which is a largely unplanned response to the failure of the public sector, and programmed privatization, which originates from the implementation of pro–private government policies (see also Bennell 1997). Regardless of how privatization is defined, its principles are based on neoliberal economic theory, which emphasizes the role of market forces in the realignment of scarce resources and favors efficiency gains over equity distribution (Farmer 2003:5). In the health sector, the most common form of privatization is state withdrawal from offering free services.

Thus, one of the key issues explored in this book stems from a well-known debate between neoliberal economists who favor privatization and political economists and health activists who are critical of privatization and the introduction of "free market medicine" in third world countries. On one hand, proponents of the privatization of the health sector argue that it raises the efficiency and quality of health-care systems by liberalizing demand, diversifying supply, and improving incentives for stakeholders who supply and demand health-care services (Nordyke and Peabody 2002:939). More specifically, the proponents argue, on one hand, that charging user fees in public health facilities has an efficiency-enhancing effect because it rationalizes attendance, discourages frivolous consultations, and forces patients to use the referral system for specialized care (Mwabu 2001; Turshen 1999:35). On the other hand, many scholars have been critical of the moves that governments in developing countries have made to privatize the health sector in accordance with the World Bank and the International Monetary Fund (IMF) mandate. For these scholars, it is clear that World Bank and IMF-inspired structural adjustment programs (a.k.a. the "Washington Consensus")[37] and the privatization of health care have had a devastating effect on the survival, health, and well-being of the poor, the sick, and women and children who are most in need of health-care services (see Bassett et al. 2000; Cassels 1995;

Lugalla 1995a; 1995b; Oxfam International 2009; Pfeiffer and Chapman 2010).[38] As Brooke Schoepf et al. have argued, "Shrinking access to health care and deteriorating quality of care available, both direct results of SAP policies, leave the poor increasingly exposed to suffering and death that relatively modest health expenditures could prevent" (2000, 112).

In essence, neoliberal economic policies disproportionately heighten the vulnerability of poor and marginalized people, especially women, children, and the elderly (Bassett, Bijlmakers, and Sanders 2000; Bissell 2005; Briggs and Mantini-Briggs 2003; Farmer 1999; 2003; Ferguson 2006; Foley 2010; Gysels et al. 2002; Janes 2004; Lugalla 1995a, 1995b; 1997; Manjate et al. 2000; Pfeiffer 2002; 2004; Sanders 2001; Setel 1999; Turshen 1999). In theory, neoliberal structural-adjustment policies are introduced on the assumption that the proximate austerity measures, including the devaluation of currencies, the deregulation of internal and external trade, the reduction of state bureaucracies, and the privatization of state and parastatal industries, will lead to long term gains (Ferguson 2006; Sabea 2001). Privatization practices within the health sector such as those witnessed in Tanzania were not meant to be implemented alone but, rather, were meant to be couched within a range of safety nets, including third-party insurance schemes, sickness funds, and social security systems (Turshen 1999; Swantz 1997; Mwabu 2001). Because these systems are either currently not fully in place or are inadequately implemented, poor and marginalized people in Tanzania have little choice but to bemoan the ongoing changes in their political, economic, and social lives, and to deal with the consequences of this lack of safety nets.

Neoliberal economic reforms often fall short of their ostensibly humanistic goals because of their one-sided emphasis on economic or material concerns, which, in turn, neglects the importance of people's social and cultural lives. Since 1991, the Tanzanian government has encouraged the growth of the private health sector by allowing entrepreneurs to set up private health clinics and private retail pharmacies. It has also introduced user fees at public health facilities. However, it has not adequately implemented the mandatory safety net programs, and it has not undertaken concomitant, worthwhile poverty alleviation and employment generation programs to improve the purchasing power of those who are most in need of health care. For the majority of the people in the region of Tanzania where I conducted my fieldwork, the reforms introduced by the government during the postsocialist period have not improved their economic and social well-being. As Todd Sanders has observed: "For a great many Tanzanians, these are times of austerity, not prosperity" (2008:33). Elderly men and women, in particular, repeatedly and nostalgically told me that they were worse off now than during the 1970s and the 1980s. Nostalgia, after all, involves the longing for something that cannot be restored, something dead and gone (Bissell 2005:225). While one could certainly argue that their longing may be for a socialism of the kind that never existed, or for a type of socialism that will never realize its potential (see Kamat 2008; Pitcher and Askew 2006:8), it is more germane to recognize the fact that their talk of the idealized cultural and historical past is essentially a critical moral commentary on the present. This commentary implies a life out of balance—one that has drastically changed for the worse. Their stories of woe intimate how the harsh realities of neoliberal restructuring have *not* enabled them to better their lives.

In summary, my main concern in this book is to make a case for why malaria must be examined as an economic, political, and social problem, and not just a mosquito-borne infectious disease that is amenable to biomedical interventions. Political and sociocultural factors are central in determining malaria risk and its persistence. Therefore, there is a need to pay attention to social factors such as gender, marginalization, and inequity that constrain individuals' choices and their ability to exercise those choices in illness prevention and treatment. At the community level, the most economically marginalized populations are at greatest risk for malaria because of limited resources, including lack of proper housing, access to education, health-care facilities, and good quality health care. Placing the burden of controlling the disease on individuals and families and overlooking the structural conditions that made them vulnerable to malarial infection is unlikely to lead to the achievement of the lofty goal of malaria elimination, at least in the foreseeable future. There is substantial ethnographic evidence to show how neoliberal economic and social policies have fostered tremendous increases in social inequality, and how the growing hegemony of corporations and the financial sector have augmented the role of institutions that police the lives of the poor. More specifically, "bureaucracies across the globe have taken on the job of generating ideologies and practices that construct inequality in ways that transfer responsibility for human misery from international organizations, states, and corporations onto the shoulders of poor citizens" (Briggs and Mantini-Briggs 2003:309–312). Finally, as Leeanne Stratton et al. have asserted, "If the Millennium Development Goal to reduce malaria incidence by 2015 is to be met, a long-term view and comprehensive approach is necessary. There is an urgent need for a sustained multilateral and multisectoral commitment to addressing malaria as a disease of poverty and structural global inequality. A focus on poverty reduction along with investments in the environment, health-care systems, and malaria research will lay the foundation for sustainable change" (2008:860).

At a time when disease-focused, vertical interventions and funding models have reemerged as the dominant mode in global health, this call for the revitalization of the basics to address global health problems resonates with the sentiments of most medical anthropologists committed to health and social justice. For most medical anthropologists of my generation, it is reminiscent of the wisdom contained in the Alma-Ata Declaration of 1978, and the comprehensive versus selective primary health-care debates that followed, in which medical anthropologists played a crucial role (Janes 2004; Rifkin and Walt 1986). Thus, while one might argue that the counter-discourse found in the writings of scholars like Stratton et al. (2008), is "old wine in a new bottle," the relevance of their analysis and disposition toward malaria control is as critical today as it would have been three or four decades ago. From an anthropological perspective, the challenge today, as in the past, is to articulate the relevance of these analyses in local contexts—to bring the local lived realities to the attention of "the global" so that global discourses and practices are in accord with what happens in "local communities."

Plan of the Book

The literature on malaria is enormous and continues to expand further in light of renewed advances made in the biomedical and molecular aspects of the disease, and also, more recently in the wake of Bill and Melinda Gates' inspired call for malaria elimination. However, detailed ethnographic studies on malaria that trace the global-local configuration, cultural nuances, meanings, and human experiences of the illness are missing. Much of the social science and anthropological literature on malaria has focused on the language of illness, cultural meanings and interpretations associated with certain illness categories, and the socioeconomic context of treatment-seeking behaviors and practices. This book, however, challenges conventional anthropological approaches to the study of childhood malaria, with its focus on belief systems and practices, by emphasizing and demonstrating how the study of childhood malaria "locally" is de facto the study of global discourses and practices surrounding malaria control and malaria elimination.

Each of the following chapters concentrates on a particular analytical problem or theme that is relevant to the book's main focus: global neoliberal discourses on malaria and their impact on local communities. In chapter 2, I describe the fieldwork setting: the topography, the people, and the oral history of the villages where I conducted fieldwork, particularly Mbande, a large predominantly Muslim village, which I used as a homebase during most of my fieldwork, the people, the linguistic, and cultural heterogeneity of the community, and some of their cultural practices. I present excerpts from life stories of particular individuals and situate them in the larger context of neoliberal economic reforms to illustrate how ordinary people understand and interpret the social transformation that has taken place in Tanzania since the mid-1980s.

In chapter 3, I examine the history of Tanzania's socialist past. I review the scholarly literature focusing on the factors leading to the country's ideological shift in favor of neoliberal economic policies in 1991, the privatization of the health sector, and the introduction of user fees. I provide a brief history of how health care in Tanzania, which until recently was "socialized," became privatized, commercialized, and pluralized. Using stories elicited from elders who were witness to the *ujamaa* era and structural changes that ensued, I introduce the reader to the cultural meanings of "life is hard" (*maisha magumu*)—a pervasive theme in the narratives analyzed in this book.

Chapter 4 hones in on a crucial question: why do some mothers and caretakers delay in seeking help, while others take their sick children to a biomedical health facility promptly, often within twenty-four hours after the onset of fever? Through concrete examples and ethnographic analysis, I illustrate the treatment decision-making process surrounding what many mothers and caretakers regard as an "ordinary fever" (*homa ya kawaida*). I show how, in addition to economic considerations, cultural knowledge about disease etiology, symptomatology and treatment, and factors of gender, power relations, and styles of communication between health-care providers and patients, all interact to influence and produce particular patterns of treatment-seeking behaviors and outcome for childhood malaria.

I continue with the discussion on therapy-seeking in chapter 5, with a focus on degedege. In analyzing the narratives of three bereaved parents surrounding their child's fatal illness, I explain why, even though cultural knowledge and etiological beliefs about degedege may be shared locally, there is significant variation in the therapeutic pathways that parents follow to deal with an actual episode of the illness. As such, the chapter highlights the importance of the social context and contingent circumstances, including poverty and lack of resources that prompt parents to make certain decisions when dealing with their sick children, often resulting in tragic consequences.

In chapter 6, I broaden the discussion on the social context of childhood malaria to illustrate the social conditions and structural aspects that predispose certain people, even within poor communities, to experience the debilitating effects of childhood malaria more intensely than others. I focus on poor women, many of them single mothers, who live in an increasingly insecure social and economic environment, and ask the question: How does childhood malaria affect the everyday lives of single mothers who have to care for their children often in the context of very limited social support? The chapter brings to light the structural constraints that affect single mothers, their experiences of gender inequality, economic vulnerability, social suffering, and their survival strategies in the historical and political context of gender-power relationships and socioeconomic transformation that has occurred in Tanzania since the early 1990s.

Chapter 7 is about the politics of malaria treatment policies. Mainly through stories, personal encounters, and excerpts from illness narratives, I document people's perceptions of the changing malaria treatment guidelines and how these have affected their therapy-seeking strategies for childhood malaria. Demonstrating the range of variations that exists in perceptions of antimalarials even within small communities, I show why health planners need to be cautious about their assumptions regarding the efficacy and acceptability of globally mandated antimalarials at the local level. This is especially important at a time when global funding agencies and partnerships have invested enormous resources in the scaling-up of artemisinin-based combination therapies (ACTs).

Finally, chapter 8 focuses on pharmaceutical governance and the pharmaceuticalization of malaria control. Since mid-2008, policy makers in Tanzania have been seriously considering allowing private pharmacies to stock and sell ACTs and rapid diagnostic tests (RDTs) as a cost-saving measure and a strategy against indiscriminate prescriptions for ACTs. While the move to "proactively partner" with private pharmacies represents an important shift in Tanzania's malaria control policy, I argue that this strategy skirts the real problem by not acknowledging the complex global "pharmaceutical nexus" that is driving the antimalarials market. I provide an ethnographic perspective into how the new policy is being translated into practice, and the extent to which the recent initiatives have potentially further medicalized and pharmaceuticalized Tanzania's malaria program.

I conclude by returning to some of the key themes explored in the preceding chapters and reiterate that the seemingly well-intentioned malaria control initiatives ignore important social and economic realities, and thereby obfuscate the fundamental reasons why malaria is still a persistent health problem, especially in sub-Saharan Africa. I reflect on (a) the limitations of the recent trends in efficiency-based rationality in global health, marked by initiatives such as the large-scale deployment of ACTs and RDTs as the way forward in malaria control; (b) the lessons that can be drawn from the present ethnographic case study, with its focus on childhood malaria in Tanzania, and made applicable to other countries in East Africa (Kenya and Uganda in particular) and perhaps to other parts of Africa; and (c) the scope for medical anthropologists to provide critical perspectives to those who have drawn the roadmap to malaria eradication. Against this introductory backdrop, the next chapter provides the reader with an overview of the research setting and the social, cultural, and political context of the villages where I conducted ethnographic research that forms the basis of this book.

CHAPTER TWO

Locating the Field

Official stories of structural adjustment tell of a better life for all Tanzanians found in The Free Market, and in a world of expanded and expanding horizons and opportunities that accompany it. This "opening up" is natural, rational and so obviously amoral and desirable that it scarcely merits attention, let alone discussion. From the sidelines, ordinary Tanzanians tell a decidedly different story of the present. . . . This is a present of ever-increasing uncertainty, where hard questions must be asked, and tough choices be made.

TODD SANDERS 2001:179

But the stories that anthropologists tell from the field overwhelmingly speak to a new intensity of immiseration produced by adjustment programs that have ravaged public sector services for the poor.

JAMES PFEIFFER AND RACHEL CHAPMAN 2010:150

Mainland Tanzania is administratively divided into twenty-six regions (*mkoa*), and each region is further divided into districts (*wilaya*) and wards (*kata*). The Dar es Salaam region is divided into three districts: Kinondoni, Ilala, and Temeke, which is the largest of the three districts. It has an area of 407 square miles and, as of 2007, a population of 886,529. Temeke district is comprised of sixteen wards. One-third of the district is urban and another one-third is peri-urban—a mix of urban and rural setting. The remaining larger section of the district is predominantly rural. Of the three districts, Temeke has the largest underserved population and the least developed health facilities, roads, water, power supply, and organizational infrastructure. It is ethnically heterogeneous, with at least forty-five ethnic groups co-residing in the district (Tripp 1997).[1] The Zaramo, 98 percent of whom are Muslims, are the original settlers and the largest ethnic group in the district.

I chose Temeke district as the site for my fieldwork because the district's socioeconomic profile was well suited to my general theoretical concerns about health-care-seeking among the poor in the context of social transformation and my expectations about working at the margins of urban Tanzania. Moreover, the district's ethnic heterogeneity, the absence of the South Asian and expatriate communities, and the predominance of the Wazaramo ethnic community, were also important considerations. I conducted most of my fieldwork in the Chamazi ward on the district's periphery. Within the Chamazi ward, I initially concentrated my fieldwork in an ethnically heterogeneous village called Mbande.[2] Mbande was also my home base from which I did additional research in the surrounding smaller villages and hamlets. Mbande is located about thirty miles south of downtown Dar es Salaam, and about twelve miles inland from the coast. I conducted continuous fieldwork from August 2000 to September 2001 in the Chamazi ward,[3] followed by several short research-related visits of eight to ten weeks every summer from 2005 to 2010, totaling about thirty months of field research.[4] This length of time afforded me an advantage that stems from doing ethnographic research over an extended period; it allowed me to stay in touch with the people in the fieldwork site over several years and follow developments in their lives (see Whyte 1997). In this chapter, I provide a brief history of the main village, and then describe the physical, social, and political landscape in which people lead their everyday lives. This chapter sets the stage for an examination of the particularities of the locality that shape social relations and local responses to global neoliberal discourses and practices pertaining to health in general and malaria in particular.

Tales from the Past

Mzee Mlanzi was a poor farmer who lived on the village's periphery. He was in his early sixties when I first met him at the *baraza*, a hangout next to a small tea stall located in the center of the village market (*soko* or *magenge*). He was engaged in an intense debate with a group of village elders on the advantages and disadvantages of Tanzania's decision to abandon its one-party system and embrace a multiparty democratic system. Bedraggled in appearance, thin, bony, almost half-blind because of untreated cataracts in both his eyes, he was a well-known figure in the village. Despite his animated, argumentative style of engaging in political conversations, he was better known for his skills as a peacemaker, especially in land-related disputes, which were rare. In a life story interview I conducted with him in August 2000 at his home in Mbande, he told me that he was a Ndengereko who had migrated into Dar es Salaam in the early 1970s from his native village in Rufiji, after the government had dismantled it as part of the Operation Vijijini or Villagization program. He spoke of Mbande as a very different place in the 1970s. He recounted:

> We were in a bush . . . in the middle of nowhere. Mbande was a jungle. There were very few houses. Each household had a thatched (*makuti*) house on the farm (*shamba*). In order to go from one house to another, we had to traverse through the jungle. If it was about 8:00 p.m. and you were still in the neighboring Chamazi village, then you might as well decide to sleep there, because if you tried to come back to Mbande, you would be dead. Wild animals, especially lions, would be roaming at that time. Yes, Mbande had a lot of wild animals then. I remember a lion mauled Mzee Mpele's daughter. She was on her way to her grandfather's house . . . she wanted to spend the night at his place and it was about 8:00 p.m. when a lion attacked her. Fortunately, her father was very courageous and fought the lion. He saved his daughter, but she was badly injured. And at Mzee Mzingu's place, a lion ate someone else. Mzee Majumba buried the human remains at the same spot where the lion had eaten him. Yes, he was the only one who stayed back to bury the human remains; everyone else ran away!

As I continued to conduct life history interviews with mainly elderly men and women in the village, with the help of two of my research assistants, Mzee Ali and Bi Mwanakombo, I realized that stories featuring a lion, leopard, or cheetah (*chui*) attack on humans were part of the local lore. The telling of such stories had a mixed message. On one hand, these stories were meant to convey to me and to other listeners the message that the people of Mbande had come a long way from "living in the jungle" a few years ago; they had "developed," and they were not "primitive" people of the jungle (*watu wa porini*) anymore. On the other hand, people told these stories to lament the excessive environmental degradation, the deforestation, the depletion of vegetation, and the decreased access to natural resources and the wildlife (*wanyama*) that were once part of the local people's daily existence. An elderly man from the Makonde community, whom I met regularly at one of the local "traditional" healer's (*mganga*) residence, bitterly complained that during the "good old days" he would randomly shoot an arrow in the trees and a monkey would fall. "Life has become very hard now" (*siku hizi maisha imekua magumu sana*), he said. He had to walk for three to four hours in search of wildlife (mostly monkeys and bush babies), and he would consider himself very lucky if he were able to return home with a kill. Such stories of woe are significant because they demonstrate the different, metaphorical ways in which the people interpret their experiences and express their responses to the rapidly shifting economic, political, and social terrain.

People emphasized that there was a fundamental difference in their everyday lives during "the past," which was most commonly defined as the "Nyerere era" or *kipindi cha nyuma* or *kipindi cha* Nyerere (the 1960s and early 1970s), and how they experience their lives now, where everyone is preoccupied with their material life-world, eager for money and the commodities that are on display in shops and markets everywhere. In the process people have become greedy (*wana tamaa*), selfish, self-centered, and less trustworthy, and this in turn has led to an increase in feelings of resentment, especially between members of different generations. Gone are those days of social and economic reciprocity when one could call upon a neighbor or a kin to carry out their social obligations by harvesting crops, fixing roofs, or providing childcare. Biti Janja, one of the oldest surviving Zaramo residents of Mbande, who resented her son's individualistic, selfish, and uncaring behavior complained to me during an interview: "Even my own son expects me to pay him money to fix my roof. Now tell me where do I have that kind of money?! I'm a poor widow. People have really lost their soul, including my own son!" Biti Janja's son Shabani, in turn, would laugh off his mother's complaints saying that he too needed money to support his family and survive. After all, his mother owned a lot of land in the village, whereas he was living in a small hut adjacent to his mother's new brick house. As Holly Wardlow has noted in a different ethnographic context, "Such tensions are exacerbated in a contemporary context in which there are more things to want, in which money is increasingly needed for everyday life, and in which some people have money and others do not" (2006:36; see also Sanders 2008). Narrators' oral life histories revealed the ways in which the transition from Tanzania's unique form of socialism (*ujamaa*) to Western-styled neoliberalism has led to the erosion of social cohesion at the community level, disrupted existing social support networks, and significantly delimited access to affordable health care. Some of the elderly people I interviewed in Mbande embodied their suffering while others narratized their misfortunes to make sense of their health problems and suffering and respond to the rapidly shifting economic, political, and moral terrain. Nearly all my interviews and casual conversations with the elderly people in Mbande were replete with complaints about their hardships, the loss of respect for the elderly, their health problems, and how difficult it was these days to make a living.[5] In everyday conversations about the "human condition" (*hali ya binadamu*) and development (*maendeleo*) projects in Tanzania, the common refrain was: "*hela, hela, hela tu; kila mahali hela!*" "Money, money, money; any place you go, it's all about money!"

Birth of an *Ujamaa* Village

Mbande came into existence in 1974 during Operation Vijijini. As a state-designated registered *ujamaa* village, Mbande's history is a little more than three decades old. The people of Mbande share a common history with hundreds of other villages that were started during the Operation through the agglomeration of individual households into larger units.[6] When I began my fieldwork in Mbande in August 2000, the village was relatively small with a core population of around 1,500, with an additional almost 5,000 who lived in several smaller satellite villages and hamlets within a one-mile radius. Mbande's population was relatively stable until January 2007, when electricity finally arrived in the village. Local politicians had been lobbying for electricity in the village since 1996 when the all-weather road was completed, but to no avail. It was rumored that international cell phone service providers who wanted to install their towers in Mbande and neighboring villages had more successfully lobbied for electricity in the Chamazi ward. Following the arrival of electricity, Mbande's population increased dramatically, mainly due to in-migration. What was once a small village on the periphery of Dar es Salaam's Temeke district, with more than 90 percent of the houses made of mud and wattle, with thatched roofs, soon resembled one of the many small towns in Tanzania, with a very busy marketplace featuring several kiosks, a *daladala* bus stand, and conspicuous cell phone towers installed by the country's four major service providers—Vodafone, Zantel, Tigo, and Airtel.

Although Mbande's physical and population configuration changed dramatically, particularly since the arrival of electricity in the village in 2007, clusters of houses in the village were still being locally referred to as the *sehemu ya Wamakonde* (the area of *Wamakonde*), the *Wamatumbi* area, the *Wamgindo* area, and so forth. These cultural spaces indexed areas where households from certain ethnic and linguistic groups (*makabila*) had settled down together in the village during the Operation. The completion of an all-weather road in 1996 marked the beginning of a new wave of migrants into the village, mostly from northwestern Tanzania.

Figure 1. Elderly Zaramo men relaxing after lunch. Photo by author.

fabric of what was ostensibly an *ujamaa* community organized around the principles of reciprocity and oneness.

In the household socioeconomic and health survey that I conducted in Mbande in 2001, of the 95 percent of the local residents who were Muslim, 40 percent identified themselves as Zaramo, who are widely regarded as the original inhabitants of the Dar es Salaam region (Swantz 1995; Tripp 1997). Over the years, given the influx of people from northwest Tanzania into Mbande, the proportion of the Zaramo people in the village had dwindled. Although the Zaramo constituted the largest ethnic group in the village, members from at least forty-two other *kabila* resided along with them. Hence, this book is not so much about the "Zaramo people" or the "Zaramo culture," but a heterogeneous ethnic community whose changing configuration underscores the realities of the social transformation taking place in contemporary Tanzania.[7]

The Local Economy

At the time of my main fieldwork from 2000 to 2001, subsistence-oriented farming was the economic base for the majority of the local people, while an increasing number of villagers were engaged in small business ventures, such as the selling of *chapatis*, tea, fruits and vegetables, and secondhand clothing (*mitumba*) in the marketplace. Even so, for the majority of the people in the village, opportunities to acquire cash remained meager and therefore cash income was scarce. The 2001 household survey revealed that the average per capita, per month cash income in the village was approximately Tsh. 1475 (less than US$2).[8] In other words, several households would survive for weeks and months with little or no cash income—a reality that other anthropologists working in Tanzania have also documented (see Sanders 2001; Seppala 1998).

Cash crops, such as cashew (*korosho*), coconut (*nazi*), jackfruit (*fanasi*), and mango (*maembe*) trees, were numerous, but local demand for these items was low. Those who owned more than one acre of land usually had a plot of cashew trees, a few coconut trees, and pineapple and papaya trees, in addition to a food plot in the nearby valley (*bondeni*). The cultivation of crops was based on hoe (*jembe*) agriculture on small plots of land. The only evidence of any form of mechanized agricultural practice in this region involved the use of a pesticide spray pump. Furthermore, people were almost entirely dependent on rain as the water source for their agricultural activities. They grew corn (*muhindi*), paddy/rice (*mpunga/mchele*), cassava (*muhogo*), kidney beans (*maharagwe*), millet (*mtama*), beans (*kunde*), potatoes (*viazi*), and legumes (*bazi*), mostly for domestic consumption. Rice cultivation was done in the *bondeni*. A large number of households grew cassava in the backyard and/or front yard. In the neighboring hilly region, absentee landowners had brought vast tracts of land under cassava cultivation. Only a small fraction of the residents' livelihood came from marketing surplus produce. As noted above, for the majority of the people, cash income was scarce. Vendors who worked in groups regularly carried between 75 and 100 tender coconuts (*madafu*) on a bicycle, and made the tedious, backbreaking two-hour journey to the city center where they sold the coconuts for 200–500 Tsh. (about 20–40 cents) a piece (2001–2006 prices).

In 2000, when I started my fieldwork in the main village, there were only five retail shops that sold grocery and sundry items, including soft drinks. Businesspersons who lived elsewhere owned three of these shops. It was clear that productive investment in the village was low. Even if one were to invest in a shop selling groceries or sundry items, the returns were so small (because people had very little disposable household incomes) that it did not make economic sense to invest one's cash capital in Mbande. Only a small fraction of the residents were engaged in petty business (*biashara ndogo*) in the marketplace. Income-generating activities included selling peanuts (*karanga*), bread, tea, and fruits and vegetables.

Older people, especially women, sold chapattis, bread, cakes, deep fried cassava and sweet potato, and other foods in the marketplace by the roadside in the morning and late evening hours and in front of the local primary school during the afternoon. For the most part, in 2010, the scenario remained unchanged, except that the same activities were being carried out on a much larger scale, owing to the dramatic increase in Mbande's population.

Few villagers, particularly those who lived on the outskirts of Mbande, grew and traded in vegetables (i.e., marketing vegetables to the urban markets). Many people were engaged in a couple of different economic activities, but in most cases, secondary economic activities were carried out merely as a means to make a small profit that was enough to buy sugar, tea, and soap. In 2001, the village had only two young men who specialized in carpentry work, because there was very little demand for carpentry work in the village. With the increasing number of *matofali* houses (cement brick houses) in the village, the demand for custom-made wooden doors, window frames, and roofing had significantly increased. These two carpenters worked by commission and a customer usually provided the wood. Because government agents closely monitored the ever-increasing deforestation, it was increasingly difficult for people to fetch wood from the forest without having to pay for it. In 2009 when I did some additional health research in the village, it had more than two-dozen carpenters and masons—*fundi* (pl. *mafundi*), their numbers had quadrupled in a matter of four or five years.

For the people of Mbande, the pressure to muster cash in order to meet the basic necessities was intense, as was the need to cover the cost of some obligatory social event (e.g., ritual celebrations, ancestral obligations, puberty rituals, marriage ceremonies (*mashughuli*), and other family events that frequently require considerable sums of cash). It is important to note here that as with most rural settings, a portion of Mbande's economy was outside the monetary sector. Hence, many transactions that included services and cultural valuables involved indirect payment. For example, with regard to reciprocity obligation, one's neighbor or a relative was called on to help in harvesting crops, and in return for the labor provided, the neighbor or relative was given a portion of the harvested crop. However, given the transformation taking place in what was originally an *ujamaa* village, there was a growing demand for nonlocal products, and with this change, the demand for cash in return for service, increased.

Other income-generating activities included making brooms, tapping palm wine, stripping *raffia* from dried palm frond in order to weave mats (*mkeka/jamvi*), and buying sundry items wholesale from the city and selling them on a retail basis at the village level. In 2000, during the first weeks of my fieldwork, a small number of enterprising young women had invested about 10,000 Tsh. (US$12) into buying second-hand clothes, gowns, and *kangas* from traders in the city. They were selling these to friends and neighbors with easy payment schemes. The number of women engaged in the *kanga* business had multiplied manifold over the years, but the profit margin for all of these petty business activities remained very low. As Pekka Seppala (1998) has noted in the context of southeastern Tanzania, the low price level of local products can be partly explained by the fact that the producers systematically undermine the value of their own labor. Thus, for example, women who are engaged in the production of homemade mats put in considerable amounts of time in collecting fibers, making them smooth, and coloring and weaving them into mats, and yet they sell them at a very low price. Women in Mbande sold beautiful full-length *mkeka/jamvi* for less than Tsh. 5,000 or US$4. "This is because women who engage in the activity classify the labor effort within the bottomless pit called "domestic chores" (Seppala 1998:151).

Although Mbande was predominantly a Muslim village, and Islamic culture prohibits the consumption of alcohol, the number of bars that served liquor had steadily grown in the village. While in 2000 there were four bars or "pubs" that were owned and operated by Makonde Christian women who brewed the *pombe*, their numbers had grown to ten in 2009, with two such bars designed as a "guest house" complete with five to ten independent (self-contained) rooms. The regular bars sold mostly coconut beer—*pombe* and *gongo* (the stronger version) as well as some of the popular bottled African beers—in the late evening hours. All the new bar owners were Chagga, originally from the Arusha region in northern Tanzania.

Village Infrastructure and Living Conditions

HOUSING. In 2000, nearly 90 percent of the people in Mbande were living in their own houses, which were mostly wattle-and-daub houses with thatched roofs made of palm fronds or coconut tree leaves and/or dry grass. Those who could afford to replace their *makuti* roofs with corrugated iron sheets (*mabati*), did so by spending Tsh. 4,500 (US$1 = 800 in 2000) per sheet of iron. For the majority of the local residents, *mabati* roofs were far too expensive, as everyday economic necessities took priority. Most households had a small kitchen hut (a thatched hut with a hearth made of three stones—*ukumbi* or *mafiga matatu*) outside the main house, and a roofless pit latrine (*choo*), with a closure made of palm fronds, which may or may not be shared among neighbors. According to the census data that I gathered in 2000, 95 percent of the households had access to a pit latrine. Since 2001, the village witnessed the growing popularity of *matofali* houses that are built with prestressed bricks made with a mixture of sand and cement. *Matofali* houses became extremely popular because of the protection and prestige they offer. However, given the cost involved in building a *matofali* house, for the majority of the people in Mbande who did not have assets to sell, such a house was likely to remain an unfulfilled dream. Nearly all of those who owned *matofali* houses had raised the money for the project by selling a substantial portion of their land. By 2009, however, nearly 90 percent of the houses in Mbande were made of *matofali*, most of them built by recent migrants to the village or absentee landlords. The number of *matofali* houses had quadrupled in a matter of five to six years, radically changing the village's profile. Tracks in the village that I was familiar with, and which allowed me to "cut short" the walking distance, had all but disappeared. Mbande resembled a small town, with more than 50 percent of its population comprised of people who had immigrated into the village in the last five or six years.

WATER AND ELECTRICITY. Safe drinking water in Mbande is privatized and sold at a price. The first of the three borewells in the village was dug and fitted with a hand pump in the year 2000, nearly twenty-five years after the founding of the village. The central part of Mbande has three wells fitted with hand pumps. However, because one has to pay for the water (Tsh. 10 a bucket/jerry can in 2000; Tsh. 50 in 2009), people continue to draw water from the local wells. According to the census data I gathered in 2000, while 41 percent of the households relied exclusively on one of the borewells for drinking water, 58 percent used a community well as the primary source of water. Only five households relied on both a community well and a borewell for their water supply.

Finally, as noted earlier, the people of Mbande did not have access to electricity until January 2007. None of the houses had a solar panel, and the ones that were installed on the dispensary's roof when it was built were stolen within the first week. Thus, during the time I was doing my main fieldwork in Mbande, most of the local residents would go to bed by 9:30 p.m. (3:30 p.m. Swahili time). Those who stayed up either sat in the dark or in the flickering light of a little kerosene wick-lamp. Since 2007, with an increasing number of houses being supplied with electricity, local notions of space and place have changed dramatically. The main marketplace is open late into the evening, as are the local bars. In some, more affluent

Figure 2. Qur'anic school. Photo by author.

homes, people commonly huddle around a television set after the evening meal. Nearly all these households are recent immigrants who purchased plots of land and built large *matofali* houses.

SCHOOL. The people of Mbande take great pride in the only primary school in the village. As noted earlier, in 1976, after the founding of the village, the government helped the villagers to construct a modest school building. In 1995, with funding from a Danish nongovernmental organization (NGO), the school was remodeled into an impressive building that offers classes to local children (both boys and girls) up until the highest primary level (7th grade). This is not to suggest that all of Mbande's eligible children attend this school. While school enrollment in Mbande in 2000 was reasonably good, I gathered only impressionistic data on the quality of the education provided at the school. In addition to the primary school, Mbande also had a Qur'anic (or Koranic) school, which was held under a mango tree near the old mosque. On any given day, at least fifty children (boys and girls) attended the Qur'anic school. Those who attended did not attend the government-run primary school, and vice versa. Religious and political leaders saw no contradiction in children being sent to one school and not the other, as moral education was as important as formal "commercial" education. As Mzee Wahid, the *Shehe* (Qur'anic teacher) at the local mosque explained to me in an interview: "Being a good human being and a good moral person is as important as being successful in the commercial world where formal education is important." Although Mbande did not have a secondary school, in 2005, an enterprising family from Dar es Salaam invested in building a large private secondary school in the neighboring village of Kisewe, complete with boarding facilities for the students, a school bus, and uniforms. Significantly, more than 90 percent of the children who attended the private secondary school in Kisewe were nonresidents of Mbande. The private school catered to less than 10 percent of the school-going children of Mbande, given that the private school charged fees that were beyond the means of most parents.

Local Health Arena

The local health arena was pluralistic as villagers had access to traditional Swahili medicine as well as biomedicine and pharmaceuticals, provided they were able to pay for therapy. The village dispensary (*zahanati*) was located five minutes walking distance from the marketplace. It was staffed by an experienced medical officer and three nurses, two of whom were mother and child health specialists (MCH), and the other an auxiliary trainee nurse. The dispensary was originally a one-room structure built in 1976. It was remodeled and refurbished in 1997 under the health sector reforms program and funded through the Urban Health Program and an NGO from The Netherlands. The dispensary had four rooms, a spacious veranda with a seating area that acted like a waiting room for patients, residential quarters for the doctor and MCH nurses, a public toilet, a borewell, and plenty of space for the dispensary to be expanded into a full-fledged ten-bed mother and child health center. The villagers referred to the dispensary as the *hospitali*. However, when they did so, they referred specifically to the left wing of the dispensary building where patients were received, examined, and treated. The MCH clinic, which occupied the right wing of the building, was referred to as the *kliniki*. A doctor and three nurses staffed the dispensary, which was considered the lowest rung of the urban health-care system. A system of user fees had been in place since 1996. Notably, although user fees were collected from all patients (MCH services such as immunization shots were provided free of cost), patients were not required to immediately pay the fees. Instead, services were often provided on credit. In other words, patients were rarely turned away or refused treatment or services just because they had not brought with them the required fees. All health activities provided by the dispensary were offered only at the site of the dispensary. While the majority of

Figure 3. Dispensary in 2002. Photo by author.

the patients who came to the dispensary did get some treatment, there was also a good referral system in place for patients. Cases of acute respiratory illness (ARI), which were deemed complicated and could not be treated at the dispensary, were regularly referred to the Temeke district hospital. In case of an emergency, it was possible for the villagers to reach the district hospital in about an hour using a *daladala* bus, and faster if one could afford to pay for a taxi.

In 2005–2006, the dispensary was upgraded to a ten-bed MCH Center managed by a medical officer, three nurses who specialized in mother and child health, and a trainee nurse. Although the practice of charging user fees remained in place at the dispensary since the time it was formally initiated in the mid-1990s, patients, especially children, were rarely refused treatment even if they were unable to pay the required fees. The dispensary was generally well equipped. However, the dispensary staff were not trained in the Integrated Management of Childhood Illnesses (IMCI) until very recently (for details about IMCI, see Armstrong Schellenberg et al. 2004). Patients were occasionally referred to the Temeke district hospital, located approximately fifteen miles from the village. Each year, more than 1,000 cases of fever, excluding those diagnosed with ARI, were treated at the dispensary. Until 2008, nearly all the fever cases were clinically diagnosed at the dispensary without the aid of a microscope. In most cases, mothers would arrive at the dispensary forty-eight to seventy-two hours after they had first noticed that their child had a fever.

The private health sector in Mbande had also undergone remarkable changes over the years. In 2000, when I started my fieldwork, there were three retail pharmacies (*duka la madawa* or *duka la dawa baridi*) in Mbande. One of the shops had an attached pathology laboratory (*maabara*), the other sold pharmaceuticals alongside cosmetics (*vipodozi*), and the third, the smallest of the three drug shops, sold only pharmaceuticals. While none of the people who managed these pharmacies were qualified pharmacists, they all offered a range of over-the-counter pharmaceuticals and high-level, broad-spectrum antibiotics. By 2009, there were ten such retail pharmacies in the main village, and a few more in the smaller neighboring villages. During the time of my fieldwork, competition among the retail pharmacists was intense. Much of it was influenced by people's health-seeking behaviors. Shabani, who owned the pharmacy with the pathology laboratory, received a steady flow of customers, especially on weekends when the municipal dispensary was closed. In the summer of 2006, a private medical practitioner set up the first private clinic in Mbande, attracting a sizable number of patients daily.

TRADITIONAL HEALERS. During my main fieldwork from 2000 to 2001, Mbande had four known *waganga.* Sofia was in her early forties and treated her patients using *rungu* divination. Mzee Mwalile, who also used *rungu* divination, was better known for his expertise in circumcising boys during *jando* (the Islamic ritual of circumcision). Both Sofia and Mzee Mwalile mainly treated "mental" patients (*mambo ya akili/wateja wa akili*). As such they received only one or two patients each month. Their infrequent practice made it impractical for me to work with them or to document their skills and healing practices. The third *mganga*, Mzee Tinyango, was an octogenarian who was the only *mganga* who practiced on a full-time basis and received between five and ten patients per week. Many of his patients stayed at his house for extended periods of time ranging from two days to two months. Unlike Sofia and Mzee Mwalile, Mzee Tinyango was also an herbalist. Many of his clients traveled from distant places. I have described my work with Mzee Tinyango elsewhere in detail (see Kamat 2008). The fourth *mganga*, Mzee Mkondya, was a fifty-two-year-old Matumbi person who had recently migrated into Mbande from the neighboring district of Kilwa. Significantly, he was Mzee Tinyango's tenant. Although he maintained a *kilinge* inside his house, where he displayed his wares, he rarely ever received local patients. In practice, Mzee

Figure 4. Family portrait of a Zaramo traditional healer. Photo by author.

Mkondya was an itinerant *mganga* who traveled by bicycle to Mbagala, the town nearest to Mbande, and offered his services on the roadside. He described himself as a "love doctor" (*daktari ya mapenzi*).

The Heart of the Village

The marketplace (*soko* or *magenge* or kiosks) was the heart of the village. It was the locus of all common activities that affected the everyday lives of the old and the young, the rich and the poor people of Mbande, and people from the neighboring villages and hamlets who ventured into and who traversed through the village. There were a dozen small shops that mostly sold grocery and sundry items, and three small teashops (*mgahawa*) measuring less than fifteen square feet each. Everything else at the marketplace was sold on movable, makeshift benches that were laid along the roadside. The marketplace, the main mosque, the local government administrative center, the Chama Cha Mapinduzi (CCM) party office, the police post, and a defunct cooperative storage (*godowni*) and marketing center (originally a microfinancing project sponsored by a German bank) were all located within a 100 feet radius of Mbungo—Mbande proper—or the marketplace. As mentioned earlier, the dispensary and the village primary school were located within a five-minute walking distance from the marketplace.

Figure 5. Marketplace in 2002. Photo by author.

The village office block was at the center of a bitter legal dispute between Biti Janja and the local district authorities. The office block accommodated the office of the village chairman and a village executive officer as well as a CCM office. Adjacent to the office block was the police post and the now defunct *godowni*. These structures were built on a disputed piece of land. Biti Janja's grievance against the government was that she had not been fully compensated for the land that the government had taken from her to build the office block and other facilities. In my conversations with her, she would often complain that she had "sold" that land to the government, but had not received the full compensation that the government had promised her. "I'm asking the government officials to pay me the remaining compensation but they don't pay any heed to my pleas." She wanted the money to complete her new house. She lamented that the government had taken her land, along with the trees. They had cut down all the orange, mango, and jackfruit trees. "Now when I ask them for compensation, they say that the land belongs to the village government. When I insist that they pay me my compensation, they simply bluff (*wananiongopea*) saying that they won't be able to do anything until the ward executive officer (*mtendaji*) comes in person and deals with the issue. But when the ward officer actually comes, nothing happens." Biti Janja told me how angry she was that the government had not paid her any compensation

Figure 6. Marketplace in 2011. Photo by author.

for taking away the land that belonged to her, although they had built a storage for cashew nuts, a police post, and the CCM party office. "I've been to the Chamazi ward office and the court so many times, but there too everyone lies to me." Disputes over land, such as the one between Biti Janja and the government, were very rare in Mbande. It is important to note here that given the gradual demise of village life based on the spirit of *ujamaa*, the increased commoditization and commercialization of village land, and the increased premium placed on land in the recent years, land-related disputes were likely on the rise.

Food and Diet

Regardless of ethnic identity and wealth, the staple food for nearly everyone in Mbande was *ugali*, a thick porridge made from maize flour, which is typically eaten from a common plate in the form of small dumplings (*tonge*) dipped in *mchuz*i or gravy prepared from vegetables that are green and leafy and coconut milk (*tui*), or beans (*maharagwe*). Dried and/or fried fish, especially sardines (*dagaa*), was a favorite relish, but few could afford to eat fish regularly. Beef (*nyama*) was also sought after in Mbande, but because it was an expensive food item, few could afford to eat meat on a regular basis.

The Ndengereko, who constituted the second largest ethnic group in Mbande and claimed to be ethnically and culturally closest to the indigenous Zaramo people, were known for their penchant for eating rice. However, rice as compared to maize flour was expensive. Therefore, few people could afford to buy and eat rice on a regular basis. Unless one cultivated rice in one's own field, the item was part of the diet only once or twice a week. Thus, because of poverty, *ugali* made from maize flour was routinely cooked and served for lunch and supper in nearly all the households in Mbande. When families ran out of maize flour, they turned to eating *ugali* made from homegrown dried and ground cassava flour. This glutinous product was not very popular. Households consumed cassava *ugali* during "hard times" when they had no money to buy maize flour. Casssava *ugali* was usually eaten with or mixed along with chutney/relish made from cassava leaves.

During the course of my fieldwork, I periodically monitored the availability and affordability of the food items in the local market. I noted the prices of all the food items that were sold in Mbande. Other than the price of sugar, which increased by 100 Tsh., the prices of all other food items remained reasonably constant during the period from August 2000 to August 2001. The price of cooking oil and kerosene kept fluctuating during this period and was a matter of concern to everyone in the village. By 2009, the prices of all food items had, on an average, quadrupled. Several of the food items were available at one of the local shops at wholesale rates—rates that were significantly lower than what one had to pay for the same item purchased at retail price. However, given the general scarcity of cash in Mbande, only a negligible number of households could purchase their food items on wholesale basis.

Ethnic Diversity

Although Mbande was known as a Zaramo village, it was an ethnically heterogeneous community. Intermarriages between ethnic groups were common. Some of my key informants who were in their mid-seventies, told me that their parents and grandparents came from very different ethnic backgrounds. For instance, Mzee Mtosa, a Zaramo in his early seventies, who had recently married a Makonde woman (his fifth marriage) said that there was nothing unusual about being married to a Makonde woman because his own father was a Zaramo, his mother was a Ndengereko, and one of his grandfathers was a Makonde. Ethnicity was not a major divisive issue in Mbande. The only exception was the Mozambican Makonde about whom people occasionally spoke of in negative terms, as they were called *watumwa wa shamba* (agricultural slaves), and depicted as "primitive" and "uncultured" because "they have no qualms about sleeping on the bare floor, [and] eat anything, including monkeys, small reptiles, rodents, and spiders" as one of my key informants put it. For the most part, it was the religious identity, a sense of belonging to the village, and the need for mutual understanding that overrode the emphasis on ethnic or language-based social identities. Not surprisingly, according to the census data that I collected in 2000, although Mbande was comprised of people belonging to at least forty-two different ethnic groups, Kiswahili was the neutral language; it was the lingua franca for everyday social discourse. While nearly all residents of Mbande spoke Kiswahili, they did so with varying levels of competence. For example, Sukuma women who had recently migrated into Mbande from the lake region (Mwanza in particular) could neither speak nor understand Kiswahili well. The WaSukuma in particular invariably greeted each other in Kisukuma and would often code switch between Kisukuma and Kiswahili, when continuing the conversation. Significantly, none of the Zaramo people I interacted with spoke Kizaramo. All of them spoke only in Kiswahili. Many admitted that they had completely forgotten their mother tongue. My research assistant, Bi Mwanakombo, often complained of the difficulties she was having while transcribing some of the interviews because she could not make sense of some of the sentences, which according to her were grammatically incorrect. Thus she would complain: "These people, they have been living in Tanzania for life, but they still don't know how to speak Kiswahili!"

The Zaramo, who comprised the single largest ethnic group in the village, considered themselves to be the original inhabitants of the Pwani (coastal) region.[9] Ethnically, the other numerically significant groups who were living in Mbande at the time were the Ndengereko, Mgindo, Matumbi, and Makonde, all of whom came from the impoverished southern coast of Tanzania, namely, the Kilwa-Lindi-Mtwara region.[10] Over the years, Mbande had also accommodated other numerically significant ethnic groups, most of whom were migrants from central Tanzania and the lake regions, and who typically identified themselves as Mhehe, Sukuma, and the Nyamwezi. The Sukuma youth in particular had left an indelible mark on Mbande's social and economic landscape by bringing in okra (*bamia*) cultivation, which was a novelty in this region.

Religion

Mbande's population was predominantly Muslim. Nearly 90 percent of the residents were followers of Islam and those remaining were either Christian or did not express adherence to either major (organized) religion. Since 2001, Mbande witnessed a significant expansion in the number of local religious institutions. Three new places of worship were constructed in the village. In 1998, the modest one-room Roman Catholic Church (*Kanisa la Katholiki*) was upgraded to a larger building with funding from the Catholic Mission. The following year, the mission station bought ten acres of land surrounding the church, which made it a significant place of worship for the Catholics of Mbande and neighboring villages and hamlets. However, regular churchgoers, who belonged to different ethnic groups, constituted a small minority. The church catered primarily to the growing number of Christians, mostly the Nyamwezi and Sukuma people who were migrating into Mbande from central and the lake regions of Tanzania, and the Luguru from the Morogoro region. Membership to the local Roman Catholic Church and the interpretation of the Catholic faith was apparently not too rigid because the church was keen on increasing its number of followers. Even though the church tended to overlook the polygamous status of some of its members, many of the members who had concubines and women who were concubines kept their status secret by falsely claiming to be married. Thus, the wives of the polygamous men were readily accepted among the congregation, and so were also the men and women (young girls in particular) who had children outside of marriage. For example, Vumilia, an unmarried mother in her early twenties, was able to baptize her son at the local church, even though all her neighbors knew that the man she was living with was not her husband, and that she was his mistress (a.k.a. *nyumba ndogo*, literally "small house"). Other than the large piece of land, the church was not endowed with substantial economic resources, and church members were invariably those who were relatively new to the village and poor. Their contribution to running the church's services was negligible.

According to my key informants, in 1998, the village elders, after much deliberation, decided to build a new mosque in Mbande behind the marketplace. The existing mosque that was built on private land by one of the village's founders was too small to accommodate the rapidly expanding Muslim population in the village. Besides, the existing mosque was located nearly half a mile away from the village center. The village did not have an *imam*, although during religious occasions, including the *hitima*

(Qur'anic readings most closely associated with a burial ceremony) or *maulidi* (a festival in celebration of the birth of the prophet Mohamed), one was invited to the village from one of the larger mosques in mid-town Dar es Salaam. Mzee Wahid, the *shehe* who was in his mid-fifties at the time of my initial fieldwork, was at the forefront of all Islamic religious activities.[11] Additionally, there were at least five *mwalim* (pl. *walimu*) or Qur'anic scholars in the village. In comparison to the mosque, the administrative structure of the local Roman Catholic Church was small. The church provided very few services to its worshipers. In the month of August 2001, an Apostolic church called the New Apostolic Church, funded by an Italian mission, was constructed on a prime spot, a minute's walk from the marketplace. In 2006, amid much fanfare, a recent immigrant started a Pentacostal church in Mbande, but closed it down following rumors that he had embezzled, or failed to return the money he had borrowed from his former employer. Apparently the police were going to apprehend him shortly, and confiscate his house (which served as the church) and his other belongings.

The Gendered Nature of Zaramo "Culture"

The Zaramo are traditionally matrilineal. However, because most of the Zaramo are Muslims, in actual practice and when the law is involved, the father is the one who is seen to have the primary responsibility and privilege (see Swantz 1995:76). Despite the influx of migrants from various parts of Tanzania into Mbande, when the villagers spoke of Mbande's "culture" (*utamaduni ya wenyeji*) they referred to it as the Zaramo culture (*utamaduni ya wazaramo*). Thus, Mbande's culture was synonymous with the Zaramo culture, which in turn was equated with coastal Swahili cultural traditions. While the Zaramo took pride in pointing out this equivalency, non-Zaramo residents did not speak of the Zaramo culture with the same deference. Occasionally, non-Zaramo people made discrete statements about the Zaramo culture in disparaging terms. The Zaramo men were said to have a reputation for being pathologically lazy (*uzemb*e), leading a leisurely lifestyle and working only when they had to. As noted earlier, they were regularly compared with the Sukuma people who had built a reputation for being extremely diligent, and who reaped the benefits of their hard work. The comparison was often made to explain why some people were doing well economically, while others were struggling. Biti Janja, whom I have quoted earlier, remarked during an interview, "Yes, our men here are lazy; they want us (women) to work the land and grow food while they remain at home playing *mbao* . . . they just want to play balls (*kete*) throughout the day; they don't want to work!" Biti Janja's frustration was directed not only toward Zaramo men in Mbande, but the men of Mbande in general who wanted their women to both work hard at agricultural tasks and at home, while they spent their time playing *mbao*. Participant observation and informal interaction, including photographic sessions at several *mbao* games in the village, made it clear to me that men, regardless of their ethnic identity, took to this game and played it for several hours at a stretch with deep passion.

Whereas women commonly described Zaramo men as being inherently lazy, men in turn commonly described Zaramo women as being indulgent and promiscuous. Mzee Wahid, the local *shehe* who was not a Zaramo, said to me in an interview:

> You know, Mbande is a Zaramo village. The local culture is that of *mafiga matatu* [three stone hearth]. I've been here since 1993, and I've seen that all that these Zaramo women want to do is go to a *ngoma* dance. They want to dress up well, dance, and have fun, rather than working hard to maintain a stable family and a good life. When they run out of resources, they go to men other than their husbands.

Mzee Chekeche, a Makonde man who lived with his three wives in the neighboring hamlet of Kimbangulile, had recently divorced one of his non-Zaramo wives on the grounds that "she had become too much of a Zaramo"; that is, she had taken to "the Zaramo way" (*njia ya Wazaramo*) of life, in which she wanted to participate in every *ngoma* held in the village. Rather than working the fields and concentrating on family life, she was only interested in dressing well and visiting friends and relatives every other day. She constantly wanted new clothes so that she could dress well for these occasions.[12]

Marriage and Divorce

Alhough Mbande was a heterogeneous community, certain events brought people together, regardless of their ethnic identity. While some of these events were rooted in people's religious beliefs and identities, others provided the people with a sense of belonging to the village, and thus brought them together. People were in the festive mood between the months of July and September. This was the time when people were almost finished harvesting most of their crops and they had a good supply of food. Outdoor activities were organized during these months when people felt that they were relatively better off in terms of food reserves. This was the time of the year when people bought new wares, built new houses or upgraded old ones, repaired bicycles, made new hoes, ordered from the tailor, and most importantly addressed serious health problems. In addition, dances (*ngomas*) and weddings (*arusi*) were held in Mbande from August to October when food was readily available and the demand for agricultural labor decreased.

*Ngoma*s were highly publicized events. On the last day of the *ngoma ya mwali* ceremony (the day the *mwali* [a young girl] is brought out from seclusion), anywhere between 200 and 400 people would participate in the ceremony. In contrast, weddings tended to be low-key events, with thirty to sixty invited guests. During my 2000–2001 fieldwork, I was surprised to find out that, while my neighbors and key informants would inform me well in advance of a *ngoma* organized by a particular family on a particular date, they rarely informed me of weddings in the village. I would invariably learn of a wedding in one part of the village only after I had seen smoke emanating from the hearth of a particular house coupled with the aroma of *pulav* being cooked in large quantities. I would learn about weddings in Mbande only by asking my research assistant, a key informant, or a passerby in that neighborhood. Most wedding ceremonies were modest. Marriages called "*mkeka* marriages" (*arusi ya mkeka*: lit., an agreement made while sitting on a mat) involved minimal expenses.

During the entire course of my research, I was able to attend and document only three Zaramo wedding ceremonies—the most memorable one was that of my host's daughter. It was her second marriage. Unlike other wedding ceremonies in Mbande, however, this one was elaborate. A Kadhi officiated the marriage ritual, and the Sheik read out the marriage contract (*ndoa*), and the groom had to pay a bride price (Tsh. 40,000 or US$50). The bride price was to be paid in installments so that only a part was paid before the marriage was consummated. In this case the groom, who lived in a village that was fifty miles away, paid Tsh. 27,000 in advance and promised to pay the remainder over a six-month period. Because divorce is very common in coastal Tanzania, divorces were even less publicized occasions.

While in most societies marriage is regarded as a major institution that facilitates group formation and social intercourse, in Mbande, and in this region of Tanzania, marriage was not one of the most revered institutions. Divorce and remarriage were very common. Marriage did not have an undisputed prestige as the cornerstone of an orderly life, nor did it have a dominant position as the most important personal attachment. Similar to what Pekka Seppala has observed in the Lindi-Mtwara region, "Marriage as an institution is respected at the general level for the sake of moral order but the actual norms do not require a person to keep one single marriage as a life-long bond" (1998:101). A woman's first marriage normally takes place during her youth. If formalized properly, the marriage is sealed with the payment of the bride price, which can be any amount between Tsh.10,000 and Tsh. 100,000 in cash (no livestock or goods are given in lieu of cash payment). The bridegroom or his parents pay the bride price to the bride's parents. An Islamic Kadhi supervises the first marriage, a marriage certificate is not given, and the bride price may be paid only partially before marriage. In the subsequent marriages the bride price tends to be very low or nonexistent. At a later age when both men and women have attained a degree of economic independence, marriages can be contracted and dismissed without external intervention. The fluidity of marriages is apparent from the divorce statistics derived from the household survey I conducted in 2001; 48 percent of the 116 respondents in the survey had divorced at least once. On average, the spouses had over three divorces or widowhoods in their past.

Single mothers and unmarried young mothers were common in Mbande. For example, in 2001, of the forty-five mothers I recruited at the local dispensary to interview about their children's illness, 58 percent were married, while the others were unmarried, and a small number of them were cohabiting, divorced, or widows. Several children did not have a named father at all. According to Seppala, "the repeated occurrence of [unmarried mothers] indicates that the social parenthood is perceived to be separate from biological parenthood" (1998:102–103).

There were scores of able-bodied young men in the village who were leading a life of uncertainty. These young men had few opportunities to engage in gainful economic employment. Only a small number of them had the resources and the confidence to lead a married life. In many cases, these young men would end up having affairs with young women in the village. They would provide the young women with basic necessities for short periods of time, and abandon them once they found out that the woman was pregnant. This observation was common knowledge in Mbande village. During the course of my fieldwork, I encountered scores of young single mothers in Mbande and in the neighboring villages who had an all-too-familiar story to tell: their boyfriend or fiancé had promised to marry them, and he had even sent them the customary proposal letter (*barua*), but he had reneged, and in some cases simply disappeared from the scene. While some parents were visibly distraught by the misfortune, others rationalized the situation by stating, "Oh! At least we got a wonderful grandchild!" (*Lo! Tume pata mjkuu!*).

Although Islam allows its male followers to have up to four wives at any given time, in 2000, Mbande had only seven men who were polygynous. All were above the age of sixty and they were relatively wealthy. Excluding one, all were original inhabitants of the village. These men had used polygyny as a conscious part of a diversification and accumulation strategy, in order to expand the scope of social and economic relationships.[13] All three male *waganga* in Mbande were polygynous. Mzee Tinyango Pazi had married several times and was living with four wives. Another wealthy Zaramo, Mzee Mwalile, was engaged in business (he owned three shops—one in Mbande and two in the neighboring villages) and had four wives. He needed several wives to accomplish the tasks on the home front. It was common that one wife took care of the household chores while the other worked the fields and/or supervised the agricultural laborers or managed the shops. This division of tasks was possible when the wives lived near each other so that they could help each other in childcare and cooking. One of my key informants, Mzee Chekeche, justified his polygamous lifestyle by revealing that he owned nineteen acres of land and he needed wives (i.e., cheap, reliable labor) in order to work the land. While all the women who were interviewed on the topic of marriage, divorce, and polygamy in Mbande unanimously attributed the practice of polygamy to *tamaa* or greed/lust on the part of men, the polygamous men interviewed on the same subject gave the need for "variety," "utility value," and a religion that permits God's wish as justification for them to lead a polygamous lifestyle.

Politics

Mbande was traditionally a stronghold of the ruling CCM party. Long-term residents, who had consolidated their hold through the expansion of their material and social resources, dominated the day-to-day village politics. Recent immigrants had little or no say in communal affairs. With the introduction of the multiparty system in the country in the early 1990s, one of the opposition parties—the Civic United Front (CUF)—was active in the village, relying mainly on the energy and the support of the youth, who were increasingly invested in the changes occurring around them. During the 2000 elections, much to the disappointment of the local and district-level leadership, the people of Mbande elected a CUF candidate, but because the municipal ward as a whole elected a CCM candidate, heads did not roll at the local CCM party office. In the subsequent elections (2005 and 2010), the CCM party consolidated its hold on Mbande.

As I describe in chapter 3, multiparty democracy was introduced in Tanzania even though only 20 percent of the polled respondents were in favor of this change. The first multiparty parliamentary elections were held in 1995. Benjamin William Mkapa of the ruling CCM was elected as the president. The second elections were held in the year 2000, around the time when I had just started my fieldwork. Therefore, it was hard for me to overlook local level politics. I attended several political meetings and interviewed all the local leaders on the topic of multiparty democracy in Tanzania. I interviewed several local leaders with whom I had established a good rapport on their thoughts regarding multiparty democracy. Their responses were mostly ambivalent. Nearly everyone reiterated that even though only 20 percent of Tanzanians had originally voted for a multiparty democracy, the government had gone ahead and introduced the system anyway. None of the people I interviewed spoke in explicitly negative terms about multiparty democracy, however. The characteristic response was: "In principle, it's good, but politicians have been taking advantage of it. They are misusing their powers and in the end, multiparty democracy has brought much violence into the country." To date, for the most part, mainland Tanzania has remained peaceful. As Kelly Askew has observed: "In a world region where ethnic dissonance reigns supreme (Hutu-Tutsi conflict in neighboring Rwanda, Burundi, and the former Zaire; Luo-Kikuyu conflict in neighboring Kenya; and the conflicts in Somalia and Mozambique that are tainted with ethnicity although framed in other terms), Tanzania stands alone in its lack of overt ethnic conflict" (2002:222).

In the October 2000 elections, Benjamin Mkapa was reelected as president. In 2005, Jakaya Kikwete, a staunch supporter of the neoliberal revolution, was elected president; he was again re-elected in the 2011 elections. To put all this into the larger frame, in the following chapter I review the historical context of Tanzania's transition from a one-party state espousing the ideals of socialism to a multiparty democracy wedded to the principles of neoliberalism.

CHAPTER THREE

Commanding Heights and Failed Promises

Composed of two formerly independent entities, Tanganyika and Zanzibar, the United Republic of Tanzania is a state wracked by contradiction, fraught with multiple cleavages, and characterized by a condition of what can only be termed "consistent inconsistency."

KELLY ASKEW 2002:5

Throughout much of Africa one also finds a widespread and profound sense of foreboding, a perceived crisis in the fundamental conditions of social production and reproduction brought on by neoliberal policies and market orthodoxies. From Angola to Zanzibar, people are confronting the restructuring of global capital in terms of an economics of impossibility that renders daily life ever more precarious.

WILLIAM BISSELL 2005:222

Promises

In August 2000, the political atmosphere in the village was tense. Rival party leaders and representatives were making political speeches in a large open space close to the marketplace late into the evening hours. The two rival political parties were the CCM and the CUF. Tanzania, which was until recently a one-party socialist state,[1] was in the middle of the second parliamentary elections when I started my fieldwork in Temeke district. Bi Mwanakombo, my research assistant, warned me to be extremely careful about what I said to whom in the politically charged atmosphere, at least until the elections were over. I appreciated her advice. In any case, given my limited linguistic competence at the time, I could barely muster the courage to engage in any serious political conversation in Kiswahili.

The usual elaborate and formulaic exchange of greetings was followed by the three-stage handshakes that are characteristic of East Africa. I could sense that the village leaders, who had invited me to the CCM office, were sizing me up. After I had handed over my research permit and ethics clearance papers, Mzee Chautundu, the village executive officer, told me that I was most welcome to do my research in the village. The CCM party chairman, Mzee Kingwandala, joined in the welcoming statements—and added:

> We are a peaceful country. We are not like out neighbors. Yes, we fight, but only with our words. No guns, and we don't kill each other. Mwalimu (Julius Nyerere) was an intelligent man, he knew what he was doing. He united us with our language—Kiswahili. Welcome, welcome to Tanzania (*Karibu sana, Karibu* Tanzania).

I sat through the discussion that followed out of politeness, wondering about Mwalimu's legacy. In the famous Arusha Declaration of 1967, Mwalimu Julius Kambarage Nyerere, Tanzania's first president and *Baba wa Taifa* (Father of the Nation) guaranteed the people of Tanzania, among other things, access to health as a basic right. His philosophical and ideological commitment to the people of Tanzania was embedded in his version of African socialism—*ujamaa*. As Todd Sanders has recently noted, "Nyerere was widely admired and respected, both nationally and internationally, for his *ujamaa* vision. However, for a range of reasons the experiment eventually went sour, negatively affecting all sectors of the Tanzanian economy. In the end, Tanzania's particular form of African socialism failed to deliver what it promised: a modern, self-reliant socialist nation" (2008:30).

Tanzania's failure with socialism was to be expected; it was a fait accompli, given the momentous political changes that were taking place in the other socialist countries (especially the Soviet bloc) at the time (see Verdery 1996). My aim in this chapter is to briefly examine what went right and what went wrong with the *ujamaa* experiment, and the factors that led to the ultimate derailment of one of the greatest experiments in social engineering on African soil. In conjunction with the previous chapter, the material discussed in this chapter sets the stage for a better appreciation of why a nation that was once a net exporter, with a positive foreign exchange balance sheet, soon became one of the most aid-dependent countries in the world. The country's agricultural production dramatically declined, and its foreign debt reached $8 billion, leading the World Bank to declare Tanzania as the second poorest nation in the world in 1993.[2] The information I provide in this chapter is cursory; it is neither original nor new, but is essential to my analysis, and to the reader who may not be familiar with Tanzania's political economy and political history. I have synthesized the relevant literature, which sets the stage for a better understanding of the antecedents of neoliberalism in Tanzania and the consequences it has had on the lives of the people of Tanzania over the years, and continuing today. As Kelly Askew notes, "because historical narratives continue to inform current politics in significant ways, it is necessary to be familiar with the key agents, events, and processes that helped create and define Tanganyika" (2002:31).

Socialism (ujamaa) to Privatization (ubinafsishaji)

In the 1980s, the worsening economic situation in Africa led many sub-Saharan African countries to accept the World Bank and IMF-prescribed "shock therapy,"[3] which included economic liberalization, stabilization (increasing interest rates, reducing cheap loans, and raising taxes), and privatization programs. The recommended packages of prescriptions were standard and universally applied, regardless of a country's specific historical, social, political, or economic situation (Turshen 1999). Typically, these prescriptions involved trade liberalization, devaluation of the local currency, rationalization of public sector employment, phased removal of subsidies, emphasis on the export of cash crops, reduction in social spending, and privatization, decentralization, and enforcement of cost recovery in the health and education sector (Atkinson 2002; Baregu 1993; Bassett, Bijlmakers, and Sanders 2000; World Bank 1993, 1994). However, the dynamics surrounding the acceptance of these measures, the pace at which they were implemented, their overall impact on the economy, and the specific political and economic experiences associated with their implementation varied according to each country.

Several scholars have argued that in most sub-Saharan African countries, structural reforms, which leaned heavily toward increased privatization of the economy, coupled with political reforms such as the institutionalization of Western-style multiparty democracy, were the result of intense pressure from the World Bank, IMF, and major donor countries. The reforms were rarely a result of the country's own policy initiative. The only cited exception in this case is Zambia, where the country's privatization efforts were part of the ruling Movement for Multiparty Democracy's (MMD) election manifesto. Undeniably, many African countries undertook privatization in an effort to assuage donor fears over domestic reform commitment rather than out of ideological or economic conviction (see

Kayizzi-Mugerwa 2002). Especially around the end of the 1980s, political conditionality was added to the economic conditionality that had emerged around a decade earlier (Pender 2001; Wiseman 1995:3). After 1989, any government or party that talked convincingly of privatization increased its likelihood of access to aid, credits, and investment, especially from the World Bank and IMF (Verdery 1996:210). Most African countries, however, did not passively accept conditionalities such as privatization of the economy without serious debate. The exchanges between African politicians, bureaucrats, and other stakeholders were often bitter, as the conditionalities attached to privatization by donors and multilateral agencies caused sharp disagreement (Kayizzi-Mugerwa 2002:1–8; see also Appiah-Kubi 2001; Mengisteab and Daddieh 1999).

As stated in the Arusha Declaration of 1967, a manifesto in which Julius Nyerere outlined his vision of the Tanzania of the future based on the principle of *ujamaa* or African Socialism,[4] Tanzania had committed itself to a path of non-Marxist socialism (*ujamaa*) and self-reliance (*kujitegemea*) (Lal 2012). It reluctantly accepted the World Bank/IMF–recommended structural adjustment reforms.[5] Indeed, privatization became a key feature of the agreement only after protracted and acrimonious negotiations (Baregu 1994). Many of the reforms initiated in the early 1990s are still in the process of being implemented. However, few countries have undergone such a dramatic change of the entire social, economic, and political setup in such a short time as Tanzania (Bigsten and Danielson 2001), and without the upheavals associated with democratic transitions elsewhere in Africa, Eastern Europe, and the former Soviet Union (Hydén 1999). The scale of the changes witnessed in Tanzania, particularly between 1990 and 1995, was so extreme that Tanzanian scholars use the term *mageuzi*, meaning a complete turnaround, to refer to a period that saw the shift from African socialism to the market economy, and from a one-party state to a Western-style, liberal multiparty democracy (Baregu 1994; Sabea 2001; Weiss 2002).

The Zanzibar Declaration of 1991, as it became known, boldly challenged and consequently amended the 1967 Arusha Declaration. In reality, the Zanzibar Declaration radically undermined rather than updated the Arusha Declaration's original vision (Sanders 2003:152).[6] It disengaged the socialist leadership from the main tenets of the Arusha Declaration, and officially marked the end of socialism in Tanzania. Sheik Ali Hassan Mwinyi, the second president of the United Republic of Tanzania, formally announced that the state had rejected the Arusha Declaration.[7] In its stead, Mwinyi adopted the reforms of structural adjustment required by the IMF to finance Tanzania's transformation into a post–"African

Socialist" society (Weiss 2002:94–95). In effect, Tanzania reluctantly "shed its socialist mantle and adopted political pluralism" (Askew 2002:225); it abandoned its commitment to a socialist health policy and embraced a policy that was in favor of privatizing the health sector. The immediate effects of this policy change were remarkable.

Ideological Swings: From Optimism to Despair

To understand the significance of the changes that have unfolded in Tanzania over the last several years, it is necessary to examine the larger historical processes of economic and political transformation in which they occurred. Specifically, it is important to consider the historical moment in which Tanzanian leadership committed the nation to a path of socialist construction of the society, even as neighboring countries (Kenya and Uganda became independent around the same time as Tanzania) chose the capitalist path.[8] In addition, it is also useful to consider the historical context of the change of heart among the country's leadership. The government began to favor a capitalist ideology that emphasized the privatization (*ubinafsishaji*) of the economy instead of socialist economics and supported the replacement of one-party rule with Western-style multiparty democracy (Bagachwa and Mbelle 1993a, 1993b; Makinda 1996). The following section briefly traces the historical antecedents that led to the rise and fall of socialism in Tanzania and the circumstances surrounding the shift in the 1990s toward the radical restructuring of the country's health-care system. It also tracks the process of privatization and increased commercialization of medicine that came with the transformation.

Tanzania has experienced at least four major ideological shifts since its independence in 1961: (1) the Arusha Declaration of 1967, in which Julius Nyerere articulated his *ujamaa* policy; (2) the *ujaama* villagization scheme and the Operation Vijijini (forced villagization) of the early 1970s; (3) the politics surrounding the economic crises and the IMF/World Bank supporting the structural adjustment program (SAP); and (4) the *mageuzi* years, starting from the early 1990s, during which the country formally abandoned its commitment to *ujaama* when it replaced the one-party state with a Western-style multiparty democracy committed to market reforms.

The Arusha Declaration and Tanzania's Commitment to Socialism (1961–1967)

After gaining independence in 1961, the leadership of the mainland part of Tanzania (Tanganyika, as it was then known) showed no signs that it was going to formally commit to socialism. The leadership did not introduce any noteworthy changes in the economic policies that had been implemented by the colonial powers. The post-colonial state continued to pursue a food self-sufficiency policy vis-à-vis the peasantry (Bryceson 1993:5). Peasant agriculture continued to be based on the use of the traditional hoe, and although industrial development was promoted with a relatively mild import substitution policy, the bulk of the capital investment came from private investors. The economy remained fairly open and it was highly dependent on revenue from agricultural commodity exports such as sisal, tea, coffee, and cashew (Bigsten and Danielson 2001:14–15). Indeed, when Nyerere became the country's first president, he did not assume power on the basis of an explicit socialist platform. It was the political experience he gained during the first five years of independence that enabled him to be more explicit about his vision of the Tanzania of tomorrow and how this vision could be realized (Hydén 1980:96–97). As the story goes, in 1962, during a sojourn in his native Zanaki village, Nyerere wrote and later published a small pamphlet with the title "*Ujamaa*—the basis of African Socialism" (see, for details, Stoger-Eising 2000:118).[9] In this essay, Nyerere described a non-Marxist socialist society in which everyone worked and cared for one another. Such a society, he wrote, was much like precolonial, traditional African society (McHenry 1994:16). "He wove together elements of a somewhat altered past with elements of a contemporary political philosophy for the purposes of producing a national identity and national culture at once socialist yet African, internally oriented yet modern" (Askew 2002:180). His principles became the core ideology of the Tanganyika African National Union (TANU)[10] when the National Executive Committee (NEC) adopted the Arusha Declaration on the February 5, 1967, and put the country firmly on the path of socialist development. One of the most immediate results of the Arusha Declaration was the emergence of a highly centralized state that placed itself at the center of the development agenda (Tripp 1997).[11]

The adoption of the Arusha Declaration marked a turning point in Tanzanian political and economic history. It was an "economic manifesto," a blueprint for Tanzania's socialist construction (Townsend 1998:14).[12] Originally drafted by Nyerere and revised slightly by the NEC, the declaration defined a socialist society as one (1) without exploitation; (2) with the major means of production and exchange under the control of the peasants and workers; (3) with democracy; and (4) with leaders and masses believing in, and committed to, the realization of such goals (McHenry 1994:19; see also Stoger-Eising 2000). One of the principal and controversial tenets of the Arusha Declaration was the nationalization and state control of the "commanding heights" of the economy (the principal financial, manufacturing, and trading institutions). Thus, almost immediately after the pronouncement of the Arusha Declaration, the government of Tanzania, in the course of one week, nationalized all the private banks, the major food processors, and eight major foreign export-trading companies. In addition, the government announced its intention to secure majority control of the sisal industry and of six major manufacturing companies (Mwanasasu and Pratt 1979:12).[13] The single-party state emphasized manufacturing and agricultural production within the nation, for the nation. Self-reliance was the goal (Sanders 2008:30).

The Arusha Declaration called for a complete stop to the accumulation of private wealth by leaders in the dominant party and the government. The declaration indicated the party's desire to give priority to rural development, which thereby enabled a more effective utilization of domestic as opposed to foreign resources. The Arusha Declaration was not only a measure aimed at reducing capitalist influence in Tanzania, it was also directed toward what Göran Hydén has called the "economy of affection"—an economy in which affective ties based on common descent, common residence, prevail. According to Hydén:

> In the economy of affection, economic action is not motivated by individual profit alone, but is embedded in a range of social considerations that allow for redistribution of opportunities and benefits in a manner which is impossible where modern capitalism or socialism prevails and formalized state action dominates the process of redistribution. Based on the social logic of the peasant mode, the economy of affection negates many of the power relationships that characterize the modern economies. . . . In the economy of affection an element of reciprocity exists that is structurally induced. (1980:18–19, see also 96–97)

The *ujamaa* approach as articulated in the Arusha Declaration was conceived as part of a radical political transformation. The approach meant to neutralize the powers of the petty-capitalist farmers and eradicate the hold that they and the petty bourgeois had on the economy of affection. Through such measures rural smallholder producers would get more opportunities to participate in the construction of a socialist economy. Nyerere saw *ujamaa* as an attempt to base development efforts on an indigenous perspective instead of borrowing models and ideas from outside the country (Hydén 1980:104–117). By equating the state policies with "African traditions," Nyerere sought to domesticate state policies and practices and deny a separation between the state and civil society (Snyder 2001:128). Ironically, as noted earlier, although the Arusha Declaration emphasized self-reliance, Tanzania ultimately became one of the most heavily indebted poor nations on the African continent (Bigsten and Danielson 2001:24; Sabea 2001:291). Several scholars have identified a range of factors to explain why Tanzania ended up becoming such a heavily aid-dependent country in a matter of few years.

Operation Vijijini (1971–1974)

In the first ten years of independence, with nearly 90 percent of the country's population living in rural areas, the government launched what became known as *ujamaa* villages or development villages. These villages were developed mostly on an experimental and contingency basis in selected locations. They were to serve as prime examples for the population—models for the rest of the country to emulate. Persuaded by political education and by example, rural people were encouraged to live together in villages, to work together in communally owned fields, and to share the product of their collective work. The villages were to be democratically run by local members and production decisions were to be coordinated with regional and national economic development plans (Barker 1979:95). There was no obligation to establish collective production, although local leaders could urge and indeed require this to be done. However, at the national level, development villagization was a policy aimed solely at nucleating rural settlements into villages on or adjacent to roads in order to facilitate the distribution of productive and social service infrastructure (Bryceson 1993:9). *Ujamaa* villages were conceived as a first step upon which the entire countryside would ultimately change from a situation of low-level production and poverty to one of high-level production and prosperity (Townsend 1998:57). Of course, there was a high degree of idealism and voluntarism involved in this vision of society, and the leadership was well aware that there would be problems in the actual implementation of the *ujamaa* policy. Nevertheless, in outlining his rural development strategy, Nyerere traced three basic assumptions underlying what he called "traditional *ujamaa* living": (1) respect—each member of the family recognizes the place and rights of the other members; (2) common property—everyone accepts that whatever one person has in the way of basic necessities, they all will share these necessities; and (3) obligation to work—every member of the family, and every guest who shares in the right to food and shelter, must take for granted the duty to join in whatever work needs to be done (Hydén 1980:98).

Nyerere and other leaders emphasized that *ujamaa* villagization was not simply a strategy of going back to traditional living. It was a strategy to raise the quality of life of people in rural areas. Progress toward socialist agricultural production would follow thereafter, as it was hoped that people eventually would come to see the wisdom of co-operative production (Mascarenhas 1979:150–151). The creation of *ujamaa* villages was a strategy to bring the scattered rural population together, to slow the movement to towns, to increase production, to permit the introduction of new technology, to increase peasant per capita income, to reverse the trend toward inequality, to provide better social services to the people, to encourage self-reliance, and to reverse the trend toward centralization. In sum, *ujamaa* was a means to overcome the major problems hindering Tanzania's development (McHenry 1979:4). Villagization was seen as a prerequisite to a whole range of desirable, indeed essential, social, economic, and political developments (Pratt 1979:207).

By 1973, over 2 million Tanzanians were reported to live in such villages. While the quantitative implications of the operations and campaigns required to start *ujamaa* villages were quite impressive, it is important, however, to recognize that these impressive figures were severely misleading. As Hydén (1980:104) explains, first of all, *ujamaa* villages were registered even if their communal efforts were not successful. In some cases even villages without any communal cultivation were registered as *ujamaa* villages. Second, not all villages were new creations. People were simply told to move to the nearest existing village or trading center and political efforts were made to create an *ujamaa* village out of that newly enlarged unit. Finally, the first years of *ujamaa* campaigns did not lead to more than a partial villagization.

In the Rufiji district (the district neighboring Dar es Salaam), which had been hit by a flood, and in the Handeni district (Tanga region), which had experienced drought, people were compulsorily resettled in villages (Freyhold 1979; Seppala 1998). Thereafter, a new phase followed the introduction of the second five-year plan in 1969. Emphasis shifted from the "selective approach" to what was called the "frontal approach." The frontal approach was a more comprehensive strategy in which the "whole range of government and political institutions is mobilized behind the principle of *ujamaa*." Exhortation was supplemented by inducement via preferential access to government resources. In the Dodoma region, which had experienced drought and famine, government resources were channeled in an impressive way, and the operations program was initiated (Mascarenhas 1979:150–151). The number of *ujamaa* villages rose from 1,956 to 4,484 between 1970 and 1971. The following year the figure exceeded 5,500. The massive resettlement operations carried out earlier in the Rufiji district (1969), Dodoma region (1970), and Kigoma region (1972) were later extended to all regions (Barker 1979:95; Boesen 1979; Boesen et al. 1986).

It was not until 1973, however, that the third distinct phase of *ujamaa* villagization began, with the introduction of a massive villagization campaign characterized by a willingness to use direct coercion. The *ujamaa* part of the policy was noticeably de-emphasized after 1973. In August 1973, Nyerere announced that with the ruling party's ratification, it was now compulsory for all rural people to live in *ujamaa* villages by the end of 1976. The passing in Parliament of the Rural Lands Planning and Utilization Act in July 1973 preceded the president's announcement of compulsory living in *ujamaa* villages. In order to speed up the process, the Presidential Circular No. 1 of 1969, which removed the voluntary aspect of the resettlement program, also imposed the element of coercion (Jennings 2002; Schneider 2004). This Act allowed the regional administration to organize the resettlement programs. The implementation of these programs was referred to as Operation Vijijini, literally meaning "villagization" (Kikula 1997:22).

Over the next three years, large numbers of rural households were forced to relocate into villages that soon acquired legal status (as incorporated entities), and these villages were governed by elected councils along with government-appointed civil servants. As legal entities the villages could manage local trading stores and communal farms (Sarris and van der Brink 1993:11). Although people were not forced to move far when being relocated, they had to agree to abandon their previous residence and land. Where people refused to accept this condition, coercion was applied. The party and government were anxious to prove their capacity to mobilize the people and consequently no resources were spared. In some cases, the actions of the government entailed destroying previous residences and other properties. Existing government programs were abandoned in favor of villagization and army units were called in to supplement personnel and equipment. Although some campaigns were quite well planned, others were carried out in a great hurry; regions competed for the title of who was more capable of villagization (Hydén 1980:130–131). Significantly, Operation Vijijini coincided with the drought that hit large parts of Tanzania in 1973–1974. Thus, according to Hydén (1980, 146), the drought was a blessing in disguise for those promoting villagization, as it facilitated the movement of people. There was little the people left behind on the land and consequently it was easier for them to accept living in the new villages. This is one of the reasons why some people did not object to moving and did so without government pressure.

Tanzania's villagization program was unique. It involved the largest number of people in the history of African resettlements; the program relocated between 5 and 9 million rural Tanzanians (Barke and O'Hare 1984; Kikula 1997; Mascarenhas 1981). Estimates vary regarding the actual number of people who were moved during the villagization program. According to one estimate, 9,100,000 people were moved (Nyerere 1977:41).Villagization resulted in the abandonment of the traditional scattered, semipermanent settlements and the adoption of concentrated and permanent settlements (Kikula 1997:14). By 1976, it was declared that practically all rural Tanzanians were living in these new development villages. By 1978, the government estimated that 86 percent of the population lived in 7,768 villages as compared with only 809 villages recorded in 1969 (Bryceson 1993:63). This did not mean that the resettlement program affected every villager. Those peasant areas in which settlements were already a way of life, and those who were already accustomed to land shortages and close quarters were largely unaffected by this program. The registered villages, including old as well as newly designated settlements, were completed in June 1979. There were 8,299 villages with a total population of 14.9 million, which accounted for 87 percent of the country's population (Townsend 1998:62–63). Over the years, scholars have debated the merits and demerits of the villagization program, particularly the forced manner in which the program was implemented. They ask whether or not large settlements were a necessary prerequisite for the achievement of the goals of villagization, and whether or not Tanzania had the resources to initiate such a large resettlement program (Scott 1999; Townsend 1998:39–40). There is a general consensus, however, that the effects of the villagization program were both positive and negative (Lal 2012). Although the villages could provide some services, it is also clear that the disruption caused by the land tenure arrangements had negative effects on agricultural production. While the villagization program seriously disrupted the social fabric within the villages (Seppala 1998:17), the villagization policy was certainly sensitive to gender issues. Thus, every adult, regardless of sex, was eligible for land use rights either for housing construction or for farming. Women were given the chance to have land in their own right in the new settlements. As a result, this opportunity was very popular among female heads of household (Koda 1998:207).

The Economic Crisis Period (1974–1985)

In the mid-1970s, Tanzania suddenly spiraled into economic decline and stagnation. The start of the economic decline coincided with the peak of Operation Vijijini and lasted until President Nyerere's resignation in 1985. During this period, agricultural production stalled, industrial production faltered, and development goals were not met. The protracted economic crisis led to a shift in state policy toward the centralization of state power and a top-down approach to governance (Barkan 1994; Coulson 1982; McHenry 1994; Ndulu and Mwega 1994; Snyder 2001:135; Tripp 1997).[14]

Both domestic failures and adverse international structures were responsible for Tanzania's economic crisis, a crisis that necessitated major economic and political changes (Biermann and Wagao 1986). The first oil shock in 1973, which led to the quadrupling of world oil prices necessitated sharp increases in import expenditures and a decline in export proceeds (Sarris and van den Brink 1993:12). Recurring droughts in 1973–1974 were followed by the break-up of the East African Community (Kenya, Tanzania, and Zambia) in 1977.[15] The OPEC II oil crisis in 1979, the subsequent world recession, the war with Uganda,[16] the rapid depletion of international reserves (foreign-exchange) following the end of the coffee boom in 1978, and the abortive import liberalization that same year all resulted in a fiscal deficit that plunged the Tanzanian economy into economic crisis. External debts developed rapidly and after the end of the war with Uganda foreign inflows fell dramatically as the government clashed with donors over macroeconomic policy. The dialogue with the IMF broke down in 1978–1979, when President Nyerere vetoed an IMF agreement that included a 15 percent devaluation of the Tanzanian shilling.

In response to the economic decline, the government implemented its own National Economic Survival Program (NESP) in 1981–1882, but the reforms were limited, poorly designed, and thus unsuccessful. This program, which placed emphasis on domestic resource mobilization and self-reliance, lasted only for one year primarily because Tanzania continued to be denied foreign resources. By 1982, Tanzania had reached an informal agreement with the IMF to introduce a structural adjustment program (SAP) in order to release foreign resources withheld by donors on condition that an agreement was reached with the IMF. From the agreement onward, liberalization and adjustment began to dominate economic policy and became the linchpin of government/IMF/World Bank collaboration (Baregu 1993:108). A second domestic effort, the Three-year Structural Adjustment Program was implemented with the hope that it would lead to an agreement with the

IMF and the World Bank. This effort went further than the first NESP, but did not address important issues such as exchange rate overvaluation and the liberalization of agricultural marketing (Bryceson 1993).

By this time, donors who had been attracted to the egalitarian principles set out in the Arusha Declaration had become more and more aware of the negative effects of *ujamaa* on economic efficiency. By 1983 most donors had begun to withdraw their support for the Tanzanian experiment. Aid flows declined (Bigsten and Danielson 2001:17), and by the end of 1984 Tanzania's debt was $3.3 billion. Moreover, the country's debt-service ratio had risen to 70 percent. Finally, in 1986, a three-year economic recovery program (ERP) was launched. The ERP measures included exchange-rate adjustments, raising official producer prices, lifting price controls, increasing foreign-exchange allocations, and raising the level of domestic savings in order to improve the infrastructure and major rehabilitation projects. The initiation of the ERPs, however, could not solve Tanzania's foreign-exchange crisis.

From the late 1970s onward, Nyerere strongly resisted the IMF/World Bank pressures toward economic liberalization for three main reasons. First, Nyerere argued that Tanzania's economic problems had external rather than internal origins. Second, he rejected the association of the problems with the *ujamaa* policy with the single-party system.[17] Third, he insisted on the sovereign right of Tanzania to choose its economic and social goals (Baregu 1993:112; see also Baregu 1987).[18] As a result of Nyerere's resistance, foreign-exchange supplies for Tanzania dried up. Eventually, the government had little choice but to return to the IMF. An agreement with the IMF was reached in July 1986, in which the IMF provided Tanzania with a structural adjustment facility (1987–1990) (Tripp 1997:75).The socialist ideologues in the party, who were led by Nyerere, continued to resist the liberalization policies of the economic recovery program. However, the pragmatists (reformists)—who were mainly in the government with the support of the World Bank and IMF—realized that Tanzania had little choice but to submit to external pressures or face the collapse of the entire formal economy. Thus, the reforms continued to push for liberalization (see Baregu 1994:167–168).

Mageuzi: Economic Liberalization, Privatization, and Multiparty Democracy (1986–1990s)

Economic liberalization in Tanzania did not come easily. The first major move toward liberalization came in 1984, when the government of

Tanzania adopted an "own-funds" scheme. This scheme allowed importers to obtain licenses without declaring the source of their funds. Consequently, by 1989 the government was unable to control the kinds of goods that were being brought into the country. A substantial proportion of the money was spent on luxury goods instead of urgently needed industrial imports that the liberalization policy had intended to bring. The result of these new policies, in particular the liberalization of imports, was the depletion of foreign reserves (see, for details, Tripp 1997:66–67, 93–94). At the same time, Tanzania resisted the pressure to devalue its currency (Bigsten and Danielson 2001:18).

On November 5, 1985, Nyerere announced his decision to step down as president, and he made way for the less charismatic, but more managerial, Sheik Ali Hassan Mwinyi.[19] Nyerere's resignation and Mwinyi's accession, however, did not imply the automatic removal of the former president's political influence. At Mwinyi's request, Nyerere retained his powerful post as chairman of Chama Cha Mapinduzi (CCM)—the only political party in Tanzania—for five more years (Townsend 1998:2). Nevertheless, President Nyerere's retirement opened the way for a future agreement with the IMF on the ERP from 1986 to 1989 and later on for a new ERP from 1989 to 1992 (Bigsten and Danielson 2001:27–28). The 1986 IMF agreement marked a major substantive and symbolic turning point in Tanzania's political and economic history. The conditionalities the agreement imposed required the abandonment of many previous socialist policies (McHenry 1994:159). In 1989, the currency underwent a devaluation of 22.1 percent. The government adopted an investment code, and it started to dismantle parastatals (semigovernment institutions), and it also introduced cost recovery arrangements in education. Politically, these measures signaled a formal break with the CCM ideology of *ujamaa*. They resulted in the breakdown of consensus in the party. According to Baregu, this break is what finally triggered Nyerere's resignation as chairman of CCM in May 1990 (Baregu 1994:168–170).

In the meantime, the global political scene had changed, especially with the fall of communism in Eastern Europe and in the Soviet Union (Verdery 1996). In March 1991, President Ali Hassan Mwyini recognized the inevitability of a political as well as economic adjustment. In order to avoid the possibility of an antagonistic and militaristic movement toward democratization being led by forces hostile to the state, he appointed Chief Justice Francis Nyalali, a respected judge, to head a commission that was to tour the country (and several foreign countries) and poll Tanzanians on their views concerning a multiparty political system.

Both foreign donors and local groups had been pushing the government for reform. Most important, of the more than 36,000 of the people who were polled and expressed their opinions, an overwhelming majority (77.2 percent) favored continuation of the one-party state (Dzimbiri et al. 2000; Kiondo 1995). The most commonly expressed fear was that multipartyism would result in chaos, as witnessed in neighboring Kenya and Uganda. Yet, in 1992, the government conceded to external and internal pressure (coming from urban areas) and approved a multiparty political system, which thereby initiated a process of political reform from above. Among the ingredients of this reform was a freedom for opposition parties to organize and the separation of state and state party (CCM) at various levels (Tripp 1997). Ironically, Nyerere himself supported multiparty politics as a way of forcing the CCM to renew itself and to reinvigorate its role as the party of the people (McHenry 1994:65; Nyang'oro 1995:186–187; Snyder 2001:138).

On July 1, 1992, Tanzania legally became a multiparty state after a span of twenty-seven years under the heavy influence of single-party system.[20] Previously, the CCM and its predecessors had an exclusive monopoly on formal power and authority. They wielded enormous influence on almost every aspect of the social fabric of Tanzania (Ngware 2000:55). An ideology advocating Western-style multiparty democracy was adopted. The new principles emphasized the rights of individuals, the importance of competition, and the freedom of expression of different points of view (Snyder 2001:129). According to Mwesiga Baregu, "The demands for multipartyism and democracy in Tanzania were the culmination of a long and cumulative (albeit uneven) struggle against authoritarian rule" (1994, 159).

Tanzania concluded its first presidential and parliamentary multiparty elections in October 1995. The overwhelming winner of the elections was CCM, which gained 78.1 percent of the total seats in the parliament (Nyang'oro 1995:189). The new president, Benjamin Mkapa, took office in a peaceful handing over of power from President Ali Hassan Mwinyi. Mkapa was re-elected in the second multiparty elections held in October 2000.[21] His chosen successor, Jakaye Kikwete, was elected president in 2005 and reelected in October 2010.

Forced Pace of Privatization: Who Loses and Who Gains?

In 1967, when Tanzania formally committed itself to the program of socialism and self-reliance as set out in the Arusha Declaration, health strategy contributed little to this decision. The main priorities then for socialist transformation were agriculture, industry, and education, but not health.[22] Nonetheless, the Arusha Declaration opened Tanzania to the influence of socialist medical systems elsewhere, especially to the influence of China.[23] Initially, the leadership did not seek to restructure the health sector in light of the *ujamaa* philosophy. However, at the TANU party conference of September 1971, the leadership ruled that rural health services should have top priority in socioeconomic development plans. The new policy was later defined to treat people as close to their homes as possible in the smallest, cheapest, and most simply equipped rural health units. This meant reallocating the budget from hospitals and doctors to health centers, dispensaries, village health posts, and auxiliaries. A key goal was to shift expenditure away from referral hospitals where doctors were concentrated (Iliffe 1998:202–207).

Significantly, health expenditures reached their peak in 1973 and 1974 when 9 percent of the total government budget was spent on health, the very years when Tanzania experienced its first financial setback because of a severe drought.[24] Meanwhile, the government of Tanzania passed the Private Hospitals (Regulation) Act of 1977, which was enforced in full in 1980. The minister of health at the time contended that only a small percentage of the population made use of private doctors anyway, so the Act was mainly for symbolic impact. In the late 1980s, the minister for health and social welfare estimated that the few existing private hospitals treated only 3 percent of the patients in the country, while those run by religious institutions treated 40 percent, and government hospitals treated the rest of the population. The government fixed the fees charged at the private hospitals, and the religions institutions were non-profit. Thus, health services had been expanded to reach a higher proportion of the population, and a high degree of government control had been established (McHenry 1994:83).

By the late 1980s, most likely due to lack of funds, the country's health infrastructure was in shambles, and the socialist medical experiment was close to failure (Iliffe 1998:212). Severe cutbacks were introduced, and the government budget allocation for the health sector fell from 9.4 percent in the early 1970s to 5 percent in 1990–1991 (Harrington 1999:218). The government desperately needed money to refurbish the facilities and streamline the management of the existing facilities, including drug supplies. As in other areas, during the early 1990s privatization became a central element in the mainland health policy. Following the Zanzibar Declaration of 1991, restrictions on private practice were removed, and as already noted, this resulted in the dramatic transformation of the health sector, which primarily affected urban areas.

Tanzania's decision to restructure the health sector came about as a result of intense pressure from the World Bank and other donor countries whose contributions accounted for almost 40 percent of the health sector budget. The World Bank recommended that privatization in the health sector should occur in four forms, and Tanzania followed suit accordingly. In summarizing the different forms of privatization, Meredeth Turshen notes:

> First, to recover costs, governments should charge users of state health facilities, especially consumers of drugs and curative care, on a fee-for-service basis. The reasoning was that by making the "rich" pay for curative care, governments would have more money to spend on community services and public health care for the poor. The second form of privatization was self-financing insurance. To enable users to pay for health care, governments should promote various third-party insurance schemes as well as sickness funds and social security systems. A third form of privatization was investment in the private voluntary sector. To promote private facilities, donors would invest in upgrading private hospitals and clinics to make them more attractive than state services. The fourth privatization measure was decentralization: governments should decentralize planning, budgeting, and purchasing for state health services, and they should use market incentives to motivate staff and to allocate resources. (1999:47)

A major trend that emerged in privatization campaigns was the use of charities to deliver health services, which formerly had been administered by the state.

Thus, as the economy was liberalized, most of the hospitals and health facilities and assets, which once belonged to NGOs but had been nationalized following the Arusha Declaration, were returned to their original owners.[25] Some of the state-owned facilities and services were either sold to private entrepreneurs or transferred to private charities and NGOs. Subsidies provided to public health facilities were either reduced or completely eliminated. Individual practitioners were allowed to set up their for-profit private medical practice. The private sector enterprises were encouraged to provide goods, such as pharmaceuticals, that were formerly available only through the state. In addition, privatization resulted in budgetary cuts within the health ministry. As a result, many ministry personnel lost their jobs and user fees were introduced for the use of public health facilities (Turshen 1999:43).

Beginning in July 1993, cost sharing through user charges in the public health-care system was introduced in phases, initially at the level of referral and regional hospitals.[26] Thereafter, in July 1994, charges were introduced in district hospitals, and in 1995, the plan was extended to health centers and dispensaries (Msamanga et al. 1996:4). User fees were introduced in government health facilities in the hopes that this extra income would lead to the generation of significant revenue to meet part of the recurring health expenditure. It was argued that the introduction of user fees would make it possible to improve the quality of health services, increase the utilization of the government health facilities, and improve equity in health-care delivery (Mwabu 2001:198). Despite the fact that research in neighboring Kenya and Uganda showed that all of these above assumptions were false, as utilization rates at government health facilities fell substantially and quality improvements in government health facilities generally did not materialize (Creese 1997; Mbugua, Bloom, and Segall 1995; Mwabu, Mwanzia, and Liambia 1995; Mwesigye 1995; see also Russel and Gilson 1997), Tanzania decided to go ahead with its cost-recovery program under pressure from the World Bank.

The application of a user fee system presumes the existence of perfect markets for health care and the existence of a system of medical insurance schemes (Mwabu 2001:206). Moreover, a market economy requires an institutional framework within which to incubate the policies (Burawoy and Verdery 1999:5). In Tanzania, there is neither a perfect market for health care, operating along market principles of supply and demand, nor is there an elaborate system of medical insurance that covers the majority of the population. In other words, the ushering in of privatization in Tanzania can be compared to the metaphor of putting the cart before the horse.

Finally, in March 1996, the government of Tanzania, with the approval of parliament, the World Bank, UNICEF, and the major donors, prepared and piloted the country's health sector reform program. In April 1996, all partners in the health reform effort reviewed and approved a health sector reform plan for 1996 to 1999 (Swantz 1997:13). However, the quality of services provided by the expanding private for-profit health facilities was poor. This led the health ministry in 1996 to suspend the certification of nearly half of the country's private for-profit facilities for not conforming to quality standards. The facility operators were given six months to conform to the new standards, after which they would be forced to close (Msamanga, Urassa, and Mujinja 1996:90; Munishi 1997:x). In the current context, it is common knowledge that several private for-profit facilities, especially private pharmacies, continued to operate without meeting the quality standards set by the government. Between 2001 and 2005, a number of private health facilities, including pharmacies and pathology laboratories in Dar es Salaam, had a large red "X" mark painted on the door by the Ministry of Health, in order to warn the customers that the practitioner had not paid the license fees and/or that the facility was illegal.

Resource allocation in health continues to be skewed in favor of tertiary hospital services and urban areas. With regard to the preventive-curative services balance, a recent analysis of government expenditure indicates that 77.9 percent of government resources are spent on curative care, despite the government's focus on preventative care. Preventive care takes only 15.4 percent of the expenditure, mostly from donors, and community health takes about 6.6 percent. Private medical practice is even more skewed in favor of urban areas. Furthermore, as noted above, the expansion of its activities has not been accompanied by appropriate regulatory mechanisms to ensure adherence to medical ethics (Wangwe, Haji, and Tibandebage 1998:75). As John Iliffe has commented, in 1997, "The country was littered with the debris of past systems, with the remains of socialism lying thick and the surface patches of private practice still spreading" (1998: 219).

To recapitulate, Tanzania has gone through various stages in its transition from a nation committed to the ideals of socialism to a market economy in the 1990s onward. During the first few years following independence, Tanzania witnessed a political climate that was marked by a deep sense of optimism. The new nation, built on the principles of *ujamaa* and steeped in self-determination, saw itself as an example for other newly independent African nations to emulate. Indeed, for more than a decade (1963–1973), Tanzania was perhaps the only country in Africa that was a net exporter of raw materials and had a foreign exchange surplus. The mid-1970s, however, ushered in a series of crises that plunged the economy and the people of Tanzania into despair. SAPs introduced in the 1980s did little to strengthen the economy. In fact, scholars have shown that the living conditions of the people of Tanzania worsened during this period. In the 1990s, international financial institutions and donor countries lauded the government's decision to privatize the economy and introduce multiparty democracy, despite the skepticism of the Tanzanian citizens. Privatization within the health sector in particular has resulted in some remarkable changes in the health infrastructure. Yet, all indicators suggest that these changes have not improved the lives of the majority of the people of Tanzania, especially the poor and the marginalized; in fact privatization and neoliberalization of the economy has only worsened their situation. As Todd Sanders has vividly described: "After decades of shortages under *ujamaa*, enterprising Tanzanians have today filled their cities with mountains of consumer goods and goodies—as well as dreams for a better future. . . . Plenty of Tanzanians and Tanzanianists now recognize that economic liberation has come with devastating costs. . . . Many villagers these days are growing more crops, risking more in marketing them, spending more in cultivating them, and earning less for their sale" (2008:32).

As will be discussed later in this book, the proliferation of commodities of desire in the country has not only ushered in an era of *tamaa* or greed and selfishness, undermining the very basis of Nyerere's vision of the future of the Tanzanian nation, it has also exacerbated social and economic inequalities on an unprecedented scale. In the chapters that follow, which are this book's ethnographic core, the impact of Tanzania's unique historical, political, and economic features on people's everyday lives, and particularly health, will become clear.

PART TWO

Local Practices

CHAPTER FOUR

Micropolitics of Childhood Malaria

User fees are a common financing mechanism used to increase resources available to the health care system and to recover a portion of costs.

ALLISON BEATTIE ET AL. 1996:9

User fees, they don't reduce costs, they increase inequities.

ANDREW CREESE 1997:202

One early afternoon in April 2001, on my way to Kimbangulile, a small hamlet that sits on the top of one of the hills surrounding Mbande village, I recognized Zaituni, a woman in her mid-forties, as she was coming down the slopes of one of the hills. Two weeks earlier, I had engaged in an informal conversation with Zaituni at the dispensary in Mbande, regarding her daughter's sickness. I had expressed my desire to visit her hamlet sometime soon. In her distinct husky voice, she told me that she was the mother of nine children; two of them were already married, and her youngest daughter, whom she had brought to the dispensary on that day, was a year and a half old. As I greeted her mid-way down the slope, I saw that she was carrying her daughter tied to a *kanga*-sling on her back. Following the usual elaborate exchange of greetings, she told me she was on her way to the dispensary. Her child looked very sick, with beads of sweat all over her head and face. I spontaneously touched the child's neck and noted that her body was very hot. "You need to rush!" I said, expressing a sense of urgency. "Did you sponge her?" I asked. "No," she replied, and continued: "If I sponge my child (*mkanda maji baridi*), then they [the dispensary staff] won't believe me [when I say that she is very sick]; they'll just give her aspirin and tell me to go home. So I have to take her to the dispensary while her body is still hot." Zaituni's matter-of-fact reply left me momentarily nonplussed, as she continued with her journey to the dispensary, which was a good forty-five minutes walk from the spot where we had met. I continued with my climb up the mountain to interview a potential respondent, wondering all along whether Zaituni was perhaps being an *uzembe* (careless) mother (a common expression that people in the village used to characterize "careless or negligent mothers"), and putting her child's life at risk, or was she indeed being strategic and exercising agency in her child's best interest—to ensure that the dispensary staff gave her child the best treatment available (an injection), and not just paracetamol, which she could buy on her own over the counter. Effectively, she had delayed in bringing her sick child to the dispensary. A few days later I learned that the delay had complicated matters, requiring Zaituni to take her child to the Muhimbili National Hospital where she was hospitalized for two weeks and subjected to blood transfusion.

This chapter engages the complexities surrounding the process of treatment-seeking for childhood malaria in the context of an increasing emphasis placed, globally and locally, on "responsibilization," or empowering citizens to take responsibility for their health, rather than depending on an infrastructure that would make health possible (Foley 2010:61; see also Nguyen 2005; Collier and Lakoff 2005; Ong and Collier 2005). Drawing on excerpts from illness narratives, case materials, and some quantitative data, I rethink the problematic of user fees and make a case for addressing issues that go beyond the user fees debate (Lagarde and Palmer 2008; Meessen et al. 2011). To this end, I provide a more contextualized understanding of why some mothers and caretakers delay in seeking early diagnosis and treatment for their young, febrile children at government health facilities. Central to this chapter is a discussion on whether user fees deter or do not deter mothers from seeking prompt treatment for their children, especially when they have high fevers. In historical perspective, following the publication of the World Bank's 1993 report on investing in health, user fees and cost recovery programs became important concerns among policy makers, malaria researchers, and health economists in particular in the 1990s (see for example, Berman 1995; Gilson 1995, 1997; Gilson and Mills 1995; Gilson, Russell, and Buse 1995; Mubyazi et al. 2005; Mushi 2007; Shaw and Griffin 1995; World Bank 1993).[1]

In what follows, I first examine cultural models of fever (i.e., local perceptions or interpretations of fever), and factors underlying treatment delays among the people I worked with, followed by a discussion on why mothers who bring their sick children to the local dispensary often engage in strategic symptom reporting, that is, selectively reporting symptoms to health personnel. I then discuss issues of treatment costs as they relate to treatment delays. Finally, I delve into the problematic of misdiagnosis and subsequent treatment delays. I use cases studies as illustrative examples of the travails that mothers face in their search for therapy for their young, febrile children. Through these case studies I highlight how health-care-seeking surrounding childhood malaria is often mediated by a multiplicity of factors that go beyond economic considerations (user fees in particular), cultural meanings, perceived severity and past experience, structural disadvantages affecting women's access to societal resources, contingent circumstances, and the patterns of communication between patients and/or caretakers and health-care providers in government health facilities. As such, this chapter also provides the theoretical and substantive background for chapter 5, which focuses specifically on the illness *degedege*.

Saving Lives

Most malaria researchers and policy makers agree that delay in seeking appropriate medical treatment for childhood *P. falciparum* malaria (the more serious form of malaria) often results in severe complications, if not always death. Not surprisingly, the WHO has repeatedly emphasized the importance of early diagnosis and effective biomedical treatment as one of the key factors in preventing high levels of malaria-related deaths in sub-Saharan Africa. Those who are involved in the planning and implementation of malaria control programs in East Africa, and elsewhere, have all along added a sense of urgency to the question of delay in treatment-seeking, while also making serious calls to optimize malaria treatment, with artemisinine-based combination therapy (ACT). Until recently, one of the key questions that researchers and policy makers have been asking about treatment delays is whether the practice of charging patients a nominal fee-for-service acts as a deterrent or as an incentive (i.e., people who perceive free medicine as tantamount to poor quality medicine may be more willing to pay if they are assured of better quality service) in seeking prompt treatment at government health facilities.

In 1990, the government of Tanzania commissioned a study to assess people's opinions about user fees in the public health services, and their willingness to pay the nominal fees. Significantly, the study suggested that 80 percent of people in Tanzania were willing to make a financial contribution toward improving the quality of services in the health sector (Mujinja and Mabala 1992; Mushi 2007). Thus, effective July 1993, the Ministry of Health (MOH) introduced the cost-sharing policy in the

Tanzanian public health service system as part of economic recovery and structural adjustment programs aimed to improve efficiency and foster sustainability in the provision of health services through community participation (Munishi 1997). This policy was also implemented to relieve the public health sector from chronic shortage of recurrent inputs such as drugs and other medical supplies. Increased cost-recovery revenues were also suggested as a means for improving the quality, effectiveness, and coverage of health services and to contribute to people's ownership and sustainability in health service provision. The policy was introduced in a phased manner, beginning with referral hospitals and then after a few years with health centers and dispensaries (Mbuyazi et al. 2005a).

As already noted in the introduction, proponents of free market medicine have argued that cost-sharing or the implementation of user fees in public health facilities has an efficiency and equity enhancing effect. However, critics have pointed out that the introduction of user fees in poor settings not only increases inequities it also has a devastating effect on the sick, especially women and young children (Mwabu 2001; Mwabu, Mwanzia, and Liambia 1995; Nanda 2002; Nguyen and Peschard 2003; Turshen 1999). In the Tanzanian context, some scholars have argued that user fees introduced as part of a cost-recovery program deter, if not prevent, the local indigent populations from attending government health facilities (Tibandebage and Mackintosh 2005). Several scholars have argued that user fees have led to increasing levels of morbidities and mortalities, especially among women and young children in Africa (Lugalla 1995b; Turshen 1999). Therefore, on the grounds of health inequities, they made calls to discontinue the practice of charging patients user fees as this practice tends to hurt patients who are at greatest risk for disabling and fatal illnesses (Creese 1997; Gilson 1997; Russell and Gilson 1997). Other researchers in the Tanzanian context, have, however, noted that their empirical data are inconclusive on the question of the role of user fees in treatment-seeking behavior, particularly for malaria (see, for example, Mbuyazi et al. 2005a; Mushi 2007).

Throughout my fieldwork, I observed that although all patients were required to pay user fees (*kuchangia* or to make a "contribution") at the village dispensary, neither the medical officer (doctor or *daktari*) nor the nurses insisted that the fees be paid immediately.[2] In 2000–2001, patients were charged a nominal Tsh. 100 for a syringe (*bomba*).[3] Although this amount was less than the minimum fare that the local *daladala* buses charged per passenger (Tsh. 150 in 2001), it was not uncommon for mothers to bring their sick children to the dispensary without any money

Figure 7. Mother waiting with her sick child at the dispensary. Photo by author.

in hand. Thus, services were often provided on credit (*deni*). The local sociocultural dynamics of deferred payment and trust between the dispensary staff and the clientele over an extended period of time underscored this practice. The nurse would write the fees or the unpaid, outstanding amount in the patient's health record notebook that parents and caretakers were required to bring with them to the dispensary during checkups, immunizations, and treatment-seeking.

In gathering data at the dispensary from January 2001 and August 2001, I engaged in informal conversations with more than 150 mothers/caretakers and documented hundreds of doctor-patient and nurse-patient/mothers interactions. I also conducted detailed follow-up interviews with forty-five mothers over an eight-month period. These mothers had come to the dispensary with a febrile child under five years of age.[4] Interviews with these mothers were comprised mainly of life histories and interview-elicited narratives that documented the practical details and the extended case studies of illnesses.[5] In their narrative accounts of care-seeking, mothers described the symptoms they had noticed, the steps they had taken to deal with the illness, who they had consulted, the treatments they had tried, their evaluation of the treatments, how they interpreted the illness in the context of their social and economic position in the community, and what their next step would be in terms of treatment follow-up and prevention. While a total of 800 fever cases were treated at the dispensary during this period, several of them were cases of re-infection and relapse. This is a significant number in terms of the caseload, considering the fact that there were about 5,000 people living in the dispensary's catchment area that extended several square miles at the time and covered many scattered villages and hamlets. Besides, self-medication with chloroquine bought over the counter was uncommon. These cases were treated outside of the formal system. Several mothers who had arrived at the dispensary believed that their child had an "ordinary fever" (*homa ya kawaida*), only to be subsequently told by the doctor or nurse that the child had a fever that was serious and necessitated sponging with tepid water, and a chloroquine injection.[6]

Cultural Models of Fever and Treatment Delays

Nearly all the forty-five mothers I interviewed were familiar with the practice of bringing a sick child to the dispensary for treatment. In other words, they were familiar with the routine of medical consultation and the expectations and everyday practices of the dispensary staff. Mothers commonly expressed their familiarity with the dispensary by referring to it as *hospitali yetu* (i.e., "our hospital"). More than half the mothers had waited for at least forty-eight hours after the onset of fever before bringing their children to the dispensary. Many of them had waited for nearly a week before deciding to bring their feverish child to the dispensary. In response to questions about delays in treatment-seeking, two-thirds of the mothers spontaneously replied: "I thought it was only an ordinary fever!" (*Nilifikiri homa ya kawaida tu!*). They elaborated on how surprised they were when they found out what they thought was an "ordinary fever" (*homa ya kawaida*) that children commonly suffer during the winter season, had suddenly turned into a "strong fever" (*homa kali*) or malaria (*homa ya malaria*). In a small number of cases, *homa kali* had suddenly become *degedege*—the indigenous name for a severe form of illness that affects mostly young children, which is discussed in greater depth in chapter 5.

In the local cultural model of fever, if *homa ya kawaida* is left untreated, it may lead to *homa kali*, which in turn, if untreated, may lead to *homa ya malaria*. Finally, if malarial fever is not successfully treated, it may turn into *degedege*. While most of the mothers I interviewed shared the cultural understandings of the etiology of *degedege*, there was considerable variability and flexibility in how they interpreted the taxonomy of fevers and the trajectory of the illness or the "main" cause of the illness. More important, one-third of the mothers had never witnessed a child suffering from *degedege*. Furthermore, another one-third of the mothers said that they had dealt with *degedege* in the past when the illness had affected their own child. Many mothers spoke of *degedege* in terms of what they had gleaned through word of mouth. They used phrases such as "*nimesikia tu . . . na jua*." "I've heard from others that *degedege* is a dangerous illness . . . people say that it can strike any child. . . . I haven't seen it or experienced it myself, but I know what it is." Still, 80 percent of the mothers were confident that if they were presented with a situation of fever-inducing illnesses, they would certainly be able to distinguish *degedege* from other conditions. Despite this assuredness, many mothers in Mbande and the neighboring villages and hamlets had gained information about *degedege* in the form of "second-hand episodes" without having personally experienced the event (Price 1987). Drawing on her work on illness narratives in the Ecuadorian context, Laurie Price has elaborated on the ways in which individuals tend to expand the cultural models they use to think about and interpret certain illnesses; they do this, often unconsciously, through hearing stories of other peoples' experiences with particular illnesses. According to

Price, "Individuals gain information about entire illness episodes without having personally experienced those events. Such secondhand episodes are integrated with those the person has directly experienced and become part of his or her current script concerning illness. . . . Because illness stories occur in the context of conversational exchange, they contribute to 'socially generated knowledge.' Cultural models are carried by individuals, but they are partly constructed and refined through conversation and reflection. Nowhere is this more clearly seen than in the discussions of causation in illness narratives" (Price 1987:313). In other cases, while the illness label remained unchanged (e.g., *homa kali*), changes in perception of severity, through visible symptoms or based on the failure of a home-based treatment, greatly influenced the mothers' health-care response. Perceived severity of the symptoms was one of the key factors in the mother's decision to bring the child to the dispensary. Just as the way an illness is understood may change through time, the subsequent treatment options that are pursued also change. Diagnoses and interpretations change in response to different outcomes of a range of attempts at treatment—either simultaneously or sequentially.

I accompanied several mothers and, with the prior permission of the doctor and the nurses, sat through the consultations mainly to document the process concerning how the dispensary staff and parents negotiate the identity of the child's illness. During the consultations at the dispensary, only about one-third of the mothers were specifically told either by the doctor or one of the nurses that their child was suffering from malaria or *homa ya malaria*. Others were told that their child was suffering from *homa* or *homa kali*. Only one mother was told that her child was suffering from *degedege*. In nearly one-third of the cases, neither the doctor nor the nurse gave the mother a specific diagnosis (*ugonjwa gani*). Despite the fact that all forty-five children I followed were treated with chloroquine, follow-up interviews with their mothers revealed that at least one-third of them were not aware of the identity of their child's condition as labeled by the dispensary staff. In other words, the dispensary staff seldom verbalized their diagnosis to mothers. They would often not tell the mothers openly that their child is specifically suffering from malaria or *homa ya malaria*. Instead, they generalized the diagnosis as *ana homa* or *ana homa kali* (i.e., a fever or high fever). In the local context, the term *homa* was often used interchangeably to refer to ordinary fever, malarial fever, and a range of other fevers. However, the dispensary staff believed that since most mothers were dealing with malarial episodes regularly, they would read their verbalization of the term *homa* or *homa kali* as synonymous with *homa ya*

Figure 8. Doctor advising mother about her child's sickness. Photo by author.

malaria. However, as Susan Whyte, who has commented on a similar situation in the Ugandan context, notes: "This may partly reflect an assumption on the part of health workers that patients are not interested in or able to understand biomedical diagnoses. . . . The lack of communication about diagnosis may also be associated with the fact that the health workers themselves are unsure of what they are treating" (1997:213).[7]

The implications of this ambiguous style of communication in government health facilities are significant in regard to treatment-seeking behavior for childhood fevers. Ultimately, it is the dispensary staff's responsibility to ensure that mothers become more sensitive to recognizing early signs of malaria, especially among young children. This expectation is based on the assumption that by educating mothers about the symptoms of malaria, the dispensary staff can alert them to the severity of the illness. This, in turn, would result in a more timely diagnosis and treatment of the illness. In other words, if the dispensary staff were to emphasize the diagnosis of malaria and its dangers, mothers would probably bring their sick children to a biomedical health facility more promptly, and this would lead to a potential drop in fatalities. In the present case, the dispensary staff used the relatively "mild" term *homa* or *homa kali*, when in fact the child was clinically diagnosed with malaria. In doing so they were not helping mothers to seek prompt treatment for their children during subsequent fever episodes.

Mothers reported a range of symptoms that they potentially associated with malaria, including high fever, shivering, vomiting, loss of appetite, restlessness, and incessant crying. In nearly two-thirds of the cases, other family members had also noticed the symptoms that mothers recalled during the interview. In most cases it was the husband or the fiancé (*mchumba*) who also noticed the symptoms. However, it was consistently the mother who made key decisions and not a therapy management group—classically defined as the family members who get involved in the "diagnosis and the negotiation of illness identities, the selection and evaluation of therapeutic options, and the lending of support to the afflicted" (Janzen 1978:7–8; see also Nichter 2002). The fact that mothers believed that they were dealing with a non-life-threatening, recurring ordinary fever partly explains the absence of a therapy management group—the mothers believed that the treatment was known, and therefore their response was routine. Concerned others were involved only in cases where the illness was recognized as being serious and potentially life-threatening, especially following a sudden change in the visible symptoms.

Agency in Symptom Reporting

Usually I reached the dispensary well before the doctor and the nurses had arrived, as this would give me the opportunity to engage in informal conversations with mothers and caretakers of sick children who were waiting in the verandah to be seen by the doctor or the head nurse. The interactions between the dispensary staff and the patients and mothers were, for the most part, routine, predictable, and uneventful. Occasionally, the scene at the dispensary would become a bit unsettled, when, for example, a nurse advised one of the mothers to begin sponging her feverish child so as to bring down the child's body temperature. Typically, the mother would follow suit, sit on the floor, and start sponging her child with a wet *kanga*. The nurse would provide the mother with a small steel pot filled with cool water (see Figures 9 and 10).

In nearly all the cases, sponging had a positive effect in lowering a feverish child's body temperature. However, the process was lengthy, and often took between thirty minutes and four hours. More important, contrary to what I had anticipated, the dispensary staff did not routinely advise the mothers to sponge their child. This was because the majority of the children had a fever of less than 39° centigrade—a level of fever that the dispensary staff deemed as “not very serious.” Most of the mothers I interviewed had observed other mothers sponging their feverish child, or they had themselves been advised to do so during previous consultations at the dispensary. A little more than half of the mothers had sponged their febrile child prior to bringing him or her to the dispensary. However, another one-fifth said that they were simply too scared to do anything by themselves. They thought it would be better if they brought their child to the dispensary to see what the doctor or the nurse had to say. For example, Halima Mohamed, a twenty-one-year-old Zaramo mother of one child, who lived in my neighborhood in Mbande with her husband, a prosperous businessman who sold dried/fried fish, explained: “When I saw that Aziza’s fever had really shot up and she had convulsions, I was too scared to do anything on my own. So the next morning, the first thing I did was to rush her to the dispensary.”[8] While some mothers said that they had not resorted to sponging because they were not aware of this practice, another small number of them said that when they found that their child had high fever, their “mind stopped working” (*akili yangu sio nzuri*).Thus, one afternoon, when Zaina Juma’s ten-year-old-daughter Laila came running to her while she was working the field, to tell her that Ramadhani, her youngest son, had a high fever and he was vomiting and in a semiconscious state at home, Zaina dropped everything, rushed back home, picked up Ramadhani, and carried him on her hip to the dispensary—a one-mile walk along the main road. When I asked her why she had not tried tepid sponging at home as a first resort, she said in a matter-of-fact way: “I was working in the field. I had to drop everything and rush home. I knew that if I had started sponging Ramadhani, I would be late in taking him to the dispensary because it closes at 1:00 p.m. I had only one hour left to reach there, so I decided to simply pick him up and rush him to the dispensary.” Thankfully, on that day, the trainee nurse at the dispensary agreed to stay back until Ramadhani’s temperature had been lowered through sponging (the process took two hours), and he was given a chloroquine injection. Since I had stayed back at the dispensary that afternoon, I was able to document the whole process through notes and photographs. In Zaina’s case, it was not a lack of knowledge about the beneficial effects of tepid sponging that led her to rush her child to the dispensary rather than to sponge him, but was the result of exigency. Other mothers explained that when they had made the decision to bring their sick child to the dispensary, the child’s body temperature was “still okay” and therefore they assumed it was only an ordinary fever. However, upon arrival at the dispensary, the child’s temperature had shot up. At this

Figure 9. Young mother sponging her child at the dispensary. Photo by author.

point, it was necessary for the mother to follow the nurse's advice to resort to sponging the child.

I conducted follow-up interviews with mothers and held discussions with the dispensary staff to find out why so many mothers tend to refrain from sponging their feverish child prior to bringing him or her to the dispensary—given that most of them recognize the beneficial effects of this practice. Through these follow-up interviews and informal conversations with the dispensary staff, I learned that many mothers tend not to sponge their child prior to bringing him or her to the dispensary visit for fear of masking the symptoms. Arguably, as I have illustrated in the opening vignette (my meeting with Zaituni en route to Kimbangulile), past experiences had guided many mothers to believe that if they arrived at the dispensary with a child whose temperature had been lowered by prior sponging, the doctor/ and or nurses would not believe that the child was really sick. As a result, the mothers believed that the child would not get the necessary level of attention and the right medicine. They also believed that the child would be given aspirin or paracetamol instead of an antimalarial injection (chloroquine), which at that time constituted the best treatment for childhood malaria because of the injection's dramatic effect. Thus, in contexts of limited accessible health-care options, mothers were being strategic when presenting their child's illness in order to authenticate it, even if it meant that they were inadvertently putting the child at risk of developing serious complications. In a sense, it was "practical logic" or disposition (Bourdieu 1990) that was at the heart of how mothers presented their child's illness to the dispensary staff. They utilized this strategy so that the dispensary staff would take the illness seriously and invoke the best treatment possible (i.e., an injection). In this case, strategic symptom reporting did not denote "irrational health behavior" or lack of faith in biomedicine, but rather indicated a manipulation of the system toward felt needs (Nichter and Nichter 1996:120–121). In these contexts, a proactive approach on the part of health workers based on a demonstrated willingness and responsibility to treat all febrile children seriously would be a first step in convincing mothers that they need not refrain from sponging their febrile children. This would lead to better treatment outcomes. More important, none of the dispensary staff had received the kind of training that would have prepared them to assume a proactive disposition toward their patients—especially in regard to matters such as taking mothers seriously even if they came with children who did not look very sick.

Figure 10. Mother sponging her child at the dispensary. Photo by author.

Illness Narratives

By examining the following case studies, I will illustrate how, while the identity of the illness had remained the same, the perceptions of the severity of the symptoms had changed. In other cases, the identity of the illness was revised (e.g., *homa ya kawaida* to *homa ya kali*) following the failure of a previous treatment. This took the form of "diagnosis by treatment," that is, "relying less on doctors' diagnoses and more on one's own assessment of treatment efficacy" (Nichter and Vuckovic 1994:1514). Illness identities were subject to constant revision and reinterpretation with the presentation of a new diagnosis, including the recognition of a new set of symptoms, or through new information provided by family members and health workers. The following case illustrates the travails of a mother who had delayed in seeking treatment for her child's recurrent febrile illness at the local dispensary due to her concerns regarding the efficacy of the medicines prescribed there.

Case 1: Japo's Story

Japo Bakari, a twenty-six-year-old Ndengereko woman, was living in Mbande with her husband, her one-year-old son Salimin, a co-wife, and the co-wife's three-year-old son. Japo had completed seven years of formal schooling. She was also trained as a tailor. Her social support network was extensive as several of her relatives, including her two sisters and an uncle, lived in Mbande. In 1999, while she was still dating her fiancé (whom she married later), she became pregnant and gave birth to a boy. Unfortunately, the baby died within two months following complications resulting from a spina bifida surgery. The money that her fiancé had saved for their wedding was spent on their child's medical treatment at the Muhimbili National Hospital and a private for-profit hospital. Two years later, she gave birth to Salimin, her only child. During 2000–2001, when I was doing my fieldwork in Mbande, Japo lived in a rented room in a dilapidated Swahili-type house close to the dispensary. In August 2001, following a heavy storm, a large branch from a mango tree in the frontyard fell on the house, dividing it into two. Luckily, no one was hurt. Left with no choice, Japo moved in with her fiancé and his existing wife. Because Japo lived in a house that was right opposite the dispensary, we regularly exchanged greetings and entered into small conversations almost on a daily basis.

On one occasion, Japo arrived at the dispensary with Salimin who was very sick. Japo was grimfaced with worry. That morning, the doctor and all three nurses were present in the dispensary. Salimin had been sick for one full week. He had experienced bouts of fever, and Japo had decided to bring him to the dispensary to consult with the doctor. His fever had shot up and would not subside despite the antipyretic and chloroquine syrup she had periodically given him. As Japo lived very close to the dispensary, and she was married to a relatively wealthy Zaramo cashew trader, and her maternal uncle (who lived in my neighborhood in the village) was the chairman of the Village Health Committee—a key figure in the management of the dispensary—Japo had several factors in her favor that should have influenced her to seek prompt professional help for her son. During an informal conversation with her at the dispensary, I asked her why she had not brought Salimin to the dispensary earlier; why had she waited one full week after noticing that he had developed a fever? She spontaneously said, "I thought it was only an ordinary fever!" and went on to explain that because she thought she was dealing with an ordinary fever, she kept giving Salimin an antiypretic and chloroquine syrup that the child's father had bought just before he left on his business trip to Tanga, but to no avail. In realizing that the chloroquine syrup was not having any effect, she had brought Salimin to the dispensary to get some advice from the dispensary doctor. She thought perhaps the doctor would prescribe some medicine other than chloroquine or refer Salimin to the district hospital.

While Japo was narrating her story to me, the trainee nurse took Salimin's axillary temperature, which was a little over 40° centigrade. She clinically diagnosed Salimin's condition as malaria and advised Japo to go ahead and sponge him with tepid water. Japo acted upon the nurse's advice. She later mentioned to the nurse that she had already given Panadol and chloroquine to Salimin. The nurse responded with a casual "*sawa*" (okay). Two hours later, when Salimin's temperature had come down to almost normal, the nurse gave him a chloroquine injection and advised Japo to return with Salimin later for three more follow-up injections. Although Japo was visibly disappointed with the nurse's casual advice, she did not contest it. She decided to defer the medical judgment to the nurse who was in an authoritative position. Japo also knew that she needed to return to the dispensary in the future. Hence, as with most mothers who "regard the dispensary as yet another site where local representatives of powerful outside forces provide highly valued resources for ordering life" (Brodwin 1997:78) and have learned to live with disappointing encounters, Japo too endured her frustration in silence. Two weeks later, in a detailed follow-up interview, Japo explained that although she knew that they did not do any laboratory tests at the dispensary, she had decided to go there mainly because she knew that the doctor was very knowledgeable and he would prescribe a different medicine (other than chloroquine), but to no avail. Instead, Salimin was given four injections of chloroquine over four days, but his fever did not go away. Disappointed, Japo thought it was better for her to take her son to a private clinic in Mbagala town, about eight miles away, and take advice from the doctor there, because by then Salimin was convulsing. She believed that Salimin was convulsing because "he had no blood left in his body or maybe he was dehydrated." After examining Salimin, the doctor at the private clinic told Japo that her son had "a different kind of malaria" (malaria *sugu*, i.e., chloroquine-resistant) and prescribed four injections of quinine, which had the desired effect on Salimin. At the time of the interview, Salimin was doing well; his fever had not returned.

Japo had delayed in bringing Salimin to the dispensary because initially she believed that Salimin's fever was only an "ordinary fever," but when she realized that it might be malaria, she decided to administer chloroquine syrup on her own because she was familiar with it. At this point, she believed that it would be futile to take Salimin to the dispensary because she knew that the dispensary staff would only hand out paracetamol and chloroquine, duplicating her own unsuccessful efforts. Finally, after a one-week "wait-and-watch" period, Japo decided to take her child to the dispensary not to get medication, but to get a prescription for a different medicine and/or a referral slip to go to the district hospital. Japo's fears were confirmed, as the dispensary staff had nothing else to offer Salimin but chloroquine injections. Disappointed with the treatment, Japo decided to take her son to a private practitioner. Despite the considerable expenses, she was satisfied with the outcome as her child no longer had fever. Ultimately, Japo's decision to delay in seeking treatment was not because of the user fees charged at the dispensary, but mainly because of her lack of faith in the efficacy of the medicines (especially chloroquine) prescribed at the dispensary and the poor advice she was given there. During the course of my fieldwork, I documented the sentiments and experiences of several mothers with regard to treatment failure at the dispensary. Yet, unlike Japo, very few mothers in the village had the resources to take their sick children to a private health facility for treatment. The cost of doing so was five to ten times that of seeking treatment at the local dispensary; the higher fees and transportation costs were a significant obstacle.

Case 2: Husna's Story

Husna Ali, a twenty-two-year-old Ndengereko woman, was living with her parents in Mbande, along with her four-year-old son Msemo. She was married to a fisherman, who lived in Kigomboni, across the Dar es Salaam harbor, some thirty miles from Mbande village. However, because her husband was an alcoholic and had started living with another woman, Husna decided to move out of her husband's house and return to Mbande to live with her parents who were subsistence farmers. Her husband visited her occasionally and she in turn would visit him in Kigomboni once every two to three months. Husna had seven years of formal schooling and earned a small income by selling *kangas* in the village. Although I had crossed the trail near Husna's house on several occasions, I met her for the first time at the dispensary almost a year into my fieldwork. As with most mothers at the dispensary that day, Husna had arrived with Msemo, who was flushed with high fever. She had not brought the customary extra *kanga* with her, commonly used for tepid sponging, so the nurse instructed her to give Msemo a cold-water bath just outside the dispensary's verandah in order to lower his body temperature. Following an informal conversation with Husna at the dispensary, I interviewed her a week later at her home regarding Msemo's illness. According to Husna, after she had noticed that her son's body was unusually hot, she wanted to take him to the dispensary but she could not because the dispensary was closed for the weekend. Therefore, she consulted with Shabani, one of the local private pharmacists and bought Panadol and chloroquine syrup from him, and started to give the medication to Msemo as per the recommended schedule. The following Monday, when she brought Msemo to the dispensary [the day we first met at the dispensary], he was given a chloroquine injection. She took him again on Tuesday for treatment follow-up, but on Wednesday, he started convulsing. "Initially I had thought that Msemo's fever was just an ordinary fever because right now it's the winter season and it's very cold. I did not know that he would get *degedege*, so again I rushed him to the dispensary."

Unlike most mothers who only used an antipyretic as the first resort to deal with their child's fever, Husna had acted immediately by giving Msemo chloroquine syrup. While she did not specifically mention this to me in the interview, she had most likely made this decision following the retail pharmacist's advice. Her decision to take Msemo to the dispensary was delayed because the dispensary was closed on weekends. The doctor or the nurse-in-residence attended only to "emergency cases." During my fieldwork, the people of Mbande and neighboring villages and hamlets frequently complained to me that the dispensary was not open during weekends, and this caused them unnecessary hardship. I also learned through additional interviews with Husna that although she had initially believed that her son had an ordinary fever, she had acted upon it immediately because she was aware that Msemo had a history of recurrent malarial episodes, including at least four previous episodes of *degedege*. Husna's first resort was always to go to the dispensary rather than to a *mganga*. For Husna, her repeated encounters with her son's illness had led some of the symptoms associated with her son's illness to become a part of her cultural knowledge. Therefore, she was able to both recognize and describe the symptoms commonly associated with her prototypical understanding of *degedege*, and to act accordingly. Not surprisingly, she had decided to seek medical help right away, first securing medicines over the counter because the dispensary was closed at the time, and then following the treatment with visits to the dispensary.

Past experience with malaria had convinced several mothers such as Husna that their sick child's symptoms were typical of malaria. For example, Maimuna, a twenty-five-year-old Makonde mother of three children, who lived in Kimbangulile with her husband, two co-wives, and ten other children, was sure that her child had malaria because he had a high fever, was vomiting, had diarrhea, and the urine was yellowish (*mjano*) in color. Moreover, he had febrile convulsions that reminded her of a previous experience with *degedege* (Maimuna's oldest son had died of *degedege* three years earlier). While only a small number of the mothers believed that their child simply had high-grade fever (*homa za kitoto/homa kali*) and not necessarily malaria, a few also believed that their child was suffering from chest congestion (*homa ya kifua*). The remaining mothers believed that their child was suffering from any one of the following illnesses: pneumonia (heavy breathing and gasping—*alikua ana hema upesi upesi*), diarrhea and vomiting (enteric symptoms), stomach cramps (*chango*), and illness of the intestines (*ugonjwa wa ngiri*).

Treatment Delays

Significantly, for the majority of the mothers, the anticipated cost of treatment was not the main dissuading factor in their decision to seek treatment for their sick child at the dispensary. Even in the context of poverty, more than three-quarters of the mothers I interviewed said that they were willing to pay the nominal Tsh. 100 charged at the dispensary, provided they received satisfactory treatment for their sick children. This is not to discount the fact that there were scores of people in Mbande and neighboring villages where I conducted fieldwork who were in desperate need of basic medical attention. For example, during follow-up work in one of the neighboring hamlets, I met a young mother who had a festering wound on her knee, which made it impossible for her to walk. She was bedridden for two weeks because she did not have the financial means (about US$3) that could have helped resolve her wound with antibiotic treatment. I gave her money to facilitate the treatment. In my overall findings, many of the local people, especially the elderly, remained sick and did not go to a health facility, stating that they did not have the money to pay for the diagnosis and prescription. Indeed, during a recall period of two to three weeks, in 40 percent of the 116 survey households, there was at least one person who had still not recovered from his or her illness. This was due to the fact that the treatment was still in progress and/or because the patient's family did not have enough money to pay for treatment. However, the correlation between user fees and treatment delay for childhood illnesses was not definite in all the cases that I followed during my research. Overall, while user fees deterred adult patients from seeking prompt treatment for their illnesses at a government health facility, the same was not the case with young children.

Since cost considerations have been one of the central concerns in malaria treatment policies, I documented the average cost (expenses) of treating a single episode of childhood malaria. While 64 percent of the forty-five mothers I interviewed in 2001 had initially spent only Tsh. 100 on the treatment that their child had received at the dispensary, 24 percent had spent between Tsh. 200–500 and the remaining 12 percent had spent between Tsh. 600–1,000 in total. Interestingly, 60 percent of the mothers said they paid the exact amount they had come prepared to pay at the dispensary, which was based on past experience. However, 20 percent had to spend a lot more money than they were prepared to spend. As for the total expenses incurred on the index illness episode that was treated at the dispensary (including expenses incurred before and after treatment at the dispensary), while 44 percent had spent only Tsh. 100, 22 percent had spent between 200–500; 16 percent had spent between 600–1,000, 11 percent had spent between 1,100–2,000, and the remaining 7 percent had spent between Tsh. 5,000–7,000 in dealing with one malarial episode. More than 75 percent of the forty-five mothers told me that they were not particularly concerned about the Tsh. 100 they had to pay at the dispensary, because they regarded it as their "contribution." Nevertheless, about a quarter of the forty-five mothers were concerned that if they were to bring their sick child to the dispensary and he or she was diagnosed with a serious illness, then the total cost of the treatment, including follow-up visits, would escalate beyond their means. This negative aspect of having to make multiple follow-up visits was compounded by the inconvenience of long-distance travel by foot, the indefinite waiting period at the dispensary, the discovery that the dispensary was understaffed, the nonavailability of the doctor, and the ineffective nature of the prescribed medicine. The reason why so many mothers actually brought their feverish children to the dispensary was because they believed that their child may not be suffering from a serious illness, and that the treatment cost would not exceed the nominal Tsh. 100. Concurrently, one of the reasons—along with strategic illness presentation—why some mothers avoided seeking prompt treatment for their febrile children at the local dispensary was because of their concern that once they had taken their child to a government health facility, he or she might be diagnosed with a more serious condition than ordinary fever, warranting extended treatment, and extra costs. Therefore, these mothers maximized home-based treatment as a cost-saving measure.

Misdiagnosis and Treatment Delays

By the time I had started my fieldwork in Dar es Salaam in 2000, the clinical efficacy of chloroquine in Tanzania was already under question (Premji, Makwaya, and Minjas 1999). However, the perceived efficacy of chloroquine (injections in particular) among many mothers for the treatment of their febrile children was notably high. Nearly two-thirds of the mothers I interviewed strongly believed that the chloroquine injections dispensed at the dispensary were effective against malaria. This was obviously due to chloroquine's antiparasitic and antipyretic properties, that is, it not only dealt with the malarial parasites, it also helped to bring down the fever. However, 20 percent of the mothers, such as Japo and Fatuma (in the introduction), were skeptical about chloroquine's efficacy. During follow-up interviews, they commented that it had been more than a week since their child was treated at the dispensary, and yet their infant/toddler was still sick. For them, the dispensary medicine was ineffective. Ten percent of the mothers were unsure because it was still too early for them to confirm whether or not their child had completely recovered. In this context, I explored how long mothers were willing to wait before concluding that the treatment has or has not proven to be effective, and seeking out an alternative course of action. Because they did not have an alternative affordable health-care option, most mothers would wait for as long as they could—usually up to a week, before returning to the dispensary to start the process all over again. In the context of poverty, for most mothers the local dispensary was still the cheapest option regardless of the fact that they were required to contribute toward the cost of injections and other medicines. Even so, I documented several illness narratives that were replete with mothers' frustrations regarding the dispensary staff's inability to make an accurate diagnosis of their child's illness and to prescribe effective medicines. For example, Habiba, a twenty-seven-year-old single mother, who lived close to the marketplace, told me that this was not the first time she had taken Haji, her two-year-old son, to the dispensary. She had done it before, and it was the "same old, same old"—her child had high fever, she took him to the dispensary, where he was clinically diagnosed with malaria and treated with chloroquine injection, but to no avail. When she got back home, her son started vomiting and his fever also shot up. Thus, once again she took him to the Temeke district hospital where she was told that she needed to either go back to the dispensary and return with a referral slip from the doctor, or go directly to the Muhimbili National Hospital. Habiba decided to go to Muhimbili hospital where her son was admitted for one full week. They discharged him after he had fully recovered. On a similar note, Vumilia, a twenty-one-year-old mother of one child, who lived with her fiancé, a co-wife, and her six children, narrated the difficulties she had experienced following the treatment her one-year-old son Saikond had received at the dispensary. At the dispensary, Saikond was given five injections over five days, but he did not get any better. Frustrated with her experience, Vumilia decided to take Saikond to a private clinic in Temeke, close to where her fiance had his kiosk. The doctor at the private clinic conducted a series of tests and concluded that Saikond had typhoid, and not malaria. He recovered from his illness after being treated with antibiotics against typhoid. Vimilia's neighbor, Siwajibu, an eighteen-year-old Zaramo single mother, who ran a small teashop in the marketplace, had an equally difficult experience dealing with her two-year-old daughter Giviti's illness. She explained to me:

> By the time I took Giviti to the dispensary, she had been sick for three days. I simply couldn't leave my business and take her to the dispensary. When I went there, the doctor told me that it would be better if I took her to Temeke hospital, and he gave me a referral slip. I went to Temeke hospital along with Giviti and my father. There they checked her blood gave her Panadol and told us to come the next day to pick up the other medicines. My father was furious with the hospital staff for prescribing only Panadol after the long journey we had undertaken,

> and so we returned home. But because Giviti was still sick, we decided to take her the next day to a private hospital in Temeke. There she was examined and diagnosed with typhoid. She was given medications and now she is doing a little better.

As noted above, all fever cases at the dispensary were clinically diagnosed. Despite the fact that the dispensary was equipped with a microscope, the patient's blood smears were rarely taken for microscopic examination. During the entire course of my research at the dispensary, I recorded only two cases where the head nurse had actually taken blood smears from the patients and examined them under the microscope before pronouncing the diagnosis. In addition, a significant proportion of mothers did not know the identity of their child's illness as determined by the dispensary staff. In a number of cases, patients diagnosed at the dispensary with malaria were later treated for typhoid or pneumonia elsewhere. In eight out of the forty-five cases that I followed, the child was eventually taken to a private health facility or to the district hospital or to the Muhimbili National Hospital for further medical attention. This put the child, the mother, and other family members through additional anxiety and suffering as the child's condition had subsequently escalated. These successive actions involved additional expenses, inconvenience, aggravation of the illness, and a loss of precious time, all of which could have been avoided if the dispensary staff were able to make a more accurate diagnosis and refer the child immediately to the district hospital. Mothers often waited for another three to five days before the realization set in that the treatment had failed.

Case 3: Zaina's Story

Zaina Masood is a thirty-five-year-old mother of five children. She is a Zaramo and a native of Mbande. Zaina had seven years of schooling. Her husband was a subsistence farmer. On one occasion, Zaina came to the dispensary with her four-month-old twin sons, Kulwa and Doto. They were both treated for high fever. Three months later, Zaina's personal life and economic situation had considerably worsened. Her husband had deserted her for the third time and was living with another woman in a neighboring village. In an interview regarding Kulwa and Doto's illness, she asserted that the twins were born healthy and that they did not have any health problems. It was only when Kulwa had turned four months old that he started having intermittent fevers. This went on for more than a month. Then Doto also started having fevers. Meanwhile, Kulwa developed a large bump (*uvimbe*) on his head, which Zaina thought might have been caused by a fall that she had not previously noted. She also noticed that he would have high fever, but was playful as usual. His fever would shoot up during the night, but during the daytime, his body would be just warm. Then again his fever would disappear and return after two or three days, and this went on for quite some time.

Zaina took Kulwa to the dispensary where after the sponging routine, he was given an antibiotic—Procaine Penicillin Fortified (PPF)—injection. She had to take Kulwa every day to the dispensary for a PPF injection over the next four days, but the swelling did not disappear. All through this episode Kulwa had a high fever. Subsequently, one of the nurses advised Zaina to take the twins to the Temeke district hospital. At the district hospital, Kulwa's swelling on the head was diagnosed as a sign of severe malarial infection. One of the doctors told Zaina that the fever was so high that it had resulted in the swelling of the brain and the fever had been caused by the malaria parasites in Kulwa's blood. Zaina was advised to admit Kulwa into the children's ward, where he would be given three injections, costing Tsh. 300 (30 cents). Zaina was confused because she did not know why Kulwa had to be given three injections simultaneously. No one gave her an explanation for this, and Zaina did not attempt to ask anyone about the logic of the treatment. Besides, Zaina did not have the money to pay for the injections. She also had another pressing concern—there was no one around to help her take care of Doto. When she brought up this issue with the doctor, he promptly told her that the hospital's policy was to only admit sick patients. It was clear that Doto could not stay at the hospital while Kulwa was admitted for treatment. Zaina was faced with the dilemma of having to admit Kulwa, and at the same time having to send Doto back home. Her therapy seeking had become all the more complicated because it was not only about Kulwa's illness, but also about her inability to simultaneously take care of two children in two different places. More poignantly, she could not rely on her husband. She decided to return home with both Kulwa and Doto, in the hope that she could leave Doto with her younger sister and return to the district hospital with Kulwa, later. However, upon returning home, she found out that her sister was not in a position to help her because she was preoccupied with her own four young children. Her sister had also recently given birth to a boy and was busy nursing him. None of her neighbors came forward to offer help. Expressing how she dealt with the "twin trouble" (*matatizo ya mapacha*), Zaina said to me:

> I said to myself—"what do I do?" The doctor at Temeke hospital had said that he would not allow Doto to be in the same room while Kulwa was hospitalized. I realized that I wasn't going to be able to return to the hospital again with both Kulwa and Doto. . . . I decided to again go to the dispensary in Mbande instead. The doctor was away so I explained the situation to the nurse who gave Kulwa some chloroquine tablets. Within the next five days, he was all right. His fever was gone, and so also the swelling on his head. And so far he has had no problem.

Zaina's case may be interpreted in several ways as it sheds light on both the "micropolitics of the social relations of therapy management" (Nichter 2002) and the social burden of childhood malaria in the context of poverty and a rapidly changing health and social environment.[9] If the dispensary doctor had immediately and accurately diagnosed the twins' condition as indicative of malaria, Zaina could have avoided the trip to the district hospital and the ensuing hardship and anxieties. Furthermore, the fact that she had to take care of the twins all by herself compounded the problem of treatment-seeking. Kulwa was eventually treated for malaria at the dispensary in Mbande and cured at no cost to her.

Zaina's case illustrates the complex sociocultural dynamics that underscore therapy-seeking for childhood febrile illness in the context of poverty. Her husband's decision to abandon her along with the children had put her in a precarious social and economic position. She was left to her own devices when dealing with her children's sickness. Her immediate relatives who would have normally constituted her therapy management group did not come forward to help her. They were preoccupied with their own subsistence and childcare needs. Zaina had acted on her own to take her sick children to the dispensary. The misdiagnosis that ensued increased her difficulties. However, in terms of a successful end result, her decision to return to the dispensary with her children out of desperation paid off. Zaina's case is similar to several other cases I documented during the course of my fieldwork, where mothers with very sick children had little or no timely help from family members and friends. During both informal conversations and formal, audio-recorded interviews, mothers commonly spoke of "having to go at it alone" when dealing with sickness in the family. As many as 84 percent of the forty-five mothers I interviewed had arrived at the dispensary with their sick child, without being accompanied by a family member, friend, or neighbor. Treatment-seeking for children at the dispensary was highly gendered in this respect as it was up to the mothers alone to deal with their child's illness. In a small number of cases, very young mothers were accompanied by their mothers or a friend. I rarely saw men who were involved in the mother's life accompanying her to the dispensary. During the eight months of participant observation at the dispensary, I observed less than ten male partners who had brought their sick child to the dispensary. As already noted, more than one-third of the forty-five mothers were unmarried or did not have a male partner living with them on a regular basis. This factor would at least partially explain the absence of male partners at the dispensary.

The pervasiveness of fevers among children, and the fact that most mothers believed that they were dealing with an ordinary fever, did not necessitate any elaborate consultation with friends, neighbors, or the participation of the therapy management group. Thus, for example, when Mwajuma, a teenage unmarried mother, decided to take her seven-month-old daughter to the dispensary, she simply announced the decision from a distance to her *mchumba* (her child's father) who was busy doing some carpentry work. Her *mchumba* simply nodded his head in approval, and went about his carpentry work. While 20 percent of the women had consulted their husbands or the man with whom they were living, the remaining 16 percent had consulted an in-law, father, mother, or a sister. None had consulted a friend or a neighbor in making their decision. In essence, for "common" illnesses such as "ordinary fever" among young children, the therapy management group's role was minimal. The child's mother was the primary decision maker, and the decision-making/treatment-seeking was largely the mother's decision with only minimal involvement of family members. It was the ordinary nature of recurring fevers that led mothers to rely on themselves in making treatment decisions. This observation has important implications for the potential success of initiatives such as home-based management of malaria. The need to pay attention to mothers' everyday concerns, their access to social resources, and their sensitivity to malarial symptoms is critical.

In Mbande and the neighboring villages, while most children with a febrile illness were brought to a health facility forty-eight hours after the onset of fever, this delay was not primarily due to the user fees charged at public health facilities. In other words, user fees alone did not deter the indigent, especially mothers, from making their preliminary contact with the dispensary. In the present case, what led most mothers to prolong their wait-and-watch period and to extend their practice of diagnosis by treatment was their belief that they are dealing with an ordinary fever, and not a potentially life-threatening illness such as *P. falciparum* malaria.

Alternatively, they practiced selective symptom reporting to ensure quality diagnosis and treatment.

As most of the encounters between the dispensary staff and mothers were characterized by vague and inconclusive patterns of communication, repeated encounters between the two parties neither helped to heighten the sensitivity of mothers to malarial symptoms nor to lower their threshold of tolerance for fever recognition during subsequent episodes. In addition, some mothers also delayed in establishing contact with the local dispensary because of their concern that upon arrival at the dispensary, their child might be diagnosed with an illness that was more serious than they had originally expected. As Japo's case has illustrated, mothers were also apprehensive about the availability of appropriate diagnostic facilities and medications at the dispensary. While economic considerations are certainly important in treatment decision making, they are mediated by several other crucial factors: cultural knowledge, past experience with the illness, perceived severity of the illness, perceived efficacy of the medications offered at government health facilities, and the micropolitics of communication about illness diagnosis and therapy management at government health facilities.

Inaccurate diagnosis and associated treatment failure also contributed to delays in treatment-seeking during subsequent malarial episodes. During the entire course of my fieldwork in Mbande and the neighboring villages, nearly all fever cases at the dispensary were clinically diagnosed. This often resulted in exasperating outcomes for many mothers and their sick children. For example, in Zaina's case, she could have avoided taking her twins to the district hospital if the dispensary doctor had initially diagnosed the swelling on her son's head as a symptom of severe malaria. While a blood test for every case of suspected malaria would significantly improve the accuracy of the diagnosis and lead to better treatment adherence, prognosis, and prompt treatment-seeking during subsequent episodes, a number of researchers have documented the complex problems associated with differentiating malaria from other febrile illnesses (see Chandramohan, Jaffar, and Greenwood 2002; Font et al. 2001; Hausmann-Muela, Muela Ribera, and Tanner 1998; Mwangi et al. 2005).

An accurate diagnosis aided by rapid diagnostic tests (RDTs) in dispensaries such as the one in Mbande would be useful.[10] However, it is also important to bear in mind that without ready access to an effective, inexpensive antimalarial (ACT), RDTs (i.e., accurate diagnosis without an effective antimalarial) would only serve to fuel frustration among the mothers and the dispensary staff as well. To suggest that all fever cases be subjected to a blood smear test or RDTs is neither practical nor will it automatically solve the problem of misdiagnosis and all the difficulties that surround it. Far more is at stake in the diagnosis and treatment of childhood febrile illnesses than a more regular use of RDTs and ACTs. A large part of the problem of misdiagnosis is rooted in the social relations of medical decision making within households, and the micropolitics of communication between providers and patients attending government health facilities.

As I will illustrate in the subsequent chapters, even when highly subsidized and efficacious antimalarials are made available in malaria endemic communities, there is a strong possibility that many mothers, as mentioned earlier, will continue to delay bringing their febrile children to a public health facility. Training the dispensary staff to proactively and effectively communicate the severity of the symptoms of malaria will ensure that mothers do not delay in bringing their sick children to the local dispensary because they believe that they are dealing with an "ordinary" illness. Many poor patients and/or parents in due course will turn to private pharmacies to purchase antimalarials that are less expensive, but of comparatively questionable efficacy. The problem is further complicated by the fact that at the time of my research, many private pharmacies in Tanzania were unlicensed and managed by unqualified or poorly trained pharmacists (see Kamat and Nyato 2010). It is also possible that patients will consume their medications in inappropriate dosages and thus compromise the drugs' clinical efficacy. Ultimately, without carefully planned community-based health interventions that address issues of poverty, inequity and injustice, and social safety nets, and are not solely focused on a particular disease or its "biomedical" burden, the poor will continue to experience high levels of malaria-related morbidities and mortalities.

While economic considerations are important, they do not constitute the primary reason why mothers in peri-urban Tanzania delay seeking prompt treatment at a government health facility for their young, febrile children. Mothers commonly believe that they are dealing with an ordinary fever and not malaria or any other serious illness complicated by fever. Hence they extend their wait-and-watch period. Poor communication patterns between health-care providers and mothers regarding the symptoms of malaria and its diagnosis exacerbate treatment delays during subsequent malarial episodes. The illustrative case studies examined in this chapter demonstrate that therapy-seeking in regard to childhood febrile illnesses is multifaceted and context dependent. Just as poverty alone cannot explain high morbidity and mortality rates, economic considerations alone do not determine the kinds of decisions parents make in regard to their child's sickness. Illness and care-seeking are socially and culturally embedded. Cultural knowledge, gender and power relations within households, the everyday practices at health-care facilities, perceived quality of care, styles of communication between health-care providers and patients, and past experiences with misdiagnosis and treatment failures also influence treatment-seeking behaviors and outcome. At a time when the international community has effectively pressed for the implementation of artemisinin-based combination therapy (ACT) as one of the front-line strategies in malaria control, there is a need to pay closer attention to the contextual factors and sociocultural dynamics that influence patterns of treatment-seeking for childhood malaria. In the following chapter, I provide more illustrative examples and case studies to highlight the significance of cultural and circumstantial factors that influence therapy-seeking for childhood malaria.

CHAPTER FIVE

Malaria Deaths and Meaning Making

Infant deaths become routine in an environment in which deaths are anticipated and bets are hedged.

NANCY SCHEPER-HUGHES 1989:16

Mothers' failure to obtain medical care for severely ill children is due more to real-life bureaucratic and geographic barriers to access than to fatalistic or neglectful attitudes on the part of the poor.

MARILYN NATIONS AND LINDA REBHUN 1988A:141

Mwanzani, a forty-four-year old woman was desperately trying to revive her dying two-year-old daughter, Salama. Mzee Tinyango, the local *mganga*, had diagnosed Salama with *degedege*. Salama succumbed to her illness and died later that afternoon. The child's father, Mzee Omary, along with others who had arrived to mourn her death, summed up the misfortune as *mwenyezi mungu* (it's God's will). Salama was buried within two hours of her death at a graveyard (*kaburi*) behind Mzee Tinyango's house. Mzee Wahid, the *shehe*, performed a very simple burial ceremony that was attended by about forty men. None of the women who had arrived to mourn the death were present at the burial.

It was the holy month of Ramadhan, a time of fasting and prayers. I had only recently been introduced to Mzee Tinyango, and that morning I had visited him along with Mzee Ali, my research assistant, to sit in on a divination session. However, given that a death had occurred inside his house, he had either called off or postponed the divination session. At Mzee Ali's suggestion, I stayed back to observe and be part of the mourning. At that point, as I interpreted it, the mood among those who had gathered at Mzee Tinyango's place to mourn Salama's death was not visibly somber. The thirty or so women who had gathered in one corner of the verandah were all dressed in their best *kangas*. A few of them were periodically comparing their new *kangas* with each other, while others were talking in low voices about something that I could barely understand. The men who had huddled around Mzee Tinyango were not discussing Salama's death, but a case of elopement in the family, and I imagined that the women too were conversing about something other than the death that had just occurred in the Omary family. I was intrigued and a bit troubled by the lack of overt grief among those who had gathered at Mzee Tinyango's place on that day. This was the first death in the village that I had encountered, and it would eventually change the course of my fieldwork and my research focus.

As I tried to make sense of the cultural appropriateness of certain behaviors (the lack of overt grief among the mourners in particular), and the emotional disposition of those who had gathered for what I believed was a very somber and sad occasion, I turned to Mzee Ali and asked him: "Is this always how it is . . . ?" "Yes, it's a matter of fact!" he replied nonchalantly in English, and turned back to concentrate on the story that was being narrated about the elopement. His pat response left me with a lingering uneasy feeling about the "matter-of-fact" question I had asked; a question that was at once rhetorical and inappropriate.

Given that the death had occurred in the month of December, which in 2000, coincided with Ramadan, and many of the mourners were still fasting, they were not served the customary porridge (*uji*). Consequently, the ritual surrounding the death and burial was over in less than two hours. As each of the mourners offered condolences to Salama's mother, who was sitting in a dark and dingy room, they uttered oft-heard phrases in the village surrounding acceptance of death: "*bahati mbaya*" (bad luck); "*mwenyezi mungu*," and in a further resigned tone, "*tulikua fanya je*?!" (What could we have done?!). As Mzee Ali later summed it up for me, for the people of Mbande, the death of a child and the attending mourning ceremonies were routine matters, which partially explained their public stoicism. In talking about things other than the death itself (in this case, elopement), and with women wearing new, brightly colored *kangas*, people found a way to come to terms with their grief.[1]

In this chapter, I provide a nuanced representation of the therapy-seeking strategies of parents who are confronted with a life-threatening illness that is labeled as *degedege*. Drawing mainly upon detailed interpretive analyses of the narratives of three bereaved parents who lost a child to *degedege* during the time I was doing my fieldwork in Mbande,[2] I highlight the contextual, circumstantial, and relational factors involved in the deaths of three children.[3] I discuss these children's deaths as "focal events" and interpret them against their background, frame, or "field of action" (Duranti and Goodwin 1992:3).[4] In doing so, I demonstrate that many parents from urban and peri-urban areas of Tanzania who believe that their child is suffering from illnesses such as *degedege* do not necessarily prefer to consult a *mganga* as a first resort, as has often been reported in the literature, but proactively seek help from a biomedical health facility (de Savigny et al. 2004).[5] Under particularly severe conditions, however, their efforts are constrained by the lack of easy and timely access to such facilities. Consequently, many parents seek out *waganga* as an alternative to a biomedical facility because they are available for consultation at convenient hours, and they provide treatment, consolation, and flexibility in the payment of fees. I also show that many parents or caretakers of children who have developed high fevers do not simply follow a linear, patterned trajectory in their search for therapy based on some widely shared cultural model. Instead, they often follow strikingly different therapeutic pathways when dealing with an actual episode of *degedege*, as against a hypothetical scenario. They do so regardless of the fact that they share the cultural knowledge, including etiological beliefs, or the local cultural model about *degedege*. I emphasize this point in particular to illustrate the diversity of treatment-seeking behaviors and practices that can be found even within relatively small communities where people share the same socioeconomic, structural, and environmental conditions that affect their everyday lives. This observation has important implications for the oft-encountered "one-size-fits-all" interventions that are designed top down to deal with malaria in local communities.

This chapter, then, specifically calls attention to "the micropolitics of therapy management" (Nichter 2002), which entails the not-so-obvious sociocultural and structural factors that influence the manner in which people negotiate the identity of an illness and deal with it at the household level and the local health arena in a crisis situation. It emphasizes how these factors intersect with structural constraints and circumstances, and often lead to tragic outcomes. Here, I define structural, contextual, and circumstantial factors to include physical, social, and communication barriers, discriminatory and discourteous behavior on part of the health personnel, a limited ability to utilize resources including biomedical health facilities due to poverty, little or no previous experience with the illness, ill-fated timing of the illness, and the lack of social support and appropriate advice from members of one's social networks.

Child Survival and Attention to Context

The anthropological literature concerning issues of child survival and child death is voluminous. Some scholars have focused their attention on a range of proximal determinants such as maternal factors (age, parity, birth interval), nutrient deficiency, personal illness control, and more distal social and economic factors that operate at the individual, household, and community levels to influence child health and survival (Adams, Madhavan, and Simon 2002; Caulfield, Richard, and Black 2004; Mosley and Chen 1984; Nichter and Kendall 1990). Others have called attention to the contextual and circumstantial factors influencing child survival, including gender, power, and agency (Baume, Helitzer, and Kachur 2000; Castle 1994; de Souza et al. 2000; Dettwyler 1992; Finerman 1994; Molyneux, Murira, and Snow 2002; Nations and Rebhun 1988; Price 1987; Scheper-Hughes 1992). For example, in the Brazalian context, Marilyn Nations and Linda Rebhun affirm that "the seeking of medical care cannot be understood without detailed knowledge of the nature of care available and the difficulties involved in seeking it . . . [and] that decisions on treatment of severe and terminal disease cannot be understood without reference to communal medical ethics" (1988a:147). Likewise, Sarah Castle argues that in rural Mali explanations of the course of a child's death are often formulated postmortem. She also articulates that diagnoses of locally recognized folk illnesses such as *foondu* and *heendu* are acquired through a series of social negotiations within the context of the household or community hierarchy. "Applying a fatal diagnosis, often retrospectively, to a dead child's last illness shifts accountability for the death to the community as a whole, rather than leaving the individual mother personally responsible . . . diffusing responsibility for a child's death away from individual mothers via fatal folk diagnoses" (1994:330).

Thus, the medical anthropological literature on child survival and selective neglect clearly indicates that obtaining contextual knowledge is crucial to a nuanced understanding of how people in different cultural contexts deal with child survival issues, and with children's deaths in particular. In addition to local contextual factors, the broader social and political factors also play a key role in determining treatment-seeking behaviors, as is evident in Tanzania's postsocialist context where the health sector has undergone a radical transformation in a very short period. In order to place the locally recognized illness that is at the center of this chapter's discussion, I will briefly review some of the linguistic and cultural interpretations that denote the illness *degedege*.

Degedege

In Kiswahili, the word *degedege* literally translates into English as "bird bird." Researchers working on malaria in Tanzania have documented different interpretations of *degedege* (see Langwick 2011).[6] According to my key informants, in coastal Tanzania, and among the Zaramo people in particular, a coastal spirit (*mdudu shetani*), which takes the form of a bird and casts its shadow on vulnerable children on moonlit nights, is believed to bring or cause the illness. Children who come under the bird's shadow subsequently become seriously ill, develop convulsions, and in many cases succumb to the illness and die.[7] Through conversations with people in Mbande and the neighboring villages, I gleaned that they do not believe that the attack is carried out with harmful intent. Sorcery (*wakurogwa*) and witchcraft (*uchawi*) are not implicated in cases of *degedege*. Rather, it is "bad luck" or "God's will" that renders particular children to be more vulnerable than others to succumbing to the bird's shadow.[8] Thus, when I asked my key informants why some children are more prone to contracting *degedege* than others, the majority of them simply responded by saying that it was just "God's wish" or "God's work" (*kazi ya mungu*), or just the person's bad luck (*bahati ya mtu tu*).

I consulted with twenty-eight elderly men and women and the local *waganga* known for their expertise in diagnosing and treating cases of *degedege*. A preliminary analysis of their responses indicated that there was an element of "cultural consensus" (Garro 2000; Weller and Baer 2001) with regard to the sharing of cultural and etiological beliefs about *degedege*. Most elders and healers agreed that the illness had something to do with a "spirit bird." Yet, a close analysis of audiotaped interviews with mostly elderly people revealed that the information they provided varied greatly in terms of the details on the etiology, symptoms, susceptibility, treatment modality, and preventive measures for *degedege*. While elderly informants spoke with an element of confidence about the illness, younger informants, especially young mothers, spoke of *degedege* in terms of what they had gleaned by word of mouth. They stated that they had heard about *degedege* from others and knew that it was a dangerous illness that could strike any child at random.

In light of studies addressing the problem of "misdiagnosis" of malaria resulting from symptom overlap and other illnesses complicated by fever and convulsions (Chandramohan, Jaffar, and Greenwood 2002; Kallander, Nsungwa-Sabiiti, and Peterson 2004), I asked people in the village to identify the symptoms that differentiate *degedege* from other illnesses marked by fever and convulsions. Key informants, mainly mothers with firsthand experience of dealing with *degedege*, described its typical symptoms as: (a) the child's body temperature shoots up and the body becomes dry and stiff; (b) the child's eyes are closed and when they are open, one can see that they are all white—the pupils have disappeared; (c) the eyes have become large and rolled up; (d) the mouth is stiff and breathing is unstable; (e) legs and arms are stiff and the body convulses (*kushtukashtuka*); (f) the child is frothing at the mouth (*mapovu mdomoni*). For example, after her son's recovery from an episode of *degedege*, Halima, the twenty-four-year-old mother described his condition: "Salim's eyes looked as if he was terrified by something that only he could see. Then he started convulsing repeatedly and he defecated as if he had been severely constipated. He passed stools that looked just like goat's feces (*mlenda mlenda*)." For some mothers, the characteristic symptoms associated with this illness had been integrated into their cultural repertoire. As noted in the previous chapter, in sharing their experiences with *degedege*, mainly through illness narratives, they had contributed to "socially generated knowledge" about the illness in the community (see Price 1987). While the socially generated knowledge of *degedege* was widely shared in Mbande, details about the illness varied significantly from person to person.

Indigenous Therapy

Elderly people in the village affirmed that the traditional therapy for *degedege* had changed significantly over the years. They attributed this change mainly to the greater presence of biomedicine in their lives, especially following the dramatic increase in the number of private health facilities in Dar es Salaam.[9] Several elders gave graphic description of the practice where, upon noticing the first signs of the illness (convulsions), a mother will rush her child to a latrine (*choo*). There she will lay the child on a banana leaf and wash the child with her (the mother's) urine. The smell of urine is believed to repel the spirit in possession of the child's body, at which point the child would likely stop convulsing. It is only after this stage that the child is taken to a *mganga* for treatment, who normally checks the patient carefully before prescribing medicinal bathing herbs. While some *waganga* simply use knowledge from previous experience to treat *degedege* patients, others resort to divination or *kupiga ramli*.[10] The *mganga* may also give the patient some herbal medicines to drink. Medicinal leaves are rubbed on the patient's legs and often on the whole body, while some of the leaves are boiled and the decoction is given to the patient to drink. The patient usually rests for a few minutes and then passes urine or defecates. If the patient does either of these, it is concluded that the patient is on the way to recovery. If not, the patient is still in danger of dying.

Depending upon the patient's condition, the *mganga* may treat the patient for three to four days or until the child has completely recovered. If a patient recovers, she or he is permitted to return home with her or his parents and no further treatment is recommended. The parents may then pay the *mganga* his fees or they will pay at a later date if the *mganga* allows for flexibility. In case the parents are not satisfied with the treatment, they may decide to take the patient to another *mganga* in the hope that he may offer more effective options. For example, one may go to a *mwalimu ya Qur'ani* who uses *kombe*, a drinkable medicine. While one *mganga* may simply use his knowledge based on previous experience in dealing with *degedege* patients, others resort to divination (*ramli*). There are different types of *ramli*—one is by using the Qur'an and other Arabic books (*ramli ya kitabu*) and the other is the system of *kiburugwa*. If all else fails, parents may decide to take the child to a public or private hospital. If treatment at the hospital also fails, then the outcome is commonly described as "the patient's fate or predicament" (*bahati ya mtu*); there was little that anyone could have done to save the child from dying.[11]

During my fieldwork from 2000 to 2001, I recorded four cases in which a parent had brought a child to Mzee Tinyango, the *mganga*, for a possible diagnosis of *degedege* and its treatment. These cases offered the rare opportunity to actually witness and document the interaction between the parents of very sick children and the *mganga* who was being consulted. The *mganga* did not perform a *ramli* while attending to any of the four cases that he had diagnosed as *degedege*. On the contrary, in all four cases he urged everyone around him to stay calm. He laid the child next to him and closely monitored the child's condition. This preliminary therapy was meant to avoid any panic from those present. Once the child had calmed down, he would ask the parents to wash the child's body with water infused with medicinal herbs. In all of the four cases that I observed, the *mganga* made liberal use of Indian curry leaves that he picked fresh from a large tree that he had planted in his backyard. Notably, three out of the four children who were brought to the *mganga* recovered from their illness. In one of the three cases, the treatment and the healing process continued for over two months. These success stories not only acted as cultural models for some members of the local community to draw upon when dealing with childhood illnesses, they also point to the fact that parents' decision to consult a *mganga* to deal with childhood febrile illness need not be routinely categorized as "inappropriate" or "irrational," or, by extension, as responsible for the high number of malaria-related childhood deaths.

On one occasion, I witnessed a poignant scenario. The young parents of a very sick four-year-old child had come to consult Mzee Tinyango regarding her condition, which they believed was *degedege*. By my reckoning, it was highly likely that the child was suffering from meningitis, given that the child was very pale, motionless, and staring blankly in space. Her neck had a characteristic arc that would not return to its normal position despite all the herbs/ medicines that Mzee Tinyango rubbed on her body. Mzee Tinyango tried his routine treatment for a couple of hours and then summoned Hadija, his youngest wife, and instructed her to accompany the parents and the sick child to the local municipal dispensary. He even passed on a few Tshillings to his wife to help the desperately impoverished parents to gain access to the dispensary. I too recognized that the situation was very serious and urgent, contributed some money, and accompanied the parents to the dispensary. In terms of referral, this was a rare case because Mzee Tinyango hardly ever referred his patients to a biomedical health facility such as the dispensary or the district hospital, let alone to other traditional healers.

Conceivably, Mzee Tinyango had realized that the child's condition was not amenable to his therapy and that there was simply no time to lose. The scene that transpired was a good example of a therapy management group at work.[12] The parents and concerned others were gathered around the child and negotiated the identity of the child's illness and the course of action to be taken. Following a very brief discussion, which was lead by Mzee Tinyango's wife, there was a general consensus that the child should be taken to the local dispensary. Upon reaching the dispensary, the child was given some basic treatment and immediately rushed to the Temeke district hospital. On that day, the Urban Health Project's supply van had arrived in Mbande from downtown Dar es Salaam to provide supplies to the dispensary. On the way back to the city, the sick child was transported in the Urban Health Project's van along with the parents to the district hospital. Two weeks later, I learned that the child, whose condition was diagnosed by the doctors at the district hospital as meningitis, had survived. By this time, however, she had lost some of her mental and physical abilities. Upon her discharge from the hospital, the parents brought the child again to Mzee Tinyango hoping that he could do something to recover her lost capabilities, especially her ability to speak. The exhausted parents looked disheveled and sad because of their daughter's condition. Mzee Tinyango accommodated the parents and the child for nearly a week at no cost.

Preference for Biomedicine

In the literature on *degedege* in coastal Tanzania, fear of injections is commonly cited to explain the overwhelming preference among the people to consult a *mganga* as opposed to a biomedical practitioner. Researchers have described the belief that if a child who is suffering from *degedege* is given an injection, the needle will puncture the skin and allow malevolent spirits to enter the child, causing rapid death (Langwick 2011; Makemba et al. 1996; Winch et al. 1996; Tarimo et al. 2000). While the people in the villages where I conducted fieldwork acknowledged that they shared this belief, they also stated that in the present context there was an overwhelming preference among the local people to treat malaria and several other illnesses with injections. This information is in accord with studies that have documented the popularity of injections for various illnesses in Africa and elsewhere in developing countries (see Reeler 2000).

When respondents of the household survey (n = 116) were asked what their first and second resorts would be if, in a hypothetical situation, their child were to start convulsing, 46 percent of the respondents indicated that they would rush their child to the local dispensary first. Twenty-six percent mentioned that they would go to a *mganga* and another 21 percent said that they would try some form of home remedy, including the *tundu la choo* (urine) therapy. The remaining 7 percent mentioned that they would take their sick child to other health facilities, including the district hospital and private medical practitioners. More significantly, two-thirds of the respondents indicated that as a second resort, they would choose to go to a biomedical health facility. However, these statistics must be contextualized within an ethnographic framework by examining what local people do in "real-life" situations when they have to deal with an actual episode of *degedege*.

As a participant observer at the dispensary in Mbande, I documented five cases where, (a) a mother had rushed her child to the dispensary reporting that the child had experienced convulsions just before being brought there, or (b) where the child had begun convulsing while waiting to be seen by the doctor or one of the nurses. In all five cases, the dispensary staff and the mother made intensive efforts to bring down the child's temperature by sponging the child with a wet cloth. Following this, the nurse administered a chloroquine injection. Contrary to what many key informants had told me about *degedege* and the fear popularly associated with injections, none of the mothers challenged the dispensary staff's decision to treat the child with an injection. In follow-up interviews, all five mothers repeatedly stated that they had made the right decision by bringing their children to the dispensary. While in Mbande people widely acknowledged their fear of using an injection on a child suffering from *degedege*, in panic situations, many mothers rushed their child to the local dispensary, even if meant devolving agency to the dispensary staff. It is, of course, difficult to determine how many mothers chose not to bring their febrile children to the dispensary.

Narrative Representation

The following three cases analyze *degedege*-attributed deaths that occurred in Mbande during my fieldwork in 2001. These cases illustrate how parents negotiate the identity of a severe febrile illness and deal with it in real life situations. Collectively, these cases show that although the parents shared the same social-cultural and environmental context, the illness trajectories and the therapeutic actions they took were strikingly different from one another. However, in all three cases, the children died. These cases highlight the multidimensional nature of the problem of child survival in a context where malaria transmission is intense, and the majority of the people are very poor, with limited access to good quality health care.

Case 1: Salama's Story

This case concerns the dynamics surrounding a father's decision to take his febrile and convulsing two-year-old daughter to a *mganga* rather than the local dispensary, and the explanations he gave for his daughter's death. The day after Salama (the child mentioned in this chapter's opening vignette) was buried, I briefly interviewed her father, Mzee Omary, a short, lean man in his early fifties, with a severe cataract in his left eye and several missing teeth. As he was one of Mbande's oldest residents, I had previously interviewed him on the local history, some aspects of Zaramo cultural practices surrounding marriage and divorce, and documented his life history and genealogy in detail. Mzee Omary, his wife Mwanzani, and seven of their children were living in a small mud hut in the heart of Mbande—midway between the dispensary and the marketplace. Mzee Omary led the life of a subsistence farmer. However, because of his failing eyesight, his wife did most of the work in the field. As a young man, Mzee Omary had spent much of his time in downtown Dar es Salaam, working as a houseboy for a South Asian family. After working there for a few years, he realized that he was not going to be able to save any money, so he decided to return to Mbande in 1967. As a subsistence farmer, Mzee Omary would grow only food rather than cash crops—cassava (*mihogo*) and rice (*munga*), mainly to feed his family. Troubled by his deteriorating living conditions, he lamented to me in an earlier interview about his hardships and his pessimism over the scope for his children to enjoy the fruits of "development" (*maendeleo*) in the postsocialist era.

Mzee Omary repeatedly emphasized that "he had done the right thing" by taking Salama to a *mganga* rather than to the local dispensary. He justified this by saying that several years earlier, when his second daughter had *degedege*, he had taken her to the same *mganga*, and she had recovered completely. He explained that Salama had died because it was God's wish that she should not live any more, and that the family was powerless in preventing the predicament. Mzee Omary insisted that Salama's death had nothing to do with evil spirits (*mashaitani*) or witchcraft (*uchawi*) and that there was no "underlying cause" to her death other than that it was "God's wish" that it should be so.[13] He told me that Salama was playing around with her siblings as usual in the morning, but in the evening, she had a slight fever, so he gave her an aspirin tablet that he had purchased from one of the local pharmacists. The following morning she was a little better, but in the afternoon, her fever shot up. Mzee Omary thought of sending her to the local dispensary, but then he saw that Salama was rolling her eyes. "I could only see the white part of her eyes; her pupils had completely disappeared. The moment I noticed these signs, I knew that this was not a disease meant to be treated at the hospital. You see, I have seen many children suffering from this illness. I knew it was *degedege* right away, so I took my daughter to the *mganga*."

Clearly, Mzee Omary had initially dealt with Salama's fever as an "ordinary fever." When the home treatment had failed, he even thought of taking her to the dispensary. However, he associated the symptoms with *degedege*, an illness he believed would be best treated by a *mganga*. Mzee Omary did not indicate that he had consulted with his wife regarding the symptoms, the identity of the illness, or his decision to take the child to a *mganga* rather than to the dispensary. For example, in the following segment from the interview, he consistently uses the first-person "I" in the unfolding of Salama's illness trajectory:

> She started twisting her mouth from this side to that side; her arms and legs started shaking. She was convulsing this way and that way. She had lost all her strength. . . . So I sent word for my wife to come to the

> *mganga*'s house because our child's condition was very bad. . . . [The] *mganga* tried different types of medicines, but in the end it was God's wish that Salama had to die. I feel very sad. The whole of yesterday night, I cried, I cried a lot.

It is clear from the above narrative that Mzee Omary's wife was not present when he made the decision to take Salama to the healer. He had to take action and send word for her to come to the *mganga* because the child was in critical condition.

Mzee Omary's narrative can be subjected to multiple readings. At first glance, it appears that his cultural beliefs about *degedege* played a key role in his decision to take Salama to a *mganga* rather than to a biomedical health facility. A more contextualized analysis of this case, however, suggests that there was more to Mzee Omary's decision making than "irrational beliefs," "ignorance," "fatalism," "selective or benign neglect," "parental incompetence," or a decision to "let go" a child who was destined to die (Larme 1997; Scheper-Hughes 1992). Economic, structural, and microlevel social relational factors had significantly influenced his decision.

Mzee Omary had had unpleasant experiences during earlier encounters with the dispensary staff, which he had narrated to me during previous interviews and informal conversations. He would repeatedly complain about the dispensary doctor, characterizing him as "a man with a bad soul" (*mtu wa roho mbaya*), and the user fees. He claimed that the dispensary staff often told him to come back with money when he had none and ridiculed him for insisting on being treated for an illness that they believed did not exist. These experiences had led him to believe that he would be humiliated again if he were to go to the dispensary with Salama and that she would in any case be referred to the district hospital due to the seriousness of the illness. Mzee Omary did not have the material resources to transport Salama to the district hospital and pay for the treatment. His decision making was also influenced by his negative view of injectables as therapy for *degedege*. He insisted that *degedege* was not an illness that responds to injection treatment. In fact, if the patient who is suffering from *degedege* is given an injection, he or she is likely to die immediately. According to Mzee Omary, "The staff at the hospital will say that it is malaria and they'll give the patient an injection. But the illness is really *degedege* and it should first be treated with traditional medicines." Mzee Omary's behavior was influenced not only by his cultural "beliefs" about the appropriate treatment for *degedege*, but also by structural factors including poverty and lack of sociocultural access to the dispensary, gender relations, and previous unpleasant encounters with the dispensary staff. In the following vignette, his future actions emphasize this behavior.

A week after I had interviewed Mzee Omary regarding Salama, I saw him at the local dispensary waiting along with other patients to see the doctor. I was a bit surprised to see him there, especially after having heard of all the unpleasant experiences he had with the dispensary staff during his previous encounters. He said that he had come to consult the doctor regarding his own fever. Later, I followed him into the clinic room and made a note of the doctor's diagnosis and the prescription. After receiving his prescription slip, he said to the doctor "*nisamehe*," meaning that he should be excused from paying the fees. The doctor became furious and started scolding Mzee Omary: "What do you mean by *nisamehe, nisamehe*?!" he demanded. "Why should I excuse you from paying for the medications? I can excuse patients who are really poor; not able-bodied men like you!" Feeling humiliated, Mzee Omary walked away meekly to the dispensing counter. At my behest, Bernadette, the trainee nurse, let Mzee Omary go for the Tsh. 300 that he had brought with him. I made up for the difference (Tsh. 500) to save Mzee Omary from being further humiliated at the dispensary by the other staff members. The head nurse excused him from the prescription fee, but not before making a sarcastic remark that while he had neglected his daughter and let her die, he had not hesitated to come to the dispensary for his own illness.

Examined in the context of the commonly encountered statements regarding early diagnosis and prompt, effective treatment, one might ask whether Salama would have survived if her father had chosen to take her immediately to the local dispensary rather than to a *mganga*. Alternately, one might ask whether Salama died because of her father's supposed "ignorance," that is, because his etiological beliefs concerning her illness were not analogous to the biomedical model of "*degedege* equals cerebral malaria." From a biomedical perspective, it may be possible to make a persuasive argument that Salama's chances of survival would have been higher if her illness had been diagnosed not as *degedege* by a *mganga*, but, rather, as cerebral malaria by a biomedical practitioner. However, as noted above, most children that Mzee Tinyango had diagnosed with *degedege* (at least during my fieldwork) did not succumb to their illness. In other words, just because Mzee Omari had taken Salama to a *mganga* does not mean that her death was a fait accompli. Her death was precipitated by several complicating factors. Her susceptibility to a febrile illness was hastened by the fact that she was severely malnourished and weak.[14] Her impoverished parents did not own a single bednet that could afford the family with some protection from infective mosquito bites. Additionally, Mzee Omary loathed taking his daughter to a biomedical facility for a number of reasons, including financial difficulty; social relational and communication problems; his beliefs about the etiology of *degedege*; and the appropriateness of certain kinds of treatment for childhood illnesses. These combined factors exacerbated Salama's condition. Even when Mzee Omary had realized that the *mganga*'s treatment was not having the desired effect, he did not change his mind and rush the child to a biomedical facility. The critical moment in Salama's illness trajectory had occurred long before her father had decided to take her to a *mganga*. At this point, she was seriously ill, and she had perhaps already crossed the threshold of recovering from her deteriorating condition, regardless of the type of intervention.[15] As the next case will illustrate, timely contact with a biomedical facility in and of itself cannot guarantee that a child suffering from a severe febrile illness will receive appropriate treatment and survive.

Case 2: Mburuane's Story

This case highlights the sequence of events, including the context and circumstantial factors, that led a young mother to panic when her nine-month-old son became precipitously ill in the middle of the night and to rush him to a *mganga*. Rehema, a twenty-eight-year-old Zaramo woman, was born and raised in Mbande. At the time of the interview, she was living with her father, a relatively wealthy politician in the village who had supported his daughter's decision to pursue seven years of schooling and to set up a small restaurant in the village. Rehema was well known in Mbande because she had established a series of small businesses in the marketplace, due to the access she had to her father's capital. Her businesses included selling everything from homemade snacks to cigarettes, matchboxes, and loaves of sliced bread. In a life history interview I conducted with her in 2001, Rehema did not go into the details of her failed first marriage. Instead, she focused the narrative on her relationship with her current fiancé. She told me that for the most part, she was doing well in her life, which was better now than it was a few years ago. Rehema had three children, two from her previous husband whom she divorced two years prior, and her youngest, Mburuane, from her present fiancé. Mburuane was nine months old when he died.

I interviewed Rehema in her father's house the day following Mburuane's death. My research assistant, who first brought news about

Rehema's tragedy to my attention, accompanied and assisted me in conducting the interview. Four months earlier, I had interviewed Rehema on the subject of marriage and divorce. She had also participated in a group discussion on the topic of childhood malaria and utilization of bednets in Mbande. Because Rehema lived in a house that was in the heart of the marketplace, right opposite the bus stand, news about her personal tragedy spread very quickly. On the day I interviewed Rehema, she was dressed in a *kanga*, with her head covered in a black scarf to indicate that she was in mourning. Two of her closest friends, both mothers of very young children, flanked and comforted her. During the course of the hour-long interview, neither of her friends intervened or uttered a single word. In her discursive rendering of the events that led up to her son's death, Rehema provided meticulous details. It was obvious that she was telling a well-rehearsed story that she had already told to several other people, including her two friends.

Within hours after noticing Mburuane's fever, Rehama had taken him to the local dispensary where he was clinically diagnosed with uncomplicated malaria and prescribed chloroquine injections. While Mburuane received his first chloroquine injection at the dispensary, the doctor advised Rehema to buy chloroquine syrup and Panadol from one of the local private pharmacies and to continue administering the medications until she could return with Mburuane to the dispensary for follow-up injections four days later. This provisional arrangement was made because the dispensary would be closed during the weekend and also for Easter holiday (*Pasaka*). Rehema purchased all the medicines the dispensary doctor had prescribed from one of the local pharmacies and started administering the medicines to Mburuane as instructed. By Monday evening at about 6:00 p.m., before taking his medicine, Mburuane started vomiting (*akakurufuka*). By midnight, his condition had worsened. Rehema started sponging his body with a wet *kanga*, but the fever did not subside. She gave him another Panadol, but he vomited again. At that point Rehema told her fiancé that they should go back to Mbande because the child's condition was critical. "While my fiancé was closing the door, I immediately felt that my son's heartbeat had gone up rapidly; his heart was beating very fast and then it slowed down, and he started breathing rapidly. I panicked and told my fiancé, "Hurry up, the baby's condition is getting worse." I was so nervous that I told him to carry the baby. Actually we were both confused as to what was happening and what we should be doing."

It was around midnight that Rehema's fiancé suggested that they should go to his grandfather, who was a *mganga* in the same village. By then, Mburuane was shivering, his eyes were wide open, he was thrusting his neck forward and breathing heavily. Rehema went on to describe how the grandfather first put some medicinal leaves on hot coals to create smoke for the child to inhale. Simultaneously, he gave Rehema and her fiancé some medicinal leaves to rub on the child's neck. They did this until his neck had come back to its normal position and the child had coughed as a result of inhaling the smoke—deemed a sign of recovery. The child's condition, however, did not improve. Nervous about his deteriorating condition, Rehema suggested that they should go to her sister in Mbande, whose child had experienced a similar illness and had been cured by Mzee Puga, a lesser-known *mganga* in the village. Rehema contacted her sister and her mother. It was 3:00 a.m. Together they decided to take Mburuane to the *mganga*, who said that it was too dark for him to find the right medicinal herbs in his backyard and asked them to return with the child in the morning. Rehema explained that it was her mother who had told her to take Mburuane to Mzee Puga, apparently because her older sister had done the same when her child had *degedege* two weeks earlier. Thus, Rehema naturally expected that her child would also get well if she took him to Mzee Puga; that he would give the same medicine that he had given to her sister's child, who had recovered completely from the illness.[16]

By this time, Mburuane's body temperature had fallen, but he was breathing heavily. Disappointed, Rehema and the others returned home. From around 10:00 a.m. onward, several neighbors came by and tried different therapies including massaging the child with different oils and herbs. Mburuane's family members and others (his therapy management group) gave him different "medicines," but he still continued to breathe very heavily. Two hours later, his condition suddenly worsened. Rehema described those critical moments:

> His whole body was shivering. Sometimes only his legs were shivering. My mother was busy rubbing the medicinal leaves on him. His eyes and the color of his body had completely changed. He was now gasping for breath like he was yesterday and froth (*povu*) was coming from his mouth. His condition continued to be like that from 12:00 noon to 2:00 p.m. A few minutes later, he took his last breath. He was my third child.[17]

Two weeks later, in a follow-up interview, Rehema said that her son would have survived if the circumstances of his illness were different. She asserted that she had "done the right thing" by taking her child to the municipal dispensary first. If the dispensary was not closed during the long weekend, she would have continued to go there in order to complete the number of injections the doctor had prescribed. I asked her whether she believed that her child's illness (*degedege*) was the work of some spirit/transgression/witchcraft. I was particularly interested in finding out how this particular experience with *degedege* had affected her notions about the etiology of the illness, and whether she thought that witchcraft (jealousy) was suspected given that she was doing so well in her business. She immediately dismissed the idea and said that she did not think that "spirits" were involved in Mburuane's case:

> I think that it was because of high fever (*homa kali*). What can I say? I thought it was only an ordinary fever. It's not unusual for children of this age to get ordinary fever. Isn't it? One minute they have a fever and the next minute they just get up and start playing around as usual. . . . And this is not the first time that my child had a fever. He had it several times before and has had many injections. So this time too, I thought it was the same kind of a fever. . . . If the doctor knew that the child's condition could turn into something so serious, then he would have definitely done something about it. He would not have just asked me to continue with the regular medicines (not injections).

Because Rehema came from a relatively wealthy background, economic barriers did not influence her decision-making process. Instead, her decision to take her son to a *mganga* was prompted by several other factors including: (a) the timing and sudden onset of the illness; (b) the worsening of the child's condition in the middle of the night; (c) the closure of the local dispensary; and (d) the belief that if a *mganga* had successfully cured her sister's child for the same illness, he would be successful in curing her child too.[18]

Mburuane's case is a typical example of the panic that ensues when parents discover that their child is not suffering from an "ordinary fever," but a more serious illness requiring urgent medical attention. It would be overly simplistic to attribute Mburuane's death to the fact that his illness had coincided with a long weekend during which the local dispensary was closed. Rehema did not look into the option of taking her child to another dispensary in the private sector in a nearby town or the district hospital because of her conviction that she was dealing with "ordinary malaria" as diagnosed by the dispensary doctor of the kind that she had dealt with before on several occasions. This led her to underestimate how quickly an ordinary fever can become a life-threatening illness. Contextual factors and specific circumstances surrounding Mburuane's illness played a key role in the therapy-seeking process and the fatal outcome. This proposition will become more evident in the next case study.

Case 3: Zaituni's Story

This case highlights a situation where the parents of a three-month-old daughter, who were dissatisfied with the dispensary doctor's diagnosis, went in search of an alternative source of therapy. This led to further confusion and panic, and eventually the child's death. Nasla, a thirty-two-year-old Zaramo woman, was living in Mbande with her husband Hassani and her three young step-children.[19] She had seven years of schooling. Previously married for five years, she had three children of her own. When her former husband divorced her and took another wife, she returned home to be with her mother, Mama Mdambwe, one of my key informants in the village. Five years later, she married Hassani who had recently divorced his wife with whom he had three children. While Nasla's own children stayed back with her former husband, she became a mother to Hassani's children from his first marriage.

In March 2001, Nasla gave birth to Zaituni, a healthy girl. When Zaituni was three months old, she was diagnosed with uncomplicated malaria at the local dispensary and treated unsuccessfully with chloroquine syrup. Four days following the initial diagnosis, Nasla brought Zaituni to the dispensary in serious condition and reported that she had a high fever and multiple bouts of convulsion the previous night. The head nurse did a quick blood test and determined that the baby was severely anemic; Zaituni's hematocrit or packed cell volume level had dropped down to a dangerous 25 percent. Four days later, Hassani, who was on a bicycle, came up to me as I was walking toward the dispensary and showed me what looked like a prescription written by one of the local pharmacists. On the prescription was written "Pneumonia," a list of four medicines, and the total price of the medicines: Tsh. 3,000 (US$3). Hassani looked embarrassed as he handed me the prescription slip, expecting a response from me. I interpreted his gesture as an indirect way of asking me for money to cover the cost of the prescription. He said "It's pneumonia." At that time, I was uncomfortable with the idea of having to pay for the prescription. I had been disinclined to acquiesce to several such demands that were made during my fieldwork, as I realized that there was no end to such requests. It was a moral dilemma that I had come to terms with amid much emotional conflict and potentially strained relationships with some of the local people, many of whom were only acquaintances. Unfortunately, on that day, I was not aware of the seriousness of the situation. I refrained from granting the request and I said that I would see him in about two hours at Shabani's pharmacy because I had to rush to the dispensary where my research assistants were waiting for me. Upon reaching the dispensary, however, I learned from my research assistants that Nasla had come with her baby to the dispensary. The doctor had examined the baby's blood and had asked her to rush the child immediately to the Temeke district hospital. The nurses and some of the mothers who were sitting there with their own sick children, said to me in what sounded like a chorus "the baby is in a very serious condition!" (*hali ya mtoto ni mbaya sana!*). I rushed back to the spot where I had met Hassani, only to be told by a group of bystanders in front of a bicycle repair shop that Nasla, Hassani, and Hassani's brother had boarded a *daladala* bus and they had rushed the baby to the district hospital. I took relief in the belief that the baby would receive the necessary attention at the district hospital and hopefully survive. I returned to the dispensary. Later that afternoon, I learned that although Nasla and her husband had rushed their baby to the district hospital, she had not survived. I received news about the tragedy from multiple sources, including Nasla's mother, whom I had known for over eight months. At around 3:00 p.m., Nasla, her husband Hassani, and Hassani's brother had already returned to Nasla's mother's home with the dead child. I visited Nasla at her mother's place along with my research assistants. She was mourning in the kitchen, seated next to the hearth, and was being comforted by her family members, relatives, and several women from the village. Despite all the awkwardness I experienced for being the only male person there, I went up to Nasla, who was surrounded by more than twenty women, and I expressed my condolences and offered her some money (a customary practice).

A week later I interviewed Nasla about the circumstances surrounding her daughter's death. The interview took place inside Nasla's house. Her step-children and their friends periodically dropped in during the interview out of curiosity. However, for the most part, the interview went on uninterrupted. According to Nasla, Zaituni did not have any health problems until she was diagnosed with malaria at the dispensary and prescribed chloroquine and Panadol. After the baby received the medication, her condition improved a little. She was able to play as usual for two days. On the third day, however, she had a fever that rose quickly. Nasla described the sequence of events:

> I sponged my child with a wet *kanga* several times over. Her body was so hot that the wet *kanga* would become dry in a matter of minutes, as if it was being dried on fire (*imekaushawa na moto*). While I was sponging her, my baby was crying continuously. No matter what I did, she wouldn't stop crying. Finally, she started convulsing (*akamtikisatikisa*) and had froth in her mouth. I panicked but didn't know what to do as it was late in the night and it was all dark!

Past experience had convinced Nasla and her husband to be skeptical about the quality of service offered at the local dispensary. Therefore, the following morning they decided to take Zaituni to one of the local pharmacists in the hope that her condition would improve because the medicine there would have more qualitative value as compared to the medicine given at the dispensary. Unlike at the dispensary, Nasla and her husband believed that they could get everything they needed at the pharmacy—a blood checkup, different medicines, and injections, and all on credit. Upon examining Zaituni, the pharmacist labeled her condition as "pneumonia fever." He gave the child an unspecified injection and some other medications and further advised Zaituni's parents to return at around 3:00 p.m. for a second injection. He had scheduled a total of three injections per day for five days and had billed them for Tsh. 3,000, all on credit. After the couple had returned home, the baby's condition worsened. Nasla explained:

> Zaituni was gasping for breath. After a while she started convulsing and had froth coming out of her mouth. My husband and I panicked and decided to go to the dispensary, not for treatment but to get a referral slip to go to the district hospital. The dispensary doctor examined her again and found that she had no blood in her body (*kuishiwa damu*—very low hemoglobin). He gave a referral slip and told us to rush the baby to the district hospital immediately.

The couple followed the doctor's advice, but lost an hour before finding someone who could loan them money to transport their child to the district hospital. Upon reaching the hospital at 2:00 p.m., they discovered that the doctor was not in during this time of the day and they waited for him to arrive. Nasla's husband and his brother, who had accompanied them, frantically tried to locate the doctor, but could not find him. The baby died in Nasla's arms while they were seated in the waiting room. In a follow-up interview Nasla mentioned that if the pharmacist had advised her to go directly to the district hospital rather than taking matters into his own hands, her child would have probably survived. "He could have advised me to rush my child to the district hospital for further investigation. Instead, he told me to buy medicines from him and he gave one injection to my baby just there at the pharmacy." Honing on the subject of blame, I asked Nasla if she would attribute Zaituni's death to the actions of the pharmacist, the dispensary doctor, or herself. After a long pause, she replied:

> I feel that we are all to be blamed. In the first place, I was late in sending my child to the district hospital. The dispensary doctor did not tell me that my child's illness could be a serious one. And the pharmacist also made the mistake of injecting my child with some medicine, even when she did not have enough blood in her body. So we are all to be blamed for what happened.

A combination of factors precipitated Zaituni's death. First, the local dispensary did not have a program where an auxiliary nurse-midwife is entrusted with the responsibility of persuading mothers to bring their babies to the dispensary more regularly for a routine postpartum and postnatal checkup, instead of waiting until their babies are very sick. In this case, the dispensary staff should have cautioned Nasla well in advance about Zaituni's anemic condition. Furthermore, the doctor should have diagnosed Zaituni's condition more accurately and advised Nasla to take Zaituni to the district hospital. This would likely have increased Zaituni's chances of survival. In addition, the couple's negative opinion about the dispensary staff and the consequent treatment-seeking trajectory that Zaituni's therapy management group decided upon, further diminished her chances of survival. Nasla and her husband had decided to discontinue the treatment at the dispensary and take the baby to a private, unqualified pharmacist. Upon seeing that the baby was in a serious condition, the pharmacist did not advise Nasla and her husband to rush the baby to the district hospital. Instead, he came up with his own diagnosis and prescription. Ultimately, timing was a crucial factor in determining the outcome in Zaituni's case. Among other structural and contextual factors, including poverty, poor quality of health care, and nonavailability of effective treatment, this particular case draws attention to the problem of misdiagnosis, treatment failure, and the role of unqualified practitioners and pharmacists in the unacceptable health outcomes of the poor. For illustrative purposes, I have depicted the variations in the patterns of resort in the three cases, rather simplistically, below.

Variation in Sequence of Resort with Same Outcome

Case I: Salama

Home treatment with an antipyretic → *Mganga* → Death

Case II: Mburuane

Municipal dispensary → Pharmacist → *Mganga* I → *Mganga* II → Therapy Management Group → Death

Case III: Zaituni

Municipal dispensary → Pharmacist → Municipal dispensary → Therapy Management Group → District Hospital → Death

In the child survival literature, parents of sick and dying children are often depicted "as passive, fatalistic victims of their own incompetence or as coldly and flagrantly indifferent toward the survival of their offspring" (cf. Finerman 1994:5; Larme 1997). However, as Nations and Rebhun (1988a:141) have noted in the Brazilian context, mothers are often unable to obtain the necessary medical care for their sick children because of financial, bureaucratic, and geographical barriers, and not because they are fatalistic or neglectful of their children. The ethnographic data along with the three cases discussed in this chapter provide a clear illustration of the structural constraints and cultural complexities involved in the kinds of decisions parents and caretakers make while attempting to save their children from severe febrile illnesses. The case studies in particular caution us against providing purely "rationalistic," decontextualized explanations for the differentials that may be found in malaria-related child mortalities. In the present ethnographic context, while the parents of these deceased children shared the same political, sociocultural, and health environment, their access to various social and health resources, even within the same community, varied significantly. As depicted above, their decision-making strategies regarding their children's illness were strikingly different from one another. The contextual and circumstantial factors as well as the trajectory of the illness, and the manner in which the identity of the illness was continuously reinterpreted and renegotiated in these cases, were different, and yet the outcome was death. How might one explain these variations in therapy-seeking strategies of parents within a community that shares a common sociocultural and health environment? What are some of the theoretical and applied implications of this pattern vis-à-vis the global intervention strategies that are recommended to minimize malaria-related mortalities among young children?

From an anthropological perspective, studies of child survival and child mortality need to highlight the manner in which health-care decisions are "at once influenced by structural factors, cultural values, social roles and institutions, power relations and economic circumstances" (Nichter 2002:82; see also Williams and Jones 2004:157). The three cases discussed in this chapter reveal that, in addition to structural constraints, circumstantial factors including timing of the illness also play a crucial role in determining parental decision making and the illness trajectory. In Tanzania, parents decide to take their severely ill children to a *mganga*, not primarily because of their cultural beliefs and fear of injections, but more so because of their failure to gain timely access to biomedicine that is safe, affordable, and efficacious. Furthermore, their desire to seek prompt biomedical help is often thwarted by previous unpleasant encounters with health-care professionals who are inconsiderate and discriminative of patients. Following Whyte's (1997) work in Uganda, I argue that in Tanzania as well, it is the failure of access to affordable and efficacious medicine and public health facilities offering timely and good quality interpersonal care that encourages people to take interest in "alternative" providers. These alternative resources include for-profit private pharmacies which are typically managed by unqualified pharmacists who are "primarily concerned with increasing profits, not standards of health in the community" (Marsh et al. 1999),[20] and "traditional healers" who may not offer timely, appropriate intervention including referral to a biomedical health facility.

In their narratives, the three parents provided meticulous details about their child's illness trajectory, their therapy-seeking behavior, and the difficult choices they had to make in their bid to save their children. They emphasized that they were proactive and had not spared any effort to find effective treatment to save their seriously ill child. They deflected direct responsibility for their child's death by reiterating that they had done the right thing—from taking drastic action to save their children from dying, to their passive acceptance of the predicament and leaving the ultimate decision to "God's will." Such post-hoc "fatalistic" explanations may be meaningful in the local context (Castle 1994:316; Dettwyler 1992:31). As has been well documented in the anthropological literature, fatalistic statements are often post hoc rationalizations rather than prior restraints on struggle. They do not necessarily indicate fatalistic behavior; nor, more important, do they indicate neglect (Nations and Rebhun 1988a:143). In this regard, Finerman's words of caution are noteworthy—that "depictions of parents as either incompetent or negligent slaves to a 'culture of poverty,' or to other cultural norms and values encourages a view of parents as obstacles (rather than keys) to program success" (1994:7).

I argue that it is only through detailed ethnographically grounded case studies that it is possible to document the lived experience of parents who have to deal with sick and dying children and to examine the context and circumstances surrounding their child's death. Detailed interpretive analysis of parents' narratives enables us to better understand how parents try to make sense of their experiences of their child's death, and how they frame and rearticulate their experiences over time. Case studies such as the ones discussed in this chapter highlight not only the "social embeddedness and microhistorical character of therapy management" (Nichter 2002:83), but they also provide key insights into the contextual and circumstantial factors implicated in child survival and child deaths. From an anthropological perspective, then, the study of therapy management, especially with regard to child survival issues, "should entail not only what people do (and can do) and reasons for actions taken, but also what they are unable to do and what underlies apparent passivity, acceptance, or fatalism. Failure to appreciate this side of therapy management contributes to simplistic impressions that ignorance underlies 'irrational health behavior' in contexts where other factors are involved" (Nichter 2002:101). This observation has important implications not only for understanding the strategies that parents use to deal with children who are seriously ill, but also for the cultural meanings of child death for families in resource poor communities.

The narratives presented above shed light on how children's deaths can be averted in communities where malaria in endemic and where people have limited health and financial resources. In coastal Tanzania, in order reduce malaria-related mortality, people need to have access to safe, affordable, and efficacious medicine, particularly ACTs. Alongside, there has to be more effective handling of cases brought to health-care facilities, including the availability and use of better diagnostic procedures, including RDTs. Training programs are also necessary so that the content and quality of communication between health-care providers and caretakers is improved. In conceiving and developing communication-related interventions that are community-based, attention needs to be paid to the power differentials between the caretakers and health-care providers. These measures will help in resolving situations where the staff at government health facilities neither tell caretakers what their children are suffering from, nor spend enough time explaining the medications prescribed or dispensed to them.

At the community level, in addition to improving the material resources, attention needs to be paid to people's "ideational resources" such as perceived social and psychological risks of using a particular therapy (Finerman 1994). In Tanzania, there is an urgent need for contextualized health education messages that underscore the importance of early diagnosis and prompt, effective treatment as a strategy to decrease malaria-related childhood mortality. Thus, efforts should also be made to implement carefully designed interventions that emphasize caretakers' recognition of signs of severity and danger and the importance of seeking more timely medical care. Interventions should appeal to caretakers' concerns about specific symptoms such as fever associated with malarial illnesses. This will enable caretakers to recognize early signs and severity of illness so that they can initiate more prompt action that will alleviate their child's distress. Ensuring that caretakers are able to distinguish malaria-specific convulsions, a manifestation often viewed as unrelated to malaria, from generalized fever, will be crucial (Williams and Jones 2004:507).

A careful consideration of the three parents' narratives, the context in which these narratives were produced, their living conditions, and their life exigencies, all shed light on the broader social and political contexts in which people experience and deal with childhood febrile illnesses. The ethnographic data in particular demonstrate the divergent ways in which parents and caretakers who share the same environment deal with an actual episode of *degedege*. These detailed accounts put into doubt the generalization that is commonly made in the literature that there is an overwhelming preference among the people of coastal Tanzania to resort to traditional healers in search of therapy for *degedege*. On the contrary, I have argued in this chapter that many parents in coastal Tanzania are inclined toward resorting to biomedical care for childhood febrile illness, provided they have access to good quality care and efficacious and affordable medicines.

As I have argued thus far, it is important to recognize the fact that malaria does not stand alone as an isolated issue in people's lives, especially in resource poor communities where people are confronted with other pressing concerns on a daily basis. As Holly Williams and Caroline Jones have noted, in order to reduce the "social burden" of malaria, "we need to shift from solitary to integrated designs of interventions that are placed within the broader social, cultural, political, and economic context" (2004:160). In other words, we need to address the problem of overdetermination in public health interventions—the attribution of a problem to a single factor (Dettwyler 1992). Paying attention to the varied ways in which caretakers deal with *actual* episodes of severe febrile illnesses such as *degedege* can help to design locally appropriate and culturally acceptable public health interventions that are aimed at increasing child survival. There is a need to broaden our understanding of the treatment-seeking behaviors surrounding culturally recognized illnesses such as *degedege*—and look beyond the study of beliefs about the etiology of the illness. There is a need to pay attention to the cultural models about the appropriateness of certain treatment-seeking behaviors and practices; to the social relations of health-care decision making at the household level; to the micropolitics of communication at public health facilities; and to the private health sector's role in the diagnosis and treatment of childhood febrile illnesses. Finally, there is a need to look beyond fatalistic beliefs and explanations, take into account structural factors such as the privatization of health care in the context of poverty, and attend to the ways in which the quality of care already provided in public health facilities can be significantly improved.

The next chapter focuses on how single mothers experience and deal with the disproportionate burden of childhood malaria, as they negotiate elements of gender inequality and their social and economic marginalization in their communities.

CHAPTER SIX

Malaria, Single Mothers, and Social Suffering

The melancholic nature of much theorizing in the social and human sciences is perfectly comprehensible because of the ethical commitment many practitioners have to "telling it like it is," documenting and analyzing the horrors and miseries of the contemporary world, explaining how the privilege of some creates the misfortune of many, how power distorts and extracts the value and vitality of lives. This is one of the most valuable contributions the human and social sciences make to the analysis of the contemporary.

HENRIETTA MOORE 2011:69

When an observer witnesses the effects of structural injustices and sees little more than cultural difference, is this not a conflation of cultural difference and structural violence?

PAUL FARMER 1999:154

Silent Violence

One late afternoon in July 2005, I was sitting on the threshold of a large Swahili house,[1] along with Mama Afidhi, my field assistant, watching a mason putting some final additions to the exterior of a new concrete house that was about fifty feet away from where we were seated. All of a sudden, the mason turned back and shouted at a young woman who was engaged in an animated conversation with a group of friends close to the Swahili house, and demanded that she come to him right away. The young woman refused and he threatened to beat her up if she did not come immediately to him. She refused to budge. Furious at her defiance, he let out a string of profanities and threatened to kill her if she did not do exactly what he was asking. She stood her ground. The mason charged at the young woman with a hammer and another tool in his hands; she bolted, in anticipation, through the long corridor of the Swahili house, tossing both Mama Afidhi and me aside as she crossed the threshold. The mason, who I later learned was the young woman's husband, chased after her through the Swahili house. The young woman ran out the back door and disappeared into the thicket of cashew trees. Stunned by what I had just witnessed, I asked Mama Afidhi if she could explain to me what was going on. "*Hii ni kawaida tu*" (This is just normal), she said, matter-of-factly, meaning that this was just a common occurrence.[2] As we walked back to my house, she added that everyone in the neighborhood knew that the mason was a drunkard and an ill-tempered, abusive husband. Two days later, I learned that the mason had severely beaten his wife, accusing her of adultery, among other transgressions, and it was likely that they would soon be divorced. That young woman was Salma, one of the 120 single mothers I interviewed between 2007 and 2008 in Mbande and the neighboring villages on various aspects of their lives, including their experiences dealing with their children's sickness.

This chapter is not about the nature and magnitude of gender-based domestic violence in my fieldwork location. Instead it is about how elements of gender inequality and women's social and economic marginalization relate to the question of childhood malaria and child survival. The excerpts from life histories of single mothers and illness narratives presented here reveal the larger social, economic, and cultural context in which mothers, especially those who are single or previously married (many of them abandoned by their male partners), have to deal with their children's sickness, including repeated bouts of malaria. I address the question, How does childhood malaria affect the everyday lives of single mothers who have to care for their children, often in contexts of extreme poverty and very limited social support? Alternately, How does being a single mother affect care-seeking for childhood malaria and child survival? In the previous chapters, I emphasized some elements that address this question and concern. In Zaina's case in chapter 4, for example, I showed how being a single mother of five children intensified her travails when seeking treatment for her sick children—there was no help around when she really needed it. In this chapter I will discuss more closely the manner in which the status of being a single mother is imbricated in childcare and child survival, particularly in contexts of gender inequality, extreme poverty, and high prevalence of malaria and related health complications among young children.

I have divided this chapter into three sections. I begin by briefly reviewing the literature on the concepts of structural violence and social suffering, as they relate to the question of single motherhood and the social burden of childhood malaria. This is followed by a section on excerpts from life histories and illness narratives of four single mothers whose lives I documented over several years. This middle section examines the particularities of therapy-seeking for childhood malaria among single mothers: the social and financial difficulties and the humiliation they have to face in their search for therapy. I conclude with a discussion on how single mothers' stories of conjugal breakdown and marital disruption and everyday forms of violence provide insights into the larger social and economic context in which the persistence of childhood malaria and child mortality may be understood. I argue that the persistence of childhood malaria in poor communities and the manner in which single mothers in particular experience its impact, is significantly influenced by structurally induced socioeconomic changes and gender inequalities that constitute structural violence. I also emphasize that single mothers' narratives of suffering represent a moral commentary on the disrupted present and a longing for an idealized past that was uncomplicated and representative of egalitarian social arrangements.[3] The chapter is based on data gathered in three villages in the Chamazi ward of Temeke district, including Mbande, between 2005 and 2010.[4] I broaden the discussion on single mothers to highlight the larger social context and the social burden of childhood malaria, and to illustrate the structural factors that predispose certain people, even within poor communities, to experience vulnerability, uncertainty, anxiety, and the debilitating effects of childhood malaria more intensely than others. The narratives reveal how poor single mothers, in particular, must continuously negotiate their everyday survival strategies and take care of their sick children under challenging circumstances. As such, the chapter brings to light the structural constraints placed on single mothers, their experiences of economic and social vulnerability, social suffering, the kinds of agency they exercise, their resilience, and their survival strategies in the historical and political context of unequal gender-power relationships and socioeconomic transformation that has characterized Tanzania since the early 1990s. Accordingly, I have joined other scholars who have pointed out that in the Tanzanian context, the implementation of neoliberal reforms, which are closely associated with the structural adjustment policies of the IMF and World Bank, has significantly undermined women's economic security, with serious consequences for their everyday lives (Campbell, Mwami, and Ntukula 1995; Koda 1998; Lugalla 1995b; Sanders 2001; Seppala 1998; Tripp 1997). Chris Lockhart, for example, notes that "while the consequences of these wider, structural processes are complex and varied . . . the general outcome for women has been to further limit their already precarious civil and property rights in rural areas" (2005:8; see also Tripp 1997).[5] Studies conducted in the Tanzanian context have also documented the undesirable effects of structural adjustment programs on women and children, leading to increased poverty and immiseration, maternal mortality and chronic malnutrition among children, and also HIV/AIDS (Due and Gladwin 1991; Lugalla 1995b; Meena 1991; Vavrus 2005).

The literature on single mothers and/or previously married women in the African context has, to a large extent, focused mainly on fertility strategies, gender inequality, and sexuality, with an emphasis on survival sex and/or transactional sex and its structural and contextual implications for the spread of HIV/AIDS (Bledsoe and Cohen 1993; Calves 2002; Gage-Brandon and Meekers 1993; Lockhart 2005; Meekers 1994; Poulin 2007; Setel 1999; Smith 2007).[6] There is also a growing literature on the related topic of premarital sexuality, teenage pregnancies, sexual violence, masculinity, and HIV/AIDS among young people in the sub-Saharan African context (Dilger 2003; Groes-Green 2009; Haram 2005; Poulin 2007; Silberschmidt 2001, 2004, 2005; Silberschmidt and Rasch 2001).[7] By contrast, the importance of gender power relations (gender dynamics) in the community, single motherhood, management of childhood illnesses and/or health problems, malaria, and child survival has received scant attention (see Tanner and Vlassoff 1998; Vlassoff and Manderson 1998). One reason for this inattention, perhaps, is the very nature of malaria; it is an acute illness that seriously affects more infants and young children than adults. And as I have already noted in this book's introductory pages, unlike HIV/AIDS and tuberculosis, malaria is not a stigmatized illness. Therefore, it does not readily raise some of the moral and ethical questions (including gender relations) that other stigmatizing illnesses do, particularly HIV/AIDS.

I became interested in the conceptual and empirical analysis of single motherhood as a social category, and its association with the processes of neoliberalism, changing gender relations, structural violence, social suffering, and agency, during the course of my initial fieldwork in Mbande village, and subsequent analyses of the data I gathered on various aspects of peoples' lives. As already mentioned in chapter 4, I was surprised by the number of single mothers who lived in my neighborhood, and those who described themselves as "single" (i.e., without a husband, fiancé, or steady boyfriend) in the surveys and in-depth interviews.[8] The commonality (i.e., pervasiveness) of single mothers suggested that their large presence was structural and not a random statistical phenomenon. In due course, I read their situation and stories of being in abusive relationships as indicative of structural violence, and their lived experiences as indicative of social suffering, which I describe below.

Structural Violence and Social Suffering

Johan Galtung (1969), the Norwegian peace researcher, is commonly credited with being the first to use the expression "structural violence" to refer to the injury caused to individuals and groups as a result of the inequitable regulations and categories imposed on the people by structural systems or governing institutions. This inequity leads to further social stratification and results in the production of a system that undermines the betterment of peoples' lives. In making a conceptual distinction between personal or direct violence and structural violence, Galtung notes that structural violence is indirect in that "there may not be any person who directly harms another person in the structure. The violence is built into the structure and shows up as unequal power and consequently as unequal life chances" (1969:171). Paul Farmer went on to popularize the concept of structural violence, especially among anthropologists. He has used the term to refer to "a broad rubric that includes a host of offensives against human dignity: extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontestedly human rights abuses" (2004:8). Anthropologists describe structural violence in terms of both "chronic, historically entrenched political-economic oppression and social inequality" (Bourgois 2001:7) and mechanisms by which "social forces ranging from poverty to racism become embodied as individual experience" (Farmer 1997:261–262). Nancy Scheper-Hughes and Philippe Bouregeois point to the conceptual distinctions between "the chronic, historically embedded structural violence whose visibility is obscured by globalized hegemonies," the "symbolic violence and routinized everyday violence," and direct physical assault (2004:18). Structural violence is often invisible because it is part of the routine fabric of everyday social and political life (Scheper-Hughes and Bouregeois 2004). While structural violence may not directly implicate the actors of violence, it reveals the structural arrangements underlying the systemic nature of its distribution. The structural violence framework attempts to uncover the intersection of structural inequality and political economy that produces and reproduces physical and social suffering in local communities within the context of broader social and political transformations (Farmer 2003, 2004; Kleinman 2009; Pfeiffer 2005). Structural violence often manifests itself in the inequalities that exist in terms of disproportionate life chances because of disease or poverty. While these inequalities are directly caused by an unequal distribution of resources, the fundamental problem is that the power to decide over the distribution of resources is unevenly distributed. This unequal distribution of power then systematically disadvantages those who do not hold as much power at all, enhancing the agency of some but invariably at the expense of constraining the agency of others (Ho 2007). In sum, as Sarah Willen notes, "structural violence renders individuals and communities vulnerable, in multiple and compounding ways, to discrimination, racism, poverty, disease, and injury as well as more direct assaults on personhood, dignity, and physical integrity" (2007:169).

The related concept of social suffering refers to the social misery, pain, and hurt that people experience individually and collectively due to the structural violence of institutionalized inequities and systemic discrimination (Kleinman 2009; Kleinman 1997; Kleinman, Das, and Lock 1997; see also Adelson 2001; Das 2001; Farmer 1997; Green 1998; Wilkinson 2004). Social suffering focuses on "human problems that have their origins and consequences in the devastating injuries that social forces can inflict on human experience. Social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems" (Kleinman 1997:ix). According to Pierre Bourdieu "Using material poverty as the sole measure of suffering keeps us from seeing and understanding a whole side of the suffering characteristic of the social order" (1999:4). Thus, Bourdieu (1999) uses the concept of social suffering to draw attention to not just the unequal distribution of material goods in society, but also people's lived experience of domination and repression, including feelings—humiliation, anger, despair, resentment—that may accompany, for example, poverty, class, or race. Social suffering lies at the heart of the subjective experience; it represents the lived experience of the social damage inflicted by those in power on the least powerful—especially exclusion and the feelings this produces (Frost and Hoggett 2008:440). In other words, social suffering is the social representation of the lived experience of inhabiting social structures of oppression, and the social misery, pain, and the hurt that arises from this. Social suffering draws attention to the abjection, and to the nature of the "self as object" that those without power over others endure (Frost and Hoggett 2008:441). As Liz Frost and Paul Hoggett put it: "Because the exercise of 'power over' others appears natural and legitimate, the hurt that produces shame and humiliation and the losses that lead to grief become detached from the social relations which generate them. The suffering that results becomes individualized and internalized—built into subjectivity . . . and inscribed on the body: the low self-esteem, low status, lack of social capital and lack of power to direct one's life" (2008:442–452).

One of the strategies that medical anthropologists have adopted to highlight the dynamic processes through which social suffering is produced and endured is by providing detailed, "thick" descriptions of particular instances of human pain and suffering (mainly through historically and ethnographically grounded case studies and illness narratives), and an analysis of how the suffering is connected to silent systems of power and inequality, and their sometimes devastating consequences within human lives (Willen 2007:194; see also Briggs and Mantini-Briggs 2003; Farmer 1999; 2003; Kleinman, Das, and Lock 1997; Miles 2010).

These processes of structural violence and social suffering are evident in countries like Tanzania that have undergone a profound transition from a socialist economy to one underscored by neoliberal economic reforms, the privatization of the social sector, cutbacks on welfare spending, the subsequent disintegration of social safety nets, and further entrenchment of poverty (Ellis and Ntengua 2003; Lockhart 2008; Sanders 2008; Tripp 1997). In such an environment, social gradients such as gender, sexuality, and ethnicity are "structured" so that individual agency is circumscribed, and individual life chances are limited by one's social and structural position. The structurally induced fostering of socioeconomic inequality constitutes a form of violence; for example, poor women who are single mothers may be "coerced" into taking physical and/or sexual risks due to the extremes of structurally induced poverty, and these risks may be detrimental to their well-being and that of their family members, particularly children (Beckerleg and Hundt 2004; Kathewera et al. 2005; Koenig et al. 2004; Manjate, Chapman, and Cliff 2000; Sen 1999). Simultaneously, within a neoliberal discourse that advocates the dominance of an efficiency-based, competition-driven market model, "poverty becomes not only a problem of the poor, but also their responsibility" (Green 2006:1118). The structural violence analytic seeks to determine how this process is constituted in diverse cultural settings with distinct histories and unique constellations of political actors. It attempts to uncover the intersection of structural inequality and political economy that produces and reproduces physical and social suffering in local communities within the context of broader national political transformation (Farmer 2003; 2004; Kleinman 2009; Pfeiffer 2005). Given that structural violence is not always "ethnographically visible" (Farmer 2004; Lockhart 2008) but embedded in ubiquitous social structures (Winter and Leighton 2001), and social suffering is embodied and articulated through narratives and stories (Miles 2010), the empirical validation of these powerful concepts poses unique challenges.

As mentioned in chapter 4, of the forty-five mothers I interviewed in 2001 regarding childhood malaria, one-third were single, mostly young, mothers. Through their narratives, mothers elaborated on how the burden of child care in general and the practice of dealing with children's sickness, including repeated bouts of malaria, falls disproportionately on those who, for various reasons, are single, without a male member—a breadwinner—to provide economic and social support. I kept notes on the transitions that several of the single mothers I had first interviewed in 2001 experienced. During informal conversations and follow-up interviews, I recorded the complexity of their livelihood strategies, their social support networks, travails, and everyday hardships, especially involving their children's sickness. When they stopped by my house to prepare meals for themselves and me, they often relayed information about some key events in their lives such as a new relationship, a boyfriend they were seeing, a quarrel, a new business venture, sickness in the family, a birth, a death, and also mundane events. This close proximity afforded me the opportunity to observe and record aspects of their lives over an extended period.

A Village Full of Single Mothers

At one point when I asked Mama Afidhi whether she thought that single mothers (*mama ambao wanaishi peke yao*) in Mbande were as "common" as my preliminary data seem to suggest, she spontaneously exclaimed "*wapo wengi!*" (There are many!). "Mbande is full of single mothers," she claimed, and went on to give reasons why she thought there were so many single mothers in the village. As an unmarried single mother herself for nearly six years at that time, she summed up her sentiments in one phrase: "*Wanaume wanadanganya sana*" (men, they lie a lot, they cheat)—an expression that I heard repeatedly throughout my fieldwork. Accordingly, I interviewed a group of older women and relatively younger women who were single mothers to elicit cultural models (social roles and expectations) of men as husbands, fathers, and providers, and to find out if they considered the phenomenon of single mothers a more recent development, in terms of its magnitude, and whether single mothers overtly experience social stigma and discrimination in the community. I also wanted to document the extent to which they thought men's disposition (behavior and attitude) toward women were to be blamed for the large numbers of single mothers in their respective villages. In other words, I wanted to find out whether the women I interviewed and interacted with saw any connection between their everyday lives, as it has changed in the postsocialist, neoliberal era, and the rise in the number of single mothers in their respective villages. Why were there so many single mothers in the village and why do women become single mothers in the first place?

One of the first persons I formally interviewed on this question was Mama Bwinde, a thirty-five-year-old single mother of five children (at the time of the interview). She emphatically told me that single mothers were not a new phenomenon—that mothers have been living alone in Mbande and elsewhere for a long time. However, because their numbers have increased these days, single mothers have become a "normal phenomenon" (*mambo ya kawaida tu*). She went on to explain that as in the past being a young single mother was still considered a matter of shame (*jambo la aibu*). Parents want their children to be married because it brings respect to the parents; it brings them peace of mind (*wanapokea raha*). They can confidently introduce their grandchildren to neighbors and friends if they are born within marriage, but they feel awkward if their grandchildren were born out of wedlock (*heshima itakua ndogo kama walizaliwa nje ya ndoa*). As Mama Bwinde explained, there is a difference between *halali* and *haramu* children (those born within marriage and those born out of wedlock—*ndani ya ndoa, nje ya ndoa*). Above all else, there is the problem of inheritance for children who are born out of wedlock. Being a single mother lowers one's social status (*heshima inapungua*). People look down upon single mothers, underestimate them (*wanadaharau*), comment behind their backs that they are wayward (*uhuni*), promiscuous (*malaya*), and that they have nothing important to do in life. Even so, there were hundreds of women in Mbande and neighboring villages who were single mothers; many of them were single mothers not by choice but due to contingencies and circumstances beyond their control. Yet, as will become evident later in this chapter, although being a single mother is considered shameful and associated with a wide range of hardships, many women do make a conscious decision to remain single rather than commit themselves to men. In other words, some single women and single mothers do exercise agency when making decisions about relationships with men, especially when they see the relationship as only *potentially* long term.

As with Mama Bwinde, Mariam Hassani, a thirty-five-year-old single mother of three children, also told me that single mothers had become an all-too-common phenomenon. She attributed the growing numbers of single mothers to the "shortage of good men in the villages." Drawing mainly on her own experience with an alcoholic ex-husband, she explained that even though there were men in Mbande, they were "worthless," "irresponsible," and "untrustworthy," because most of them were drunkards (*walevi*). And as with most drunkards, she bemoaned, there was no guarantee that if a man were to marry her, he would not "kick her out" of his life after two or three days. Therefore, many single women in Mbande prefer to live on their own, out of abusive relationships, and make a living by doing some small business (*biashara ndogo*). They say, "Why should I bother to live with a drunkard? I'd rather be on my own, run a small business, earn a livelihood (*kupata riziki*), and lead a peaceful life." Mariam's suggestion that the rise in alcoholism in the village was a major contributor to marital instability, domestic violence, and abandonment, all of which have a direct bearing on childcare and child survival was not without basis.[9]

Mama Abhilai, a forty-three-year-old single mother of six children, who was living in and around Mbande village as a single mother since 1999, put the breakdown of religious norms, the intensification of poverty, and the erosion of parental authority at the center of her explanation for the dramatic rise in the numbers of single mothers in the village. She also explained that it was men's desire to enter into sexual relations with multiple partners, and of both men and women showing disregard for the tenets of Islam by entering into sexual relationships following casual encounters without checking on each other's character, that was contributing to the problem. Finally, she suggested that the increasing numbers of single mothers was due to poverty, which directly predisposes vulnerable young girls to engage in "survival sex" in the marketplace. Young women, she said, "choose their partners in the marketplace when they are hungry." In other words, these were "marriages of hunger" (*ndoa ya njaa*); marriages that are made in the marketplace over offers of "potato fries and egg omelet" (*chipsi na mayayi*). Elaborating on this comment, Mama Abhilai explained:

> Couples meet once or twice and then they're together; she is hungry, he promises her food and says "come let's live together, I'll provide for you, we'll be happy together." But then, she gets pregnant, he gets tired of her in two to three days, and goes to another woman. Parents and grandparents do not have the energy and the means to take care of their grandchildren, so many young children who are hungry, especially young girls, go to the marketplace, where men give them some money for sex, they become pregnant, and the cycle continues.

Figure 11. Women selling snacks in the marketplace. Photo by author.

I heard this interpretation repeatedly during my fieldwork from several of my key informants, not just women but also men. As with Mama Bwinde, Mariam Hassani, and Mama Abhilai, most of the single mothers I interviewed emphasized that being a single mother was not a new phenomenon—that single mothers have been living in their villages for a long time. In their view, however, the proportion of single mothers in their respective villages had increased dramatically over the years. The women I spoke to commonly mentioned the growing number of young women who sold snacks in the marketplace as an indication of the high prevalence of single mothers in the village. Most of them, they said, were single mothers who were making a living by selling snacks in the marketplace. Not surprisingly, when I asked my field assistants to help me with identifying single mothers, both for the survey and the in-depth interviews, in unison they said "*twende magengeni*" ("let's go to the marketplace)." However, as I discovered during my fieldwork, the "single mother" status was neither fixed nor permanent; indeed, as the single mothers' life course and life histories revealed, in many cases, the status of being a single mother was inconsistent, as women often found themselves in and out of relationships with men, including ephemeral marriages or being someone's *nyumba ndogo* (lit., "small house," mistress or a concubine).

As described in chapter 2, the marketplace was the hub of social activities; it was also the place where women would sit along the roadside in groups of five to ten and sell snacks such as chapatti, samosa, fried buns, fried cassava, cakes, sliced bread, fried fish, and sweets. While the number of women selling snacks in the marketplace had definitely multiplied over the years, from about ten women in 2000 to more than fifty in 2008, I found that not all of them were single mothers. Some of them were poor married women who sold snacks as a small business activity. Even so, asking some of them if they could lead us to women in the village who they knew were single mothers proved to be a very useful strategy in identifying single mothers in the four villages.

Life Histories

In order to contextualize the above commentaries, I present excerpts from interviews with four single mothers out of the many whose life histories I documented in detail over several years, starting with my first interview in 2001. Collectively these case studies contextualize and convey single mothers' experiences with and underlying presuppositions about men in general in the course of their everyday lives. To be sure, life stories or life histories are *stories* rather than *a story*—that is, segments of a longer story of one's life that is told discontinuously at different times, and that is always provisional, being supplemented, updated, and revised over the course of one's life (see Quinn 2005:27–28).[10] I begin with Fatuma's story. Fatuma was one of the most engaging interlocutors I met in Mbande village, and the first woman who allowed me to record her life story/history on tape.

Case 1: Fatuma's Story

Fatuma, a thirty-two-year-old single mother of three children, had endured a life of uncertainty and immense hardship. I first met her at the dispensary in Mbande in February 2001 when her daughter was diagnosed with malaria. She identified with the Mzigua tribe (*kabila* or ethnic community). Fatuma had spent the first sixteen years of her life in Somalia with her grandmother, who was originally from Nyasaland (present-day Malawi), and her grandfather, who was originally from Tanzania's Tanga region. Her grandparents had migrated from Nyasaland to Somalia several decades before. In 1993, during the civil war in Somalia, Fatuma's grandmother sent her to Tanzania to join her parents, who had relocated themselves within the Dar es Salaam region in the late 1980s. Her father would remind Fatuma, “We are not Somali, we are ‘Mzigua,’ originally from the Tanga region; we have returned to Tanzania, our homeland.” As a young child in Somalia, Fatuma did not attend school; she had to take care of the family’s livestock—cattle and sheep. Immediately upon her arrival in Tanzania, Fatuma’s father forced her to marry a man, with whom she became pregnant with her first child (daughter, Maimuna), but she did not live with him for long because he was rarely at home. He was mostly doing business in Morogoro, so Fatuma asked for a divorce, which he granted without much trouble. That same year, Fatuma’s parents also got divorced. While Fatuma’s father took on two other young wives, her mother married a relatively wealthy person in the village. Fatuma continued to live in her father’s place along with her daughter. Two years later, she fell in love with Clement, a recent immigrant from the Shinyanga region, in northwest Tanzania, who was residing in Mbande village and growing okra for a living. He agreed to marry her, but Fatuma’s father was against the relationship because Clement was a Christian. He did not formally acknowledge the relationship until Fatuma was in the seventh month of her pregnancy (daughter, Mariamu). According to Fatuma, her father harassed Clement and threatened to kill him with a machete if he did not leave her and go elsewhere. Finally, tired of all the harassment and threats, Clement left Fatuma and relocated himself elsewhere in Tanzania. As Fatuma put it: “After he left, I struggled a lot and failed to take good care of my children” (*Nimehangaika hangaika . . . nilishindwa kutunza watoto*). Then, in 2005, she met another man Athuman, who was from the Ngindo tribe, and lived with him for a few months before he decided to go to Tanga to dig for precious stones and never returned. Significantly, that year, Clement’s brother Mangombe proposed to marry her. “I was twenty-eight years old then, we met in the shamba (fields). After living together for two years, we got married, but then he contracted TB, and died when I was in the ninth month of my pregnancy. I gave birth to my son, Ahmed.” All in all, Fatuma had lived for extended periods with four men, and had three children with different fathers. She was ashamed of asking her parents and relatives for help all the time, so she worked a small piece of borrowed land and grew okra and cassava, and earned Tsh. 800 to 1,000/day (or 60 to 80 cents). She also sold snacks such as fried buns and sweet potato in the village market to make a living.

I often consulted Fatuma regarding her views on marriage and relationships. In one of the interviews, Fatuma told me that she did not see any significant difference between being in a relationship, married, and being in a relationship without being married, especially in the context of raising children. In her experience, she did not think there was much difference between being married to a man and living with him, and being with a man to whom you are not married. "I've lived with a man for two to three years without being married, and we really loved each other," she said. Fatuma had lived with a man to whom she was married; and with a man to whom she was not married. She said that she did not see any major difference because "if the couple understands each other, then it does not matter whether they are married or not." However, she added that having a husband is always an advantage because "you have a pillar for support" (*nguzo ya kutegemea*), especially during emergencies. She also explained that being in a relationship and not being married might be seen as a sinful act (*labda itakua dhambi tu*), so it is better to get married, otherwise people will call you a *uhuni*—(aimless, vagrant, drifter, floater: i.e, a loafer). "Well, it's not possible for everyone to have a husband . . . a lover is a lover, a husband is a husband (*hawara ni hawara, mume ni mume*)." As with my other key informants, Fatuma also emphasized that it was better to have children within a marriage because "your parents cannot refuse to embrace your children as their grandchildren. The husband also cannot deny that the kids are his . . . and he won't be able to ignore their crying." Fatuma was somewhat ambivalent about the importance of marriage to the success of a relationship and raising children. Although she thought that having a husband was advantageous, based on her past experience she had decided to live alone with her children.

One of Fatuma's preoccupations over the years was her daughter Mariamu's sickness, marked by repeated bouts of fever. As was often the case, Fatuma would take Mariamu to the village dispensary where should would be repeatedly diagnosed with malaria. In July 2006, Fatuma provided me with details surrounding her daughter's most recent illness episode for which she had consulted multiple sources of health care, including the local dispensary, a private pharmacy, and a traditional healer in the village. She started her narrative with an all-too-familiar pattern characteristic of childhood malaria—that Mariamu was sick for three days, during which she would get a high fever at night, start shivering, sweat profusely, and cry all through the night, but during the daytime she would look normal, and play around as usual. Fatuma gave her Panadol, thinking that it was only an ordinary fever, but soon realized that it did not help. She took Mariamu to the dispensary, where the doctor gave her sulfadoxine-pyrimethamine—an antimalarial. According to Fatuma, even though sulfadoxine-pyrimethamine helped Mariamu to get better, she started complaining of an earache (*ugonjwa wa sikio*). "I could see puss coming out of her right ear, but I did not have any money left so I didn't know what to do. She continued to suffer. Only God was helping her. I didn't have the energy to help her because I was myself suffering from severe cough and internal chest pains."

After waiting for nearly a week, Fatuma decided to consult with Chuma, one of the local retail pharmacists, who had also trained as a lab technician. She did not want to go back to the dispensary, "because the doctor there does not do any tests, he simply tells me to buy the medicines from the private pharmacist. Every time I take her there, he tells me that she has malaria; if she does not have malaria, he says that she has worms and that I should buy the medicine from the retail pharmacy." This time, however, the retail pharmacists told Fatuma that she should send Mariamu to the district hospital where they could do some tests on her—because he did not have the equipment to do any of the tests. Fatuma followed his advice and took Mariamu to the district hospital, where they did a few tests and prescribed malaria tablets and PPF injections "but her earache and headache continued. There was nothing more I could do." Mariamu was taking her medicines regularly and also the injections, but she was not showing any signs of improvement. She was given medicines for malaria, worms, and her earache. "I spent the whole year worrying about Mariamu's sickness, without any relief."

During the ensuing years, I conducted two more interviews with Fatuma, mainly to document some important changes that had taken place in her life—in particular, her stepfather's death and subsequently her mother's death. She also participated in two focus group discussions on single mothers and management of children's sickness. As such, I followed her life history with periodic updates. However, nothing had prepared me for a terse text message I received on my cell phone in October 2009: "*Mariamu amefariki*" (Mariamu is dead). At that time, I knew at least a dozen women or children in the village with that name, so I called Baba Mage, my field assistant, who had sent me the text message, to find out more. "Mama Maimuna's daughter died last week," he said. "How?" I asked. "Malaria only, nothing else" (*Malaria tu, hamna baki kitu*), he replied. "But didn't Fatuma take her to the dispensary and get ALu (Coartem)?" I asked. "Yes, but she still died," he replied. "How is Fatuma doing?" I queried. "She's okay, I think," he said.

I was wholly unprepared for the news of the death of a child in my fieldwork site, whose life I had followed and documented for nearly nine years Mariamu was nine months old when I had seen her the first time at the dispensary in Mbande (Kamat 2004, 2009, and also the introduction, this volume). Eight months later, when I returned to the field, even before I broached the topic with Fatuma, she narrated her story about her daughter's death and ended with the coda: "She died in my arms, on the roadside. I did everything I could to save her, but it was God's wish that she had to die." Fatuma's narrative raised an important and obvious question for me: Why did Mariamu die even when her mother had done everything to save her, including taking her to the local dispensary and the district hospital where she was diagnosed with malaria and given Coartem? Even though Mariamu was one of the 70,000 or 80,000 children who had died of malaria and related complications in Tanzania that year, her death in 2009, which might have been prevented, needs to be placed not only in the context of Fatuma's life as an impoverished single mother, but also in the context of recent global discourses and practices on malaria elimination, and the increasing emphasis on the promise and deliverability of new, highly subsidized artemisinin-based combination therapies (ACTs), as the way forward in dealing with childhood malaria.

Fatuma's case exemplifies elements of structural violence and social suffering as it relates to childhood malaria and child survival in several ways. Fatuma grew up in war-torn Somalia, where she did not attend school. Upon her arrival in Tanzania to join her parents, her father forced her to marry a man who was twice her age; the marriage did not last long. Over the years, Fatuma shared her life with many men (serial relationships), all of whom lived with her for short periods of time, but abandoned her with more children to look after. She enjoyed very little social support and had to endure poverty, financial hardship, social misery, parental divorce, and no state support; in sum, she was left to her own devices to earn a livelihood and raise her children. Her preoccupation with her daughter's sickness often kept her from earning a livelihood and generating savings, if at all possible; her fiancé's death when she was in the ninth month of her pregnancy and the subsequent death of her daughter contributed to her enduring grief and social suffering. Fatuma died in January 2012 in her father's house, at the age of thirty-five, following some serious health complications. I was able to gather only vague information from my key informants about Fatuma's health and the circumstances that had led to her untimely death.

Case 2: Mama Bwinde's Story

Mama Bwinde is a thirty-five-year-old single mother of five children. I first met Mama Bwinde at the village dispensary in February 2001. She was seated on the floor with two of her children who were both sick. She wanted me to take her picture with the children, and I gladly obliged. Subsequently, I gave her a print copy of the picture as a keepsake and took the opportunity to interview her regarding her children's sickness. Mama Bwinde belonged to the Zaramo tribe and was a practicing Muslim. She was born in Vyanzi, Kuranga district, and had arrived in Mbande as a child in 1974 to be with her sister. She attended the newly constructed village primary school in 1976. She was known to be a very bright student. She was keen to attend secondary school, but could not pursue that ambition because she became an unmarried teenage mother shortly after finishing primary school. I interviewed Mama Bwinde on multiple occasions over the next seven years regarding her life history. At the time of my last interview with her in August 2008, Mama Bwinde was a mother of five children, with two different fathers. She had lived with one of them on and off for seven years, but never married. As of 2007, she was living alone with her five children, making a living by selling fruits and snacks in the village market.

When Mama Bwinde was sixteen, she had an affair with one of her neighbors, who was already married, and became pregnant with her first son soon after she had finished her primary schooling. She stayed with her grandmother in Kuranga during her first pregnancy, to wait out the shame, and returned to Mbande with her son. Subsequently, she had a relationship with a traditional healer (herbalist). "He wrote the marriage proposal letter (*aliandika barua*), but he did not have any money. He was broke, and his life was hard. But we loved each other, so we just continued to live together."

Mama Bwinde explained to me that her partner "preferred to relax rather than work to earn a living" (A*na penda starehe sana, anpenda rumba*), and so they started to quarrel (*tuligombana*) frequently. When she would tell him that there was no food in the house and the children were hungry, he would beat her up. Finally, in 2007, he left Mama Bwinde and went to live with another woman in a nearby village. She threatened him with a court case of child neglect and even filed a complaint with the village executive officer (*mtendaji*), but to no avail. "My life is full of problems (*maisha yangu ni tabu tu*), everything is a problem, but I thank God that somehow I've been able to raise my children." When I asked what it meant for her to live the life of a single mother with five children, she responded saying that, for the most part, it all came down to money because without a husband or man in your life, "one day you have money to buy food and the next day you don't, so if your children are sick you're on your own." In her case, she did not have anyone who could come to help her. She had to do everything on her own, including sending the children to school, buying their clothing, their food, and everything else. If there was a major crisis (*matatizo makubwa*), she could go to her sister for help, but there was only so much her sister could do to help her because she too was poor and had her own problems. For small, everyday problems she could go to her neighbors. Occasionally, they would help her (*wanachanga, wana saidia*), but for the most part she was on her own. As for getting help from friends, Mama Bwinde explained to me that she did not have many friends to chat with or to ask for help: "I simply don't have the time and energy to socialize with friends, I'm busy, I have to struggle a lot to make a living, I have to work the land and also do my small business—I simply have no time."[11]

In one of the interviews I asked her to elaborate on how she had dealt with Kwanza, her youngest son, when he was diagnosed with malaria. She began by saying that during the daytime, he looked normal, playing as usual, but at night he would get a high fever and his body would become hot; he would start shivering, and cry a lot. His eyes were red, he had a running nose, and he completely lost his appetite. Mama Bwinde thought that she was dealing with an ordinary fever, so she gave Kwanza Panadol for two days, but on the third day she took him to the dispensary. There, the nurse checked him, said that he had malaria, and gave him Panadol and sulfadoxine-pyrimethamine. Kwanza was better for about a week, but then his fever reappeared. Again Mama Bwinde took him to the dispensary. There the doctor wrote a prescription for amodiaquine. Mama Bwinde had to buy it from Chuma, the retail pharmacist. The amodiaquine did not help either. By this time, Kwanza had a rash and boils (*vipele*) all over his stomach and on his back (along the spine). He had also developed boils and blisters in his mouth. Mama Bwinde saw no point in taking Kwanza back to the dispensary so she took him to a private hospital in Mbagala, where he was diagnosed with malaria and prescribed Panadol and quinine. Mama Bwinde had to buy these drugs from a retail pharmacy. The treatment was effective for about a week, but in the evening and night, Kwanza's body would get very hot. The staff at the hospital told Mama Bwinde that if the fever did not go away with Panadol and quinine, she should come back with her son so that they could do urine and stool tests. Mama Bwinde was still worried because her son had not been completely cured (*haja pona vizuri*), and she did not have any more money to spend, so she "left it to God." She repeatedly mentioned that she was worried because her son was still getting a fever during the night, his body would become very hot and he would start convulsing, but she did not have the strength (money) to take him again to the hospital for urine and stool tests. Due to her son's sickness, she was unable to attend to her small business, and as a result, she did not have any money for further treatment. If she were to get some money, she would send him to the hospital, and if not, "so be it." "Like I said, at the hospital, they only write a prescription and we are expected to buy the medicines from a retail dispensary. Whether it's a private hospital or a government hospital, they definitely ask for money to do the tests and for the medicines—they don't give any free medicines at these hospitals; you have to pay for everything."

In August 2007, Mama Bwinde's life took a complicated turn. Her thirteen-year-old daughter, who had an affair with a teenage boy, gave birth to a boy. Mama Bwinde had become a grandmother at the age of thirty-five. The boy's parents agreed to formalize the relationship with a nominal wedding. When I asked her if she was worried that her daughter, who was still a child, had become a mother at such a young age, she pointed to the sky and said "*hii ni kazi ya mungu*" (this is God's work/will). After all, she too had become a mother when she was only a child. In the same month that her young daughter's wedding was performed, Mama Bwinde also decided to marry a *shehe* (Qur'anic teacher). The marriage lasted for only two months. Mama Bwinde complained: "All he did was to sit inside the mosque and pray; he did not provide me with anything, not even soap; I had to come up with money to provide him with food. And then he met with an accident and broke his leg. So I said 'enough is enough' and we separated." Mama Bwinde was eager to have a man in her life who could provide her with some support, but her attempts in that direction only resulted in more trouble for her. She never formally married the man who fathered four of her children; instead she was frequently abandoned and had to take care of her children, their sickness, and their everyday needs all by herself. By early January 2011, Mama Bwinde's health took a downward spiral. She died in June 2011, after a prolonged illness. By then, her seventeen-year-old daughter had given birth to a second child.

Mama Bwinde's case is representative of structural violence and social suffering in many ways. As a young teenager, she was burdened with the task of having to raise a child who was born out of wedlock. Her partner, who fathered four of her other children, never married her, and he had abandoned her on more than one occasion. During this time, he did not provide any support to Mama Bwinde or their children. The inequalities in gender, social relations, and institutional structures were such that her complaints to the village executive officer came to a naught. Under these circumstances, Mama Bwinde had to endure a life of poverty, despair, humiliation, and hurt. Given the lack of social safety net, she had to experience financial hardship when dealing with her children's illness, as no help was forthcoming. Overwhelmed with the daily chores of having to take care of her children and her small business to feed the family, she had neither the time nor the energy to socialize with friends. As such, she lacked the social capital that she could call upon during times of distress and had to therefore go it alone. The devastating consequences of unequal power and unequal life chances in her case became evident with her death at a very young age.

Case 3: Sakina's Story

Sakina Kabesa is a twenty-nine-year-old single mother of four children. I first met Sakina at the village dispensary in January 2001. She was attending to her oldest son, Deo, who was diagnosed with malaria. Sakina was born in Mozambique and belongs to the Makonde ethnic community. Raised as a Catholic, in 2009, she embraced Islam following false allegations from some members of her church that she was having an affair with the priest. Sakina came to Mbande in 1997 from a village on the Tanzania-Mozambique border after having led a life of immense hardship as a child. Her mother died when she was four and she was sent to her aunt in Lindi, who looked after her until she was eleven. She never attended school and remembers a "life of hunger." When Sakina turned eleven, her aunt told her that she was tired of looking after her and wanted to marry her off. "I protested to my aunt saying that I was still a child ("*mimi niko bado*") . . . too young to get married." At age thirteen, however, Sakina's aunt forced her to marry Peter Augustine, who was twice her age, saying that she had already accepted the bride price (*mahari*) of Tsh. 20,000. She warned Sakina that if she refused to marry Peter, she would drive her out of the house and she would be left to fend for herself. Left with no choice, Sakina accompanied Peter to Mbande in 1997, and soon found out that he was an alcoholic.

Between 2001 and 2008, I conducted five interviews with Sakina. She also participated in two focus group discussions organized to gather information on local perceptions on antimalarials and the phenomenon of single mothers and child survival. And because Sakina lived in my neighborhood, I was able to observe and record aspects of her everyday life, especially her struggles with raising her children and managing their sickness. In August 2008, Sakina elaborated on the hardships and difficult relationship she had with Peter, her husband. "He would ask me to borrow food from our neighbors, and if I came back without some maize flour, he would beat me. I often ate in my neighbor's house, and also slept there because I was so fearful of my husband. He would come back home drunk and start beating me for no reason." Apparently, an Indian businessman employed Peter to work on his banana plantation near Masaki, but when he saw him beating Sakina for no reason, he scolded Peter saying, "You're hitting a child, why did you marry a child?" and fired him from the job. Then a retired army officer gave Peter a plot of land to tend in Mbande, but he did not pay him for all the work he did on the land. Peter would get so drunk that he wouldn't come home for up to a week. "People would often tell me, 'Do something, your husband has vomited and made a big mess at the bar.'" Finally, Sakina ran away with her children to her brother in Bagamoyo. She came back after several weeks and settled down in Mwembebamia, a village close to Mbande, and started cultivating okra on a small plot of borrowed land. She sold the produce in Tandika market. By that time, her husband had disappeared, and she had no idea where he had gone. Amid all the hardship, she had given birth to two boys Deo (twelve) and Pascal (ten). While Sakina was at Mwembebamia, she met another man, Juma Ali, and lived with him for about eight months. "He got me pregnant (*Alinipa mimba tu*), that's all." She gave birth to her third son, Fazil. Juma did not marry her, he just kept telling her that he would marry her; "he was just lying (*alinidanganya tu*)," and then one day he simply disappeared. Sakina told me that she did not quarrel with Juma even once, but that he just went away because he was unable to provide for Sakina and her children. She had no idea of his whereabouts, so she was living alone. Sakina learned afterward that Juma was already married while he was living with her; that he lived with her until his wife returned from her travels.

In 2008, Sakina met another man, Ali Abdhalla, who was in his early fifties. He told her that he was for real, that he really loved her and wanted to marry her. "He said to me "*haina tatizo, mimi nitahudumia*" (No problem, I will provide for you). So she slept with him a couple of times and became pregnant. Apparently, she told him she could not marry him because she already had three children. And what is more, they did not live together because he was already married. "He did not want his wife and children to know that he was having an affair with me." He told Sakina that he would marry her if she changed her religion, but their marriage will have to be a secret. Sakina refused saying that since she was a Christian (at the time) and all her relatives were Christians, they would definitely refuse to accept the marriage (*ndugu wangu wata tenga*). "He helped me with money and things like that during my pregnancy, and until I gave birth to Salima, but after that he stopped being helpful and the relationship deteriorated. . . . I don't want to marry him; he is twice my age, so I can't say that he is my husband. He will have to introduce me to people as his daughter or his cousin! Moreover, he is already a father of five children."

In another interview I conducted with her in August 2008, on how she managed to look after four young children without a male member to support her, she said that the real problem of not having a man in her life was that she had to take care of her children all on her own. She had to feed them, send them to school, pay Tsh. 10,000 as fees for two of her children, and if they were to suddenly fall sick, she had to come up with money. At the time of this interview, she was doing a small business of selling okra. Sometimes she would also buy chicken leftovers from the wholesale market in Tandika and sell them at retail in Mbande, but her business barely helped her to make both ends meet. In desperate times, she would go to the sand mines (*machimbo*)—considered a dangerous place—where she would sift the sand to get three to four buckets of gravel (*mchangalawe*) a day, for which she would get about Tsh. 2,000. After buying some food she would be left with only Tsh. 500 to take care of her four children.

Elaborating on the subject of children's sickness and the difficulties she experienced in receiving help from friends and neighbors, she told me that when she would go to her neighbors and ask for help, some of them would sarcastically ask her: "Why are you borrowing money from us when you are working in the sand mines, and also doing business, and you are getting money—so why are you asking us for money?" They would taunt her, saying that she underestimated (*unadharau sana*) the staff at the government dispensary, and wanted to take her children to a private health facility—even though she was poor and could not afford it. But Sakina asserted that even if she had to take her sick children to the government dispensary, she still needed money. "You think they're going to provide me with service if I don't have any money? That's not possible! (*hawezi kunipokea pale*)."

In one of the illness narratives that I elicited from Sakina regarding her youngest child—Salima—she said that her daughter was sick for about three days before she took her to the dispensary. Salima had started vomiting, refused food, had stopped playing, and her body had become very hot. Believing that it was an ordinary fever, Sakina gave Panadol to Salima, but to no avail. Sakina then decided to take her daughter to the dispensary, where she was diagnosed with malaria and prescribed Panadol and Coartem (ACT). "The doctor asked: Have you given *mseto* (ACT) to your daughter?" and I said "no," because Salima does not like tablets." Following the treatment, Salima was tired, had no energy, and her fever did not go away. Sakina was concerned because the doctor had diagnosed Salima with malaria without doing a blood test. "If you send your child there, they just look at her and they don't even tell you what she is suffering from, they just give Panadol and an antimalarial (*mseto*), and that's the end of the matter. . . . And really, they did not give me any advice. If you persuade them for advice, they look at you as if you are a crow and want to chase you away."

Frustrated with her experience with the dispensary, Sakina decided to take her daughter to the Buruda Mission Hospital in Mbagala after Ali Abdhalla, the child's father, had offered to cover the cost of Salima's treatment. There they did a blood test on Salima and said that she was suffering from typhoid and prescribed several injections. They also gave her PPF injections to deal with the boils and mouth sores and ulcers. Salima recovered from her illness and was feeling better for about a month, before she had yet another bout of fever. Sakina took her to the dispensary in Mbande and told the nurse that her daughter had typhoid and malaria, and she had been treated for both, but the fever was still there. "The nurse said that I had mixed up medicines—(*nimechanganya*)—injections and tablets. If you use too many injections, then there are side effects—she told me to buy glucose for Salima and prescribed *mseto*. Now my daughter is feeling better, her fever hasn't returned." Sakina had spent Tsh. 8,000 (about US$5) on her daughter's sickness, most of it borrowed from neighbors.

In September 2010, when I asked Sakina how she was doing, she told me that something had significantly changed in her life. She had recently returned from Mozambique, where she had spent two months working in the mines, digging for precious stones, along with her sister and nephew, and had made enough money to last her for a year. She looked me straight in the eyes and said, "I can guarantee you one thing, if I die, I will die making an honest living; I will not die of AIDS (*ukimwi*)," meaning that she was not going to engage in "survival sex."

Sakina's case exemplifies structural violence and social suffering as it relates to childhood malaria and child survival in a number of ways. Embedded in her narrative are issues of poverty, alcoholism, gender-violence, unprotected sex, vulnerability, pregnancy, religion, age, hardships, and woes. Her mother's death had led her to live with her aunt, who in turn basically sold her to a man who was an alcoholic. Traumatized by her condition, she chose to take her children and run away from her husband. She returned to live with another man with whom she became pregnant, only to be deserted by him. Finally, in another twist of fate, she had unprotected sex with a man who was nearly twice her age, and already married with five children of his own, became pregnant, and gave birth to Salima, her fourth child. Her status as a single mother had made her vulnerable to flattery by a man who promised her marriage and support. However, consequently, this short affair only increased her already existing burden by having to take care of yet another child on her own. In other words, her vulnerability as a single mother only magnified her social burden and social suffering.

Case 4: Mama Abhilai's Story

Mama Abhilai is a forty-three-year-old single mother of six children. I first met Mama Abhilai in April 2001 at the village dispensary, followed by a visit to her home in Mlamleni, a small hamlet about forty-five minutes walking distance from Mbande village. There, with the help of Mariam Mohamed, my research assistant, I conducted a detailed interview with Mama Abhilai regarding her child's sickness. A member of the Mwera ethnic community, Mama Abhilai was born in Kilwa in 1967, and completed the seventh grade in 1984. However, she was unable to continue her schooling after her father died and was left with only her mother. In 1989, Mama Abhilai married Mzee Makrugu, a Ngindo from the same village, who paid Tsh. 2,500 as bride price—"It was quite a lot then." Mama Abhilai lived with her husband for about nine years and had seven children in total, Fadhili, Hassani, Shida, Abhilai, and Zawadi; two others had died in unfortunate circumstances. She named one of her sons Shida, meaning problem or predicament, because he was born around the time when she was going through immense hardship and hunger. "I struggled (*nilihangaika*), but my husband didn't want to work. He would not work the farm and he wouldn't leave the house for weeks. I had to work the farm with my youngest child tied to my back. I had to do this to grow some food and survive." Vexed with her husband's behavior, and his decision to abandon her and their children, she went to the court to complain about his behavior but no action was taken. "He troubled me a lot—even the village executive officer came to see my living conditions and advised my husband to build a proper house, at least to protect the children from being attacked by wild animals, including lions." One day her husband divorced her and decided to live with another woman. "I still had my children on my lap, and then I had to struggle, struggle a lot." In 1999, her step-sister, who lived in Mlamleni, invited her to come and live with her. There she worked the cassava farms and was able to feed her children, but she did not have the money to pay the school fees or to buy school uniforms for her children. "Schoolteachers would send my children back because I had not paid their fees or they did not have a uniform on. I felt ashamed."

In 2009, she relocated to Mbande where she started to make a living by bringing water from one of the ponds for building construction—the boom in the construction activities in Mbande had given her a means of livelihood, however meager. But as there were so many women in the village who were in a similarly impoverished situation, there was competition even for these small jobs. While others charged Tsh. 200 to fetch one bucket of water, Mama Abhilai would do it for Tsh. 100 per bucket so that at least she could get something to eat and also feed her children. At the end of the day she received about Tsh. 1,000, with which she bought some maize flour, and perhaps some cassava leaves to make some relish (*kisamvu*). She would beg for Tsh. 200 from her neighbors to buy a matchbox and some salt; sometimes they would help her and other times they would decline. Her children also sold some cashew nuts and charcoal on the roadside, and brought home Tsh. 500 or Tsh. 800. "My life is full of struggle, and there is no way out," she said (*Ninahangaika, sina jinsi*). "I don't know what God has in store for me. I can't keep begging every day. I don't have the capital to do business, and even if I had it, I wouldn't know how to do business, I only know how to work the land and grow cassava (*kibarua tu, mihogo*)." Her main concern was to obtain food to feed her five children. "I have sleepless nights. I worry about what to feed my children in the morning when they wakeup." Luckily, she would often get some clothes from church groups who came to Mbande with donated clothing and bednets to give to the poor and needy. Mama Abhilai said she would very much like to have a husband, but "who's going to marry someone like me with five children? These days I only pray to God to help me with my family."

Mama Abhilai had a complicated reproductive health history. She had lost three of her children; one of her sons had died of severe dysentery, another accidently fell into an open well while playing, and the third, a baby girl, who was prematurely born at six months, weighed only one kilogram. She was diagnosed with malaria within six weeks of her birth and died at the Muhimbili National Hospital. Mama Abhilai has also had two miscarriages, one within two months of her pregnancy, and the other while she was in the sixth month of her pregnancy. She insisted that she had taken sulfadoxine-pyrimethamine as an IPT during all her pregnancies, "but . . . the doctor said that it will cost Tsh. 20,000 to repair the uterus (*mfuko*) to bring it back to normal, but I don't have that kind of money. The doctor said that it's because my uterus has probably gone bad because I've had eleven children so far." Her youngest daughter, Rehema, was ten months old when I interviewed Mama Abhilai about her illness in August 2011. I learned through the narrative that her husband had come to reconcile with her "for the love of our children," but had disappeared again, leaving Mama Abhilai pregnant with Rehema.

Rehema was sick for about a week. Her body was hot, she wasn't eating well, she had lost her appetite, she was lethargic (*mnyonge*), and she was coughing. Rehema also had boils (*vidonda*) in her mouth. Mama Abhilai tried to deal with it by giving her Panadol syrup, but the fever did not go away. "This is not the fever for Panadol," she realized. However, Mama Abhilai gave her only Panadol because she was scared to give her any other medication, including an antimalarial that she could have bought over the counter, without first consulting the doctor. Finally, she took Rehema to the dispensary, where the nurse attended to her child and diagnosed her illness as malaria, but said they had run out of ACTs at the dispensary on that day. Additionally, because Rehema also had diarrhea, she needed to buy an antidiarrheal from a private pharmacy. Mama Abhilai had to spend Tsh. 2,000 to buy the medicines from one of the local pharmacies, but Rehama's fever did not go away for about a week. Mama Abhilai decided to take her child to the municipal hospital in Mbagala, where they told her that it would cost her Tsh. 4,000 for the medicines. At the counter I said to the nurse, "I've heard that it's free for kids." She said, "who told you that?!" Because Mama Abhilai did not have the money, she returned home and borrowed the money from neighbors before going back to the hospital with Rehema. "I'm scared to go to the hospital because nothing is free, even for children. For people like me who are poor . . . there is no option, it's hard."

Mama Abhilai's life course is indicative of structural violence and social suffering at many levels. She had to endure a life of misery, which was complicated not only by a difficult reproductive health history that had plagued her life, but also a husband who had abandoned her and their six children. Mama Abhilai had lost at least two of her young children to unfortunate circumstances and she had also experienced a number of miscarriages. Abandoned by her husband, she was left to fend for herself, leading a life of abject poverty and daily hunger. Even after she had moved into Mbande village, she had to live a life of penury, humiliation, low self-esteem, and abjection as she had to periodically beg money from her neighbors so that she could buy salt and a matchbox to light the hearth. She also had to endure the shame of schoolteachers sending her children back home because they could not afford the school uniform. As such, she had to depend on handouts from church groups to clothe her children. Even when her husband returned to live with her, he abandoned her again, pregnant and vulnerable, with one more child to take care of. Her inability to buy the medicines she needed to treat her child who was suffering from malaria had added to her pain and further lowered her self-esteem and dignity.

Moral Imagination

These stories shed light on the collective experience of single mothers as a social category, their travails with men, and their struggles in dealing with their children's sickness as articulated through the telling of their life histories and illness narratives. They also bring to light the broader social and economic context of childhood malaria. I have framed the analysis within the everyday discourse on single mothers and their narratives, not just about their everyday lives and social relations, but also the disproportionate and growing difficulties they face when they deal with their children's sickness—because they are single and their social capital and support network is relatively thin.[12] However, as Silvia Chant (2007) reminds us, living with men (or living in a male-headed household) does not automatically mitigate women's risks of poverty; married women in male-headed households also suffer from poverty and the violence of everyday life. How then are the travails of single mothers, particularly those who are very young, and their health-seeking behavior significantly different from mothers who are married and/or have a steady man in their lives?

Given the heterogeneity of experiences of poverty and gender-based violence, even among women living within the same community, it is difficult to make definitive statements or generalizations in regard to the above question. Even so, single mothers, especially those who are teenage mothers or young adults, experience social stigma, ridicule, abandonment by irresponsible men/boyfriends/husbands, financial difficulties, poor social capital, and "having to go it alone," all of which cumulatively accentuate the difficulties they face in their everyday lives and their health-seeking behavior. Invariably, single mothers are disproportionately disadvantaged; they "have smaller social networks because they lack ties with ex-partners' relatives or because they "keep themselves to themselves" in the face of hostility or mistrust on the part of their own family networks or others in their communities" (Chant 2007:20; see also Muela Ribera and Hausmann-Muela 2011).

The growing numbers of single mothers in places like Mbande and elsewhere in Tanzania is representative of structural violence because it is the result of the cumulative effects of macrosocioeconomic and political transformations that has taken place in Tanzania, subsequent to the neoliberal restructuring and the privatization of the various sectors, including health. Scholars have described this process as having led to the breakdown of social institutions, especially the institution of marriage and gender obligations, and diminishing social cohesion in communities. They have also argued that the "demasculizing effect of poverty" has led to the increasing cases of domestic violence, irresponsible husbands/men who abandon their wives/girlfriends/fiancé, and children, and ultimately this leads to child neglect (Cleaver 2002; Silberschmidt 2001).

Concomitantly, the increasing numbers of single mothers in Mbande and other villages is to a large extent a reflection of growing poverty, gender, and social inequalities and the erosion of kin-based support networks. With increasing numbers of able-bodied men unable to find gainful employment (lack of income earning opportunities and endemic unemployment), fewer men are able and willing to commit themselves to marriage and raising children they have had with their partners. This development is contrary to the traditional, dominant cultural model of men as breadwinners (Campbell, Mwami, and Ntukula 1995). At the same time, in a neoliberal environment, when men do get access to cash income, they tend to spend their resources on material goods (objects of desire), alcohol, and women—they engage in extramarital relationships (*nyumba ndogo*) with women other than the one to whom they are committed by marriage or formal engagement (Lewinson 2006).[13] In other words, even those who have the resources and cash tend to deplete them faster than they can earn or replace their income (Sanders 2008:29–30).

Domestic quarrels and violence, such as the one depicted in the opening vignette, and in the single mothers' narratives of abandonment, are often the result of men's inability to fulfill their financial and moral obligations toward their fiancé, wives, or girlfriends—and ultimately, their children. While women in such situations experience mental, emotional, and physical vulnerability, and "choose to remain alone rather than return to ex-partners or to form new relationships" (Chant 2007:22), it is not uncommon for many single mothers to be strategic and "seek out" other men, either because their own men have failed to provide for them (financial pressures following conjugal breakdown), or that they have found divorce or separation to be a better option than their current circumstances. One key informant explained this to me in metaphorical terms, using a popular

Swahili maxim—"*kubeba chungu, lazima uweke kidumu pembeni*" (If you are carrying a pot of water on your head, it is always good to also have a bucket of water in your hand"—the pot represents the husband, the bucket of water in hand, a lover on the side). Thus, one of the pervasive concerns embedded in the discourse surrounding social suffering associated with single motherhood is the notion of *tamaa* or uncontrolled desire and greed on the part of *both* men and women for good things in life, including money.

The people of Mbande and neighboring villages, especially the single mothers I interviewed, often invoked the phrase *siku hizi imani imepotea* (lit., today, trust has been lost) or *siku hizi imani hamna* (lit., today there is no trust), to implicitly compare the present with an idealized past when men and women really cared for each other, respected each other, provided for and raised their children together, grew old together, and lived long enough to enjoy their grandchildren. This was made possible by the pervasiveness of *heshima*, or respect, that people had for each other, and for cultural norms and expectations, and the absence of *tamaa* or desire for good things, especially commodities of desire. But since the early 1990s, in a rapidly changing neoliberalized economy, where women have entered the labor force in an unprecedented manner, where cash has become central in people's lives and money is increasingly needed in everyday life, *tamaa* has redefined social relations; it has also resulted in increasing accusations of infidelity, adultery, witchcraft, and witch hunts.[14]

Following the government's decision in the early 1990s to liberalize the economy and implement neoliberal reforms, both men and women have become preoccupied with the material life world. In everyday discourse, the common lament was that people (friends, neighbors, relatives, and even family members) have become self-serving, and they have become less concerned about the well-being of others, including their own kin. This postsocialist, neoliberal ethos is a far cry from Nyerere's original invocation of Africa's familyhood in his vision of an *ujamaa* society where people cared for each other, selflessly, altruistically, as members of one's own family (Lal 2010). This was one of the overarching sentiments that people in Mbande and neighboring villages expressed in everyday discourse. "This is not our culture, our culture has been spoiled" was a common refrain, especially among the elderly people.[15] In such an environment, "the desiring self has become more difficult to manage. . . . It cannot be disentangled from the external environment which provokes and sustains this desire" (Wardlow 2006:35–36).[16]

Embedded in the narrative accounts of domestic violence, conjugal disruption, alcoholism, and mistreatment by men, whether husbands or boyfriends, are representations that idealize the past and condemn the present that reveals hardships. These "narratives of the past" at once constitute Thomas Beidelman's "moral imagination" and what Gaylene Becker (1997) has subsumed under the notion of "moral ideologies." Through their narratives, many single mothers in Mbande and other villages, including those whose stories I have documented here, discursively constructed a local social and moral world—a society, a community, that is different from the one they currently live in, and experience it in the form of their everyday lived reality. In doing so, as moral subjects, they imagine, critically reflect on, and discursively construct their lives as they would like to lead them in the imagined world—a society that they envision might be possible, because, after all, their parents and their forefathers did live in such a society in the past. In other words, their imagination itself is a commentary and a judgment about their contemporary world, a world that is becoming increasingly immoral: one that is seriously lacking moral integrity. "In this sense imaginative exercise constitutes means for criticism, for distortion, even subversion, of the social order. It offers the possibility of questioning some aspects of the version of the system in which imagination itself is rooted" (Beidelman 1986:2).

Thus, embedded in the narratives of hardship, is the single mothers' desire to transition from a distress-filled life (*maisha magumu, tuna hangaika tu*) where they have to suffer on their own, and take care of their children amid immense hardships and uncertainties, to a life such as it was in the idealized past, where the man in their lives would provide for them and also their children, especially during sickness in the family. Further, as Gaylene Becker has noted, "people's narratives of disruption are moral accounts of their lives. That is, the narratives reflect people's interpretations of their moral ideologies and their efforts to live up to them" (1997:17). While the majority of the single mothers I interviewed cherished the idea of marriage and a man in their life as husband and father to their children, they were quick to add that this was mainly to "provide for the children" and not so much to fulfill their own economic needs or sexual desires, or even companionship. They emphasized that they were overly cautious about men in general and their motives. They commonly invoked the phrase "*siku hizi magonjwa mengi*" or "*siku hizi magonjwa mabaya*" (meaning these days there are lots of diseases, or these days there are many bad diseases, especially HIV/AIDS). For single mothers, experiences of marital discord, marital disruption, betrayal, and abandonment became powerful metaphors to mark a critical transition period in their lives, "from a world of male dependency to one of female assertiveness, independence and cooperation" (Lockhart 2005:17). Chris Lockhart's observation in Mwanza, that "the women no longer considered marriage, commitment, protection or stability as resources that men had to offer" (2005:20), resonates with the scenario I documented in my fieldwork site.

To conclude, I began this chapter with a vignette that may not obviously connect with childhood malaria. But in doing so, I have called attention to the broader social and cultural context in which women lead their lives, often as marginalized individuals who are subjected to everyday forms of violence. Marital disruption, abusive relationships, and everyday forms of violence, including social and economic deprivation, in turn have a direct bearing on how mothers cope with their children's sickness. The narratives examined in this chapter clearly illustrate the financial difficulties single mothers experience when dealing with their children's sicknesses, which result in treatment delays and often no follow-up treatment at all. Thus, mothers like Fatuma and Mama Bwinde left their child's fate "to God." By broadening the context and focusing on the social burden of malaria, I have attempted to illustrate the limitations of an overly medicalized discourse on malaria control, which tends to elide structural and contextual factors such as gender inequality, marital instability, single motherhood, and the violence of everyday life that have a direct bearing on child survival in general and childhood malaria in particular. By arguing against an overemphasis on the medicalization of childhood malaria, and calling attention to structural, social, and contextual factors that predispose certain mothers to experience the burden of childhood malaria more intensely than others, I have provided some insights into how local discourses on trust and mistrust, respect and disrespect, desire and greed, are emphatic representations of people's moral imagination and their discursive rendering of anxiety, fear, distress, and the embodied social suffering that pervades their present.

In the following two chapters, I demonstrate how the shifting global discourses and practices surrounding the deployment of antimalarials have a direct bearing on people's access to these drugs in the context of poverty and, ultimately, child survival.

PART THREE

Philanthrocapitalism

CHAPTER SEVEN

Old Ideas and New Promises

Over the past ten years or so there has been a precipitous decline in the efficacy of CQ [chloroquine] across Africa and, in our view, this is the most plausible single factor contributing to the change in malaria-specific childhood mortality.

ROBERT W. SNOW, JEAN-FRANCOIS TRAPE, AND KEVIN MARSH 2001:596

The current discussions of malaria resurgence tend to place the disease in the active voice and thereby depict humans as passive victims. In the new discourse the emphasis is on the craftiness of the parasite which has become immune to medicines. . . . The resurgence of malaria has been generally blamed on the biology of the "bugs."

PETER BROWN 1997:122

Old Ideas, New Antimalarials

Hadija, a thirty-five-year-old mother of four children, was visibly distraught when she arrived at my house in Mbande for a prearranged interview. I had previously interviewed Hadija in December 2005, regarding her youngest child who was diagnosed with malaria and treated with sulfadoxine-pyrimethamine. This prearranged interview was meant to focus on her life history. Standing under a mango tree in the front yard of my house, she broke down complaining that minutes before she had left her home to come for the interview, someone had broken into her hut and stolen all her belongings—pots, pans, a kerosene stove, a bednet, and clothes. Her neighbors, she said, had probably robbed her of her belongings because they were jealous of her, and she feared that they would bewitch her out of jealousy. "They are jealous of me . . . because I have four sons!" she repeatedly exclaimed. Mama Afidhi and Mariam (my research assistant who was going to help me with the interview that day) stood in silence, listening to Hadija's story. Several of my neighbors who had gathered around

Hadija in the front yard, also stood in silence. Realizing that it would be inappropriate to interview Hadija, because she was so distressed, I could do little more than express my sympathy and offer some money to help her buy some food for that day.

Two months later, in August 2006, I interviewed Hadija, after learning that two of her four young sons had died. They had both been diagnosed with malaria at the local dispensary and treated with SP, but to no avail. I recorded Hadija's life history along with illness narratives surrounding her dead two children. Briefly, Hadija identified as a Matumbi. She was born and brought up in Kibaha, one of the districts near Dar es Salaam; she was the second of two children born to her parents. Hadija was in the first year of school when her parents decided to move to Kilimahewa, a village in Rufiji district. They returned to Kibaha a few years later. Hadija's parents divorced immediately thereafter, when she was in grade 6. While her father married another woman, her mother went to live alone elsewhere. Hadija and her older sister chose to live with their father, who moved with his new wife to Mbande. Hadija lived with her father until she met a man with whom she lived for three years, but they did not marry. She had two children with him, but he refused to marry her. Every time she would raise the question about their marriage, he would beat her. Hadija got tired of her fiancé, left him, and had a relationship with another man with whom she had her third child, but they also did not marry. "We did not actually live together, he would just visit me and provide food and soap, but then he stopped; he did not beat me or anything like that, he just disappeared one day, and I haven't heard of him since." Hadija then had a relationship with another man, Mudi, who actually married her. They lived together for about six months, but separated because he stopped providing for her. They did not have a child together. In the meantime, she tried to send her two older children to their father, but the children refused to live with their father and returned to Mbande to be with Hadija. Finally, Hadija moved in with another man, the fifth serial relationship, with whom she had her fourth child. "He was just like the other men; 100 percent of them are liars; he got me pregnant and stopped providing for me, so we separated. Yes, he lives in Mbande. Even when he passes by, he does not even acknowledge me or his son. He has not even held his son once! So I have struggled a lot (*nimehangaika sana*). I don't get any help from anyone, neither from my neighbors nor anyone else. I ask some elders for advice, especially if my children are sick—about what to do."

In June 2007 when I returned to the field, I learned that Hadija's other two sons had also died. They had been diagnosed with malaria in March

2007. When I met Hadija in July 2007, and expressed my condolences, she threw up her hands and replied "*Uchawi tu*" (just witchcraft)—"*Jirani zangu wote wana furahi sana kwa sababu sasa mimi nipo peke yangu!*" (My neighbors must be very happy now because finally I'm alone!). She attributed the death of her four children to witchcraft and jealousy, not malarial fever or drug resistance. Hadija died in March 2011, at the age of forty.

This chapter is not about what the cultural beliefs regarding witchcraft have to do with malaria and child survival. Other scholars have dealt with this topic extensively in the Tanzanian context (see for example, Langwick 2011). My goal is to emphasize community-level cultural explanations for why children become seriously ill and why they do not recover from their illness despite medical and nonmedical interventions. In other words, I illustrate why cultural explanations are often not in consonance with experts' explanations for why so many children in Africa die due to malaria, namely treatment delays and antimalarial drug resistance. On one hand, malaria experts advocate for the replacement of an existing antimalarial such as chloroquine (CQ) with SP on the grounds that CQ is no longer effective against the malaria parasite, or that the clinical efficacy of SP (both in vivo and in vitro) has declined significantly, also making it an ineffective drug against *P. falciparum* malaria. On the other hand, the people who live in malaria endemic areas may be more concerned about the bodily compatibility of the antimalarials (old and new) rather than their clinical efficacy. Thus, in malaria control, the idea of "cultural resistance" is as important as the idea of clinical or pharmaceutical drug resistance (*sugu*). In this chapter I focus attention on how people negotiated three key antimalarials—CQ, SP, and artemisinin-based combination therapy (ACT)—that have been most commonly used in Tanzania, as first-line antimalarials, over time. I discuss the cultural meanings that people attributed to the different antimalarials during different periods, specifically in terms of their perceived efficacy and side effects, and how they understood and interpreted the changes in the malaria treatment policy.[1]

Politics of Resistance

As the epigraph at the beginning of this chapter suggests, one of the most commonly cited reasons in the public health literature for the staggering number of malaria-related deaths in sub-Saharan Africa is antimalarial drug resistance. Many researchers have suggested that the resistance of the malaria parasites, especially *P. falciparum*, to CQ and SP is arguably one of the most important causes for the large number of the deaths due to malaria among children under the age of five (Snow, Trape, and Marsh 2001:596; Snow, Korenromp, and Gouws 2004; Trape et al. 1998; Yeung et al. 2004). Therefore, since 2003, malaria researchers and policy makers have called for the large-scale deployment of ACTs "to keep up with, if not stay ahead of, developing drug resistance" (Bloland, Ettling, and Meek 2003:3761).

There is no denying that the specter of drug resistance is real, with devastating consequences, in terms of the lives lost globally. As already discussed in the introduction and elsewhere, the WHO clearly recommends the use of ACTs in countries where *P. falciparum* malaria is resistant to the conventional antimalarial medicines: CQ, SP, and amodioquin (Bosman and Mendis 2007; WHO 2010). Tanzania officially replaced CQ with SP in August 2001,[2] and SP with ACT (ALu or *dawa za mseto*—artemether-lumefantrine)—a fixed dose combination medicine—as the first-line antimalarial in November 2006, while retaining SP as the drug of choice for its intermittent preventive treatment (IPT) for malaria in pregnancy and infant health (IPTi) program. IPT of malaria involves the administration of treatment doses of an antimalarial drug at predetermined intervals, regardless of parasitaemia or symptoms. IPT during pregnancy (IPTp) is linked to ongoing routine antenatal care and IPT for infants (IPTi) is delivered through the Expanded Programme of Immunization (EPI).[3] While CQ was banned and taken off the shelf in Tanzania, the same was not the case with SP. As of August 2011, retail pharmacies all across the country were selling different brands of SP, for reasons detailed in the next chapter. For example, in their study of the popularity of different antimalarials at private drug shops in Muheza, Tanzania, Frank Ringsted and his colleagues (2011) found that between July 2009 and December 2009, SP was the best-selling antimalarial, and its use was not reserved for IPTp.

To put the discussion into context, I will present a brief review of the policymaking process in regard to malaria treatment in general, and the politics behind the shifting discourses and practices surrounding the deployment of different first-line antimalarials in Tanzania. A number of researchers have emphasized that the policy-making process involving malaria treatment (i.e., determining the drug of choice for first-line treatment and its deployment, or changing from one recommended drug to another) is complex, multilayered, and time-consuming. There is a general consensus that neither the process nor the final outcome is determined by logical or rational factors, including scientific evidence about treatment failures (Bloland and Ettling 1999; Durrheim et al. 2003; Favre and Barnish 1999; Kager 2002; Kamya et al. 2002; Mbuyazi 2003;

Mulligan et al. 2006; Shretta et al. 2000; Trostle, Bronfman, and Langer 1999; Williams and Jones 2004).[4] In theory, the policy-making process is meant to follow a linear process involving a set of logical actions and rational steps aimed at a desirable goal. However, "in reality, policy making is a dynamic, somewhat amorphous process constantly shifting in content and emphasis, which evolves within a broad political, social and cultural context" (Durrheim et al. 2003:310).

Drawing on their extensive research on the topic, David Durrheim et al. (2003:310) elaborate on the complexity of the process by specifying the numerous steps that include (a) awareness that a possible change might be needed; (b) verification of the data that triggered the initial concern; (c) presentation of the data in an appropriate language and format understood by policy makers and implementers; (d) advocacy that a change is needed; (e) consensus among stakeholders that a change is required; (f) consensus on when the change is most needed and feasible; (g) identification and assessment of policy options and choice of the most appropriate policy option; (h) reaching agreement on the replacement drugs; (k) monitoring and evaluation of the change in policy; and (1) planning for the next policy change. Completion of a particular step depends on successful achievement of a variety of interrelated activities and each subactivity may involve different stakeholders. Policy directives are shaped not only by procedural steps but also by competing policy agendas, past successes and failures, brokered compromises, limited resources, and other social forces, in concert with cultural expectations and assumptions Ultimately, policy is influenced by factors that lie outside the immediate influence of those individuals and agencies most involved in championing the change agenda, for example, in malaria policy change, members of the National Malaria Control Programme or scientists conducting malaria drug efficacy studies. Durrheim et al. (2003:311) also point out that although in theory, key policy decisions such as those involving a shift in the first-line antimalarial (CQ to SP for example) are meant to be based on systematic research (because of the enormous financial implications and the lives at stake), in practice, policy makers may not be persuaded by the research findings. Other factors such as financial constraints, shifting timescales, and policy makers' own experiential knowledge may be the key determining factors that influence the policy-making process and the final outcome. In highlighting the complexity of the policy-making process, Jo-Ann Mulligan et al. have observed that "formulation and implementation of a new policy involves a broad spectrum of activities, including consultation, consensus building and policy formulation; revision and production of treatment guidelines; training public and private health workers; community sensitisation; and communication and publicity" (2006: 242).

Even so, one of the key factors that is often brought to bear on the decision-making process is the drug's efficacy—in vivo and in vitro. High treatment failure rates invariably act as the "tipping point" in policy deliberations—whether to replace the existing first-line antimalarials with a different or new antimalarial (e.g., CQ with SP). Thus, following numerous reports of high levels of CQ resistance—up to 50 percent treatment failure rates—(Kitua et a1.1999), effective August 2001, the government of Tanzania banned the use of CQ in the country and replaced it with SP as the interim first-line drug, and amodiaquin (AQ) as the second-line treatment for uncomplicated malaria (Mugittu et al. 2004). However, the process was convoluted and took longer than might have been expected for the evidence from research on antimalarial drugs to be accepted and actually translated into policy action. "The decision to change the drug policy required sufficient evidence from biomedical researchers, views from pharmaceutical traders, health care providers both in the public and private sector, information about community perceptions and their health-seeking behaviour in relation to malaria, and committed political will at national level" (Mbuyazi 2003:11–12).[5] The policy change was certainly not in the interests of the pharmaceutical industry, especially pharmaceutical traders and manufacturers, which had built up stocks of chloroquine and had profited from its popularity among customers.[6]

However, this shift was relatively short-lived, and in any case, the CQ to SP shift was an interim strategy because the idea of introducing ACT was already being seriously explored at the time. In 2006, following reports of SP resistance and better availability of ACTs, mainly through donor-assisted programs (e.g., the Global Fund and Novartis), the government of Tanzania decided to replace SP with ACT as the first-line drug in the treatment of uncomplicated malaria. While there is substantial information available on the process leading to, and the politics involved in, the change in Tanzania's malaria drug policy—especially from CQ to SP (Mbuyazi and Gonzalez-Block 2005; Mulligan et al. 2006; Williams and Jones 2004), practically nothing has been systematically documented about the process leading to the change from SP to ACT—either prospectively or retrospectively. Of particular concern is the impact these changing treatment policies have on communities that are most seriously affected by high levels of malaria endemicity. Therefore, in this chapter I focus attention on how people interpret the periodic "top-down" calls from researchers and policy makers to replace "old" antimalarials such as

CQ and SP with "new" antimalarials such as ACT, mainly on the basis of a particular drug's clinical efficacy. At the time I was conducting research on this subject, there was scant information on how laypeople, in the context of their experiences with the "old" antimalarials, perceive the "new" antimalarials when they are suddenly made available to the public on a large scale. By all accounts, the transition from conventional SP to ACT in Tanzania marked a radical shift in the country's malaria drug policy. This shift was initially characterized by uncertainties regarding the infrastructure, insufficient data regarding "adherence" to the prescribed dosages, and most important, the concerns regarding the huge costs involved in implementing and sustaining the new policy (Bloland 2003; Kachur et al. 2004; Njau et al. 2006).

A View from Below

Until recently, only few community-based, anthropologically oriented studies, which explored the people's interpretations of the efficacy and side effects of the existing antimalarials, were available (Eriksen et al. 2005; Nsimba 2006; Tarimo, Minjas, and Bygbjerg 2001, 2002; Williams et al. 1999). Existing studies explored the perceived efficacy of CQ and SP in Zambia and Tanzania during the transition from CQ to SP as the first line-drug, but not from SP to ACT. For example, Williams et al. (1999), in their study on the perceived efficacy of CQ in relation to SP in Lundazi district, Zambia, found that most parents were positively inclined toward SP, at a time when SP was still a new antimalarial in the country. The researchers also reported that the addition of paracetamol (PCM) did not improve people's perceptions regarding SP's efficacy, and that this finding contradicted the conventional wisdom regarding the need for direct antipyretic action (lowering of fever) for parents to perceive a drug as efficacious. By contrast, in the Tanzanian context, Donath Tarimo et al. (2001) found that despite the fact that half of the respondents in the study were aware that CQ could fail to treat malaria, they still preferred it over other antimalarials because of its ability to bring immediate relief in the form of anti-inflammatory and antipyretic effects. People preferred CQ because they were already familiar with it, it worked for them, and because it was an inexpensive drug that could be bought over the counter in drug shops and even grocery stores. After all, CQ had been the mainstay of antimalarial chemotherapy in Tanzania and elsewhere in Africa for over forty years. The researchers also found that SP was the least-known antimalarial in the study area. Only about one-fifth of the respondents in the study sample were aware of the drug. While SP was judged to be more effective than quinine (QN), it was considered to be "too strong" for children, leading to undesirable side effects. Therefore, despite the fact that QN was a lot more expensive than SP, the majority of the respondents preferred QN over SP as the second option to CQ. Finally, a study conducted by an interdisciplinary research team in the Kibaha district near Dar es Salaam, using a combination of data collection methods, including focus group discussions (FGDs), revealed that people seriously feared the adverse reactions induced by SP. They had an overall negative disposition toward the drug and complained about its slow ability to reduce fever (Eriksen et al. 2005; Nsimba 2006).

In the Tanzanian context, at the time when I focused my research on community-level perceptions of ACT, there was very little ethnographic information available on the process involved in the phasing out of SP as the first-line antimalarial and its replacement with ACT, which is an entirely different drug regimen. Illustrative case studies that brought to light the potential tensions among various stakeholders as a result of this transition (as was the case during the CQ to SP transition), both at the policy-making level and the community or consumer level, were missing. Given my ethnographic focus, I wanted to examine the question, What is the people's overall (and shifting) experience with SP and ACT as first-line drugs prescribed at public health facilities during different times in the last few years? Considering that SP was not really a "new drug" because it was being sold under different brand names, especially Fansidar and Orodar in the numerous pharmacies and drug shops since the mid-1990s, were people confused with the plethora of brand-name antimalarials available to them in the retail market? How might their experiences with SP, which is usually administered as a single-dose regimen, transfer onto their perceptions of ACT and their "adherence" to the new drug regimen, which requires three to five days of therapy? Finally, I also wanted to examine the perceived affordability, efficacy, and both desirable and undesirable side effects of the various antimalarials.

A number of medical anthropologists have documented the need to understand the specific cultural context of therapeutics and acknowledge the cultural reinterpretation and integration of Western pharmaceuticals through culturally specific modes of understanding (Bledsoe and Gaubaud 1988; Nichter 1980, 2008; van der Geest et al. 1990:183). As van der Geest et al. (1996) remind us, when items from one cultural context are introduced into another cultural context, they are often attributed with very different meanings. Similarly, pharmaceuticals developed according to scientific paradigms are often separated from their biomedical context and integrated into other culturally specific modes of understanding. This is often the case because there are always preexisting concepts about treatment and medicines that form a basis for the cognitive appropriation of new drugs. Furthermore, "when drugs are 'freed' from the control of professional health workers, through the process of commoditization . . . it becomes particularly important to be aware of the popular beliefs that guide self-medication" (van der Geest et al. 1990:183).

Clearly, laypeople's experiences with certain drugs influence their ideas about those drugs, the ease of access they have to the drugs, and the situations in which the drugs are consumed. As I will illustrate later in this chapter, different conceptions about a particular drug coexist in the same community, and within the same household, and these vary over time and context. Further, individuals may change their interpretations about the same drug over time and in the context of different experiences. For example, in several of the illness narratives and FGDs, mothers often said, "SP works for my older son, but not the youngest; he gets all kinds of side effects." And in Mama Rehema's case, whose story I present later, the shift in her opinion was drastic. As one of the participants in a FGD conducted in July 2008 in Mbande, Mama Rehema condemned SP and praised the efficacy of ACT (*mseto*). She explained:

> SP increases the fever but *mseto* is really good; it's good for both children and adults. When I had a high fever, I went to the dispensary, where they gave me *mseto*, and I was fine the next day. Even my older son, he had malaria and was fine after he was treated with *mseto*; he hasn't got malaria again for almost a year now. I haven't heard of anyone complaining about it. I am really thankful, *mseto* really helps.

But three years later when I interviewed her again on the subject in August 2011, she had completely changed her opinion about *mseto*. She had this to say:

> If you go to the dispensary and ask people what they think about *dawa mseto*, they'll say exactly what I'm saying now . . . that the medicine does not help, that they experience side effects and it worsens the fever, so people go to the private pharmacy and buy their own medicines. *Mseto* is no longer effective, and people are complaining about it (*dawa imepinga, watu wana lalamika*). When people tell this to the doctor, he gets angry and tells them to go away and buy their own medicine

> from elsewhere. So people accept *mseto*, they bring it home and keep it somewhere, they don't use it, they just keep it. It helps some people, it doesn't help others, and so many people buy SP or amodioquine from the pharmacies.

While Mama Rehema's assertion that several members of her community shared her own negative experience with ACT may be an overstatement, as Holly Williams et al. (1999:649) have noted, individual experiences of treatment failures or successes shape overall community beliefs about drug efficacy. Much has been written about the misuse of antimalarials; however, a close examination of the misuse phenomenon suggests that it is often the result of misdiagnosis, incorrect prescriptions, perceived inefficacy, and undesirable side effects of particular antimalarials, or confusion over different brand names of the same drug.[7] In the Tanzanian context, for example, managers of retail pharmacies are known to engage in drug dispensing practices that may seem "economically rational" but from a biomedical perspective, inappropriate and even dangerous (Goodman et al. 2007; Hetzel et al. 2007; see also chapter 8).

The data presented in this chapter were gathered in Mbande and neighboring villages between May 2005 and August 2011, starting around the time when the Tanzanian government began introducing ACT on an experimental basis, prescribed mainly through public health facilities. I will present the ethnographic data mostly derived from illness narratives and FGDs and discuss the perceived efficacy and reported side effects of both SP and ACT. I will also consider the sociocultural factors underlying "adherence" and "nonadherence" to the prescribed antimalarials, and people's overall experience with SP and ACT. I will conclude by emphasizing the importance of documenting and monitoring how people in malaria endemic areas understand and interpret the efficacy of old and new antimalarials, for effective malaria control programs.

As a first step to exploring some of the key questions pertaining to efficacy and side effects of CQ, SP, and ACT, I conducted FGDs with mothers of young children who were recently treated for malaria. These FGDs provided a platform to pretest the key questions and to gain contextual insights into the cultural understandings of efficacy and the side effects of the existing antimalarials. After reviewing the data from the FGDs, I conducted detailed interviews with mothers who were randomly recruited from four villages. For questions pertaining to SP, I interviewed fifty-six mothers from 2005 through 2006, and for questions pertaining to ACT, I interviewed 110 mothers from 2008 through 2009, with follow-up interviews in 2010 and 2011.These mothers had children who were treated for malaria less than two weeks before the interview. I elicited illness narratives regarding the children who were most recently diagnosed with malaria and treated with an antimalarial. Mothers were asked to narrate their experience of dealing with their child's most recent episode of malaria.[8] They were asked to narrate the symptoms they noticed in their child that prompted them to resort to home treatment or to take him or her to a health facility in the village or elsewhere; the duration for which they had waited before taking their child to a health facility; the duration for which they had waited before trying out an alternative therapy or an alternative source of treatment for the febrile child; and whether their child had experienced any undesirable bodily side effects (*madhara*) after being treated with SP or ACT, and if so, to describe the side effects. If the mother reported any *madhara*, then she was asked to elaborate on how the *madhara* might have been caused directly by SP or ACT and not any other factor such as a particular food or the changing weather. Mothers were also asked to compare and narrate their experience with SP in relation to CQ, and ACT in relation to SP.

The majority of the mothers who participated in the study were relatively young—most of them were in the twenty-five to twenty-eight age group, married, and half of them had at least two children. In terms of their education, the majority either had only two or three years of formal education or they did not have any formal education, and were mostly illiterate. Significantly, most of the mothers were dealing with the sickness of their first and only child, except in cases where an elder sibling had died.

Waiting

As noted in chapter 4, one of the main concerns among malaria researchers and policy makers is that of delay in seeking appropriate medical treatment for childhood malaria, because delay by even a few hours often results in severe complications, if not always death (Greenwood et al. 1987). Accordingly, the WHO has repeatedly emphasized the importance of early diagnosis and effective biomedical treatment as one of the key factors in preventing high levels of malaria-related deaths. Thus, one of the questions I pursued in my research was about the duration for which mothers would wait before they recognize that their child has a fever and that he or she is not responding to home treatment (which is usually a dose of the antipyretic Panadol), and therefore needs to be taken to a biomedical health facility. The following is a characteristic response from Mama Salehe, a thirty-two-year-old mother of three children, recorded during a FGD to the question: How long do you wait before making the decision to take the child to the dispensary?

> It all depends, the first day, if the fever is not very strong (*homa ya taratibu*) you give Panadol three times, and wait and see if the fever goes away. If it doesn't, and the child is very weak (*mnyonge*), the child is not playing as usual, is vomiting, the body is yellow, has a running nose, then you pick up the child and go to the dispensary the next day. . . . You wait for one week then go again if fever does not go away.

In regard to both SP and ACT, more than half of the mothers had waited for two to three days before taking their febrile child to a biomedical health facility; some had waited for up to a week. During the wait-and-watch period, most of the mothers had given their child a store-bought antipyretic such as Panadol. In many cases, they had also sponged their febrile child with a wet cloth to bring down the fever. In other words, "self-treatment" was mostly with an antipyretic and not an antimalarial. This observation is consistent with the findings of other researchers in Tanzania who have reported that in comparison with earlier reports of high levels of self-treatment with CQ (because of ease of access and its antipyretic properties), home treatment with SP or an ACT is relatively uncommon in the case of children. Home treatment typically involved the use of an antipyretic rather than an antimalarial, except in a small number of cases (Eriksen et al. 2005; Nsimba 2006 Nsimba et al. 2002; Tarimo, Minjas, and Bygbjerg 2001).

Many mothers whose children were treated with SP were not satisfied with the treatment that they had received at the first place of consultation outside of home. In these cases, the child's fever had persisted despite being treated with SP. Several of them had waited for three days or more, some for up to a week, before returning to a health facility for further consultation or treatment. A few others had sought help from an alternate source on the same day that they had sought help from the dispensary. Mama Salum, a thirty-year-old mother of two children, who was married into a relatively wealthy family, and lived only a three-minute walking distance from the dispensary in Mbande, told me that her one-and-half-year-old son was sick for two weeks before she decided to take him to the dispensary. She noted that he was crying all the time, refused to eat or to breastfeed, and he was vomiting, he was miserable (*ana mnyonge*;

ana regea), he had fever, and his body was very hot (*mwili inachemka sana*). Mama Salum had sponged him and given him Panadol. Finally, she decided to take him to the dispensary, where the doctor did not do any blood test but simply told Mama Salum that it was malaria and wrote a prescription for SP syrup. But even after three days, Salum's fever did not come down, so she took him again to the dispensary. There the nurse told her to continue giving him Panadol, but to no avail (*homa bado hajapona*). She took him one more time to the dispensary and they advised her to go to a private hospital in Mbagala, which had testing facilities. At the private hospital Salum was given an injection, following which he began to feel a little better (*mwanangu amepata nafu kidogo*). However, at the time of the interview, Mama Salum was worried that Salum's fever might return.

During the period when SP was the first-line antimalarial, mothers frequently experienced disappointing results from their encounters at public health facilities. It was not uncommon for mothers like Mama Salum to hesitate to take their febrile children to the municipal dispensary during subsequent fever episodes. The fact that the dispensary staff members did not do blood tests or other medical tests on their patients, especially children who have a fever, prompted this hesitation. In addition, until 2006, febrile children were typically prescribed SP, even as reports of drug resistance and treatment failures were on the rise. Repeated contacts with the municipal dispensary for the same illness episode resulted in the same prescription—SP. As with Mama Salum, nearly two-thirds of the mothers I interviewed had consulted more than one health facility in search of an alternative therapy for their sick child. Regarding the initial illness episode narrated during the interview, nearly half of the mothers had sought help only from the local municipal dispensary. At least half of the mothers, however, said that they were dissatisfied with the initial prescription because their child's febrile condition continued. They returned to the dispensary for further consultation on at least two occasions to follow up on the same illness episode. A few others had sought help as their second resort at the Buruda mission hospital located twelve miles away from Mbande, and others had decided to go to the Temeke district hospital, located fifteen miles away, as a second resort. One of the mothers had taken her sick child directly to the mission hospital, and two other mothers had taken theirs to municipal hospitals located in the neighboring municipal districts of Dar es Salaam. A small number had taken their child to another hospital directly, which included district and private hospitals and clinics. Thus, in search of therapy for their child's febrile illness, the majority of the mothers sought help from a health facility that was far away from their home village. In the process, they incurred additional expenses and loss of precious time. Notably, one-third of the mothers had not spent any money on their child's treatment for malaria. They had sought treatment at the local dispensary where their child was given treatment free of cost. A few others had spent between Tsh. 500 (50 cents) and Tsh. 10,000 (US$7). Of those who had spent more than Tsh. 3,000 (US$2.50), most of them had sought treatment from more than one source of health care. The average cost of treating a single episode of childhood malaria in Mbande in 2005–2006 was Tsh. 2,450 (US$2), which was equivalent to the price of ten pounds of maize flour at that time.

As noted earlier, people in Mbande and the neighboring villages rarely practiced home treatment with an antimalarial, especially when the sick person was a young child. Additionally, dealing with a single episode of malaria was usually an expensive undertaking because in most cases mothers had to seek treatment from more than one health facility for a single episode of malaria in their children—in order to "get results." Although much of the antimalarials-related research has highlighted the importance of the cost of the drugs and its impact on policy change and policy implementation, relatively little research has shed light on the indirect costs such as transportation and other opportunity costs (loss of wages) that are typically associated with the cost of treating a single episode of childhood malaria, and how these cost considerations affect treatment-seeking patterns and child survival (Wiseman et al. 2006; Yeung and White 2005). In the present context, the cultural constructions and perceived inefficacy of SP dispensed through the municipal dispensary illustrates that the financial burden increased exponentially for mothers of febrile children. And as already noted in chapter 6, this financial burden was all the more intense on mothers who were single, and who lacked a strong support network to help them out during a health crisis. Disappointed with the quality of locally available health care, many mothers engaged in patterns of therapy-seeking that became further removed and spatially distant from their original locale, and ultimately very expensive.

Nostalgia

The majority of the mothers who participated in the FGDs and those who were interviewed in detail were "nostalgic" about CQ. They spoke fondly of CQ and repeatedly stated "*bora tulete Chloroquine!*"—that they would be very pleased if CQ was brought back into their lives. They yearned for the time when they had ready access to CQ that was not only cheap, but also brought immediate relief to the patient. This was because of CQ's antipyretic effect, especially when administered in the form of an injection, which was considered to be more powerful than tablets. Mothers spoke of how easily they could buy CQ over the counter from one of the local drug shops or even a grocery store and store it conveniently at home for future use. They also emphasized that compared to CQ, SP was not an efficacious drug. It did not work because it did not result in a cure. CQ was also attractive because it was available in various presentations: tablets, syrup, and injections. From a cultural perspective, the "nostalgia" associated with CQ reflected the desire on the part of the mothers to revert to a medication that was trusted, and to an era when people had access to an antimalarial that was cheap and accessible. Mothers spoke about CQ in nostalgic terms despite the drug's questionable clinical efficacy, especially in relation to SP, a clinically more efficacious drug. Medical Anthropologists have consistently demonstrated that once a drug has been used for many years and is trusted, perceptions of efficacy remain strong, even in the face of declining biological efficacy (van der Geest et al. 1990).[9]

Mothers also believed that SP was a "dangerous" drug. They frequently used phrases such as *hatari sana* (it is dangerous), *inasumbua sana* (it troubles a lot), *inatisha sana* (it harasses a lot), *inachokesha sana* (it tires you a lot), *tunaogopa dawa hi* (we are afraid of this medicine), *inauua kabisa* (it kills, absolutely), and *watu wanapoteza maisha* (people lose their lives) to underscore their sentiments about SP as an undesirable drug because of its serious, adverse side effects, which are even more pronounced for children suffering from malaria. Mama Afidhi, my field assistant, who had recently recovered from a serious bout of malaria told me of the severe side effects she had experienced from SP, including scars. "Really, if you swallow SP, your fever becomes worse and it stays like that for one full week; the body becomes very hot, you don't have any strength, and when you try to stand up, you simply go limp, you feel dizzy, and you collapse."

Mothers also frequently mentioned that SP could kill malaria patients (see also Nsimba 2006; Tarimo, Minjas, and Bygbjerg 2001). When I asked them if they knew or had heard of someone who had died after being treated for malaria with SP, many of them emphatically mentioned names of people they knew, especially mothers (mama so and so—mother of so and so) whose children had died following treatment with SP. Nonetheless, most of them accepted SP to treat their children because they did not have an affordable alternative. In these circumstances, people were keen that the government should replace SP with new antimalarials that were as effective, inexpensive, and readily available as CQ when it was the first-line antimalarial—such as ACT.

During 2005 and 2006, when I conducted interviews with mothers on efficacy, not one respondent or key informant had heard of any of the artemether-based antimalarials, let alone had tried any of the thirty or more "new" antimalarials that were being sold over the counter at the time in the numerous retail pharmacies and drug shops in Dar es Salaam (see Kachur et al. 2006). Thus, even though there was a multiplicity of drug options available on the retail market, popular discourses on antimalarials commonly prescribed at public health facilities remained the dominant framework for judging and evaluating the efficacy of antimalarials in general within the villages for significant periods in time. In other words, the perceived efficacy of antimalarials is often dependent on several factors, including the community awareness, the prescribed top-down drug policy, shifts in national policy on recommended antimalarials, and the configuration of the local medicine market.

Mothers commonly believed that the different brand names of SP (e.g., Fansidar, Orodhar, and Metakelfin) were in fact different antimalarials, and that one brand name of SP was perceived to be "better" than another. Pharmacologically speaking, these brands were similar because they contained the same active ingredient. For example, in 2005, Mwajuma, a thirty-seven-year-old widow with four children, explained in regard to her two-year-old child who was diagnosed with malaria and treated with SP:

> I first took my child to the local municipal dispensary. There the doctor gave him SP, but my child's fever remained as it was. So after waiting for three days, I took him again to the dispensary to get some advice. The doctor said that the medicine was working inside the body and that I should give my child Panadol to bring down the fever. And so I waited for another three days, but the fever did not go away. Then I bought Fansidar from one of the local pharmacies. Even that did not work. The fever did not come down, so I bought Metakelfin from another pharmacy. Even that did not work. Finally, I took my child to the Buruda Mission Hospital [twelve miles away] where he was treated with quinine injections. Now he is a little better.

Mwajuma's pattern of therapy-seeking on behalf of her child calls attention to the fact that mothers who were not well informed did not realize that by treating their child with different brands of the same antimalarial, they were in fact over-dosing their child. In a country where, until recently, people were familiar with only two or three antimalarials dispensed mainly through public health facilities, the proliferation of antimalarials marketed under a plethora of brand names, and in various combinations, presented many of the poor people with both the "burden of knowing" and the "burden of choice." People may find it difficult to recognize the various brand names, and not everyone may be discerning when buying antimalarials from the *duka la madawa* to deal with malarial episodes. In the Tanzanian context, it has been well documented that health workers and retail pharmacists rarely communicate information about the drugs they are prescribing or selling to their patients (Goodman et al. 2004; Kachur et al. 2006; see also Conteh, Stevens, and Wiseman 2007).

Perceptions regarding the drug's efficacy were also embedded in the mothers' statements regarding whether their child had recovered or not from his or her illness. Two-thirds of the mothers whose children were treated with SP stated that their child had either recovered completely from the illness, or that they were satisfied with their child's health condition because the child was livelier. These mothers considered the absence of fever as the most important marker of their child's recovery from the illness. However, one-third said that their child was still sick and suffering and two of the mothers were still unsure if their child had recovered from the illness. Significantly, of the mothers who stated that their child had recovered from his or her illness, more than half of them did not attribute their child's recovery to SP, but to another antimalarial such as amodioquin or, more commonly, QN, which they had sought from the second or the third source of treatment. The perceived efficacy and privileging of the second source of treatment illustrates that what is biomedically regarded as the best first-line drug may not be consistent with the cultural construction of the antimalarials that people consider efficacious.

When mothers were asked if they thought SP was effective against malaria, more than two-thirds of the mothers said that SP was not a good medicine, either because it was too strong or too slow-acting or both. An analysis of the discourse surrounding the efficacy of SP revealed that mothers most frequently used phrases such as *haziponyeshi* (it does not cure), *homa haishuki* (the fever does not come down), *homa iko pale pale* (the fever does not go away, it remains there), *nguvu inaanguka* (lit., the child loses strength or the strength comes down), *haifanyi kazi* (no it doesn't work), and *inazidisha homa* (it worsens the fever). Only a small number of mothers believed that SP was an effective drug; that it worked. Mama

Zaina, a twenty-nine-year-old mother of one child, said that she was sure that SP was effective against malaria because it was a strong medicine. "You have to tolerate it," she said, because it may take a week before the patient feels better. Not surprisingly, when she took her child to the dispensary, they gave him SP, but his fever did not come down for three days. So she took him to the dispensary again. The nurse told her to be patient and not give him any other medicine at least for another week, but to continue to sponge the child, give Panadol and no other medicine, and to wait for a week. Although a few others said that SP was an effective drug, they were quick to qualify their statement by saying, "yes it works but it takes at least a full week for the fever to come down," and "yes it works, but children have to suffer a lot before their fever goes away." Only two of the mothers said that they were unsure if SP was an effective medication. In general, mothers did not look upon the drug favorably.

Side Effects of SP

Focusing specifically on the subject of *madhara* or undesirable bodily side effects, mothers were asked if they had noticed any adverse reactions of SP. While a small number of mothers were not aware of any particular side effect that they could associate with SP, nearly half of them said that the worsening and persistence of fever was in fact one of the primary undesirable side effects of SP. They spoke of *madhara* by using phrases such as *mwili inachemka sana* (body becomes very hot), *inazidisha homa* (it worsens the fever), and *inapandisha homa* (it spikes the fever). They elaborated on how the fever tends to spike immediately after the child has swallowed half a tablet of SP (*haishushi homa chap chap*, *homa inapanda juu*) or for that matter, the fever does not go away for nearly a week (*homa inarudi*; *homa haishuki*; *homa iko pale pale*). Similarly, some mothers said that one of SP's *madhara* was that the child becomes extremely tired and almost becomes lifeless (*hana nguvu*; *alichoka sana*). Others articulated the perceived *madhara* as follows: *alilia sana* (the child ended up crying incessantly), *mwili wote wimba wimba* (the whole body was full of boils), *alianza kuharisha* (the child had diarrhea), *ali regea regea sana* (the child was lethargic), *alianza kurumuka* (the child was feeble), *ana mnyonge* (the child became very weak and unsteady), *alianza kuwashwa washa* (the child started itching all over the body), and *alipata vipele na vidonda domoni* (the child had sores around the mouth).

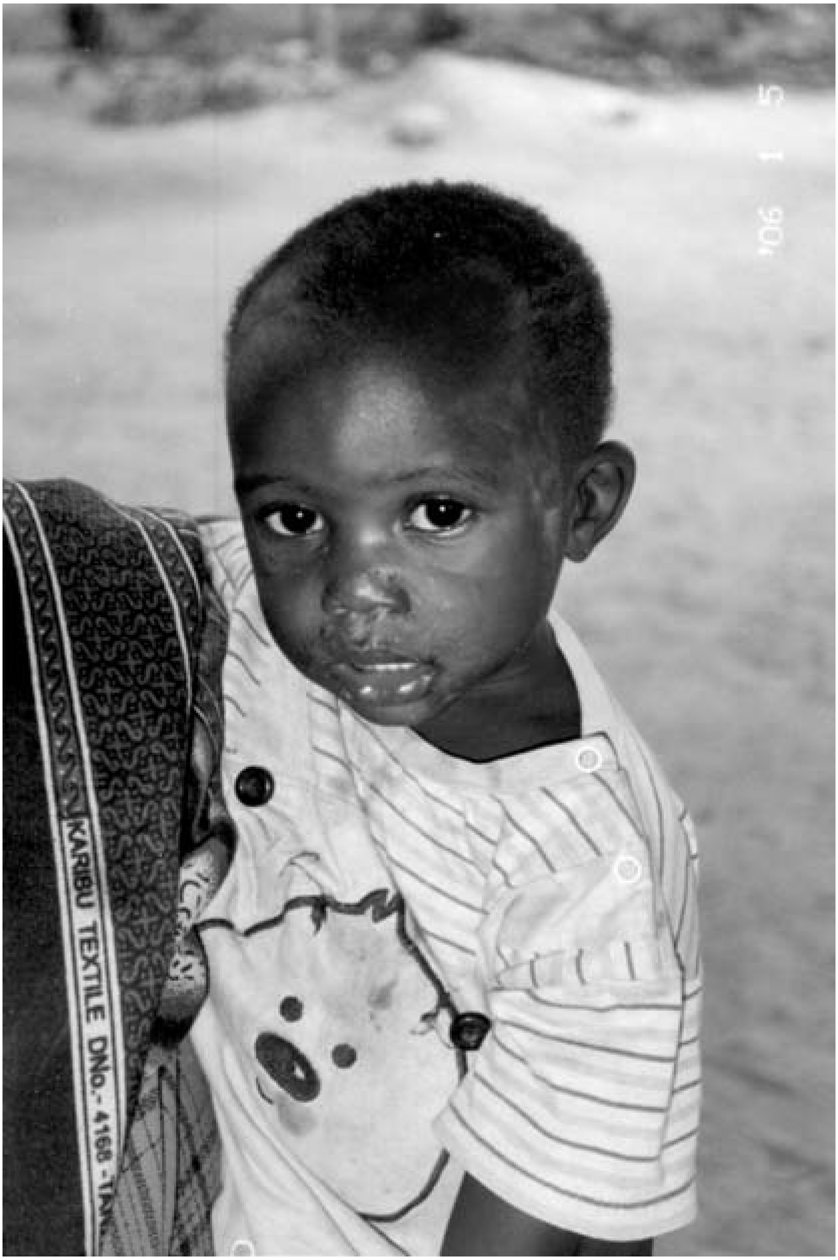


Figure 12. Child with mouth ulcers attributed to SP treatment for malaria. Photo by author.

Mothers who were asked to elaborate on how they were sure that SP, and not any other factor, had caused a particular *madhara*, made emphatic statements condemning its central role. Mama Rajabu, a twenty-eight-year-old, single mother of four children, was emphatic about the cause of her child's mouth ulcers, saying that Rajabu was eating the same food, wearing the same clothes, playing with the same children, and the weather had also been the same. Nothing had really changed, except that immediately after the dispensary doctor had given him SP to treat his malarial fever, he had developed the mouth ulcer. Thankfully, the ulcers went away after a week when he no longer had the fever and he was feeling better. "So I'm sure it's because of SP and not because my child may have eaten a raw mango or a cashew fruit or some other medicine," she said.

In the absence of an affordable alternative, rather than switching to a more effective but expensive drug, impoverished mothers such as Mama Rajabu and their sick children had to tolerate the undesirable side effects of SP. Constrained by the limited choice, they rationalized that the medicine was strong, that the side effects were an indication that the drug was working, and that the illness was leaving the body—that the body was flushing out the fever. Their perception of SP was that it was a drug that would make the illness worse before it gets better.

Finally, in 2005 through 2006 not one mother said that malaria had become less of a concern to them following the ban on CQ and its replacement with SP. On the contrary, all those who participated in the FGDs and all mothers who were interviewed unequivocally stated that the malaria situation in their village had become worse, and that they had no respite from their children being repeatedly diagnosed with malaria and suffering from the illness. As Mama Mariam, a thirty-three-year-old single mother of three children, who had recently separated from her husband put it, "these days malaria has become an ordinary illness—*magonjwa ya kawaida*." As with many other mothers, Mama Mariam narrated her experience of taking her child to the dispensary and reporting a fever, "the doctor or the nurse will simply say 'she has malaria'—just by looking at the child and not by doing any blood tests. They don't do any checkup to confirm whether its malaria, or what kind of malaria it is, or whether it is some other illness. It's the same for children and adults, its malaria, malaria, malaria." Embedded in Mama Mariam's statements regarding the banality of malaria—malaria as an ordinary illness—is the dual problem of incorrect diagnosis and over-diagnosis of malaria. Patients who are clinically diagnosed with malaria are often prescribed antimalarials when in fact their condition may need antibiotic therapy. Poor outcomes in such cases contributed to people's negative perceptions of existing antimalarials—that they don't work.

ACT (mseto) Compared with SP

In 2008, following the scale up of ACTs through public health facilities, I focused attention on local interpretations of ACT, and people's experience with the new antimalarial. Significantly, nearly all the mothers who participated in FGDs and narrative interviews, between 2008 and 2009 said that they welcomed the introduction of ACT in public health facilities to replace SP, and they had not noticed any *madhara* or "undesirable" side effect in their child who was most recently treated with ACT. They emphatically stated that they had not seen any side effects and the drug had helped the child to recover completely. They confidently stated that the drug was effective, the child had completely recovered, and was doing well, to indicate that their child had completely recovered following treatment with ACT. One mother said, "Sometimes, just like SP, *mseto* also increases the fever. Mseto 'boils the body just like children's vaccine' (*Mseto inachemsha mwili, kama chanjo cha watoto*), but then the fever drops. . . . It means the drug is working."

By contrast, when asked to compare their experiences with SP, a majority of the mothers recalled a range of undesirable *madhara* they believed were caused by SP.[10] Zainabu, a forty-year-old mother of three children explained:

> My son became very weak after he was treated with SP. I thought to myself "Have we treated the illness or have we worsened it?!" It took about two weeks for him to return to his normal self. But last week when he had malaria, he was treated with *mseto*; he woke up in the morning and started playing as usual and his condition returned to normal.

Perceptions of ACT's efficacy were closely tied to the perceived cost of dealing with a malaria episode. More than 90 percent of the mothers emphatically stated that ACT was far superior to SP because of its therapeutic efficacy, and also because treatment-seeking was a lot less expensive. Mariam, a twenty-seven-year-old mother of a three-year-old child contextualized her experience with ACT and SP, saying that it was a lot better now because ACT was really helpful. Earlier she had to pay to get SP, which in any case did not help; the fever wouldn't go away so she had to take her child to the dispensary three or four times. By then, as with many poor mothers, she would have exhausted all her money. She went on to explain that things were now different, "The medicine is good. At the dispensary they also do a blood test. If your child is treated with *mseto*, he'll get better right away. The medicine of today is genuine (*dawa za uhakika*). If you use it once, that's it, you get better right away, so there's no need to go to the dispensary again and again."

Perceptions of the drug's efficacy were also reflected in statements about the expenses incurred in the treatment of childhood malaria. Two-thirds of the mothers reported spending less money treating malaria than when SP was the drug of choice. Because ACT was given to them free of cost and did not involve multiple trips to the health facilities, they could afford to deal with a malaria episode. However, one-third of the mothers said that dealing with malaria had become more expensive than before. However, many of them added that while SP was a relatively inexpensive drug, they could not trust it because it took a lot longer for the drug to work and they had to make multiple trips to health facilities. Only a small number of mothers said that they did not find any significant difference in the expenses incurred during the SP era and now.

Persistence

While all mothers who participated in the FGDs and nearly 90 percent of those who were interviewed in 2008 and 2009 said that they were satisfied with ACT's efficacy, they frequently stated that malaria was still a big problem in the village; that it had in fact worsened and they were confused as to why this was the case. One concerned mother remarked during a focus group discussion in an exasperated tone, "this change [in the drug policy] is good because there is a lot of malaria in the village. Sometimes I think it's better to suffer from HIV/AIDS than malaria because malaria kills fast, and it kills a lot of people, lots of children lose their lives to malaria!"[11] The following case is illustrative of the tragic consequences of the persistence of malaria even at a time when ACT has replaced SP as the first-line antimalarial and is readily available in peri-urban settings like Mbande.

Mama Rehema's Story

Mama Rehema, a twenty-nine-year-old Ndengereko mother of three young children, was born in Kibiti (Rufiji district) where she completed four years of primary school before migrating to Dar es Salaam with her parents. She married Hussein Saidi when she was nineteen, and went to live with him in Mbande. Married for ten years, she has had four children. Her husband owns a small radio repairs shop in the marketplace, and she supplements the family income by washing other people's clothes or acting as an assistant cook in one of the food stalls in Mbande's marketplace; she earns about Tsh. 1,000 a day (70 cents).

In 2008, her third child, a daughter, was four years old when she became seriously ill with malaria. "She was sick from the time she was born, until she died. Her body was unusually yellow and her eyes were always red." Once, Mama Rehema thought her daughter had an ordinary fever commonly associated with teething (*meno matafunio*), so she tried some Swahili medicine, and also took her to the dispensary in Mbande, but to no avail. "The doctor stopped me at the door itself, gave me a referral slip, and told me to go to Temeke district hospital right away. He said he won't be able to treat my daughter at the dispensary because she was too sick; her body had turned completely yellow. She had a high fever and could not move." Mama Rehema rushed her daughter to the Temeke district hospital where she was diagnosed with malaria and given two injections of quinine. She explained:

> Normally, when you give an injection, a child cries, but my daughter did not cry at all. There was no water, no blood in her body. She had become completely yellow. She died while I was sitting on the bench waiting for the doctor outside the children's ward. I still feel guilty . . . she died at 2:00 p.m. I held back my tears and carried her on my back in a *kanga* as though she was still alive and returned to Mbande. The people in the bus did not realize that I was carrying a dead child on my back. . . . I took her to Mbande, and we buried her there.

In August 2011, Mama Rehema had to deal with her youngest son Salehe's illness. Salehe was one year and three months of age at the time. However, he could not stand on his feet because his left leg was shorter than the right leg, and it was twisted at the knee. When I asked Mama Rehema if she had anyone taking care of her children she said, "I have a husband, and we have been married for ten years now, but he is a husband only for name's sake. Although I have been married to him for ten years, I still haven't understood his character (*tabia*). To tell you the truth, my life is miserable."[12] Regarding Salehe, she said, "I can't remember for how long or since when he has been sick, because he has always been sick . . . but more severely so from the time he was six weeks old, I think." She continued:

> The last time he was sick, I first gave him Panadol syrup. He had a strong fever and then he started convulsing, his eyes became dark yellow. I panicked and took him to the dispensary where they did a blood test and determined that it was malaria and prescribed *mseto* (ACT), but after two weeks, the fever returned. I went to the dispensary three times. They said *mseto* is a strong medicine, but it didn't help. My son could not pass urine, so I took him to the municipal dispensary in Chamazi. There they said he did not have malaria, but probably a UTI because his urine was dark yellow and had a foul smell, but he also had a fever, it did not go away. So I brought him back to the dispensary in Mbande and there they did another blood test and found that he had malaria. I pleaded with the doctor for a different medicine, so he prescribed amodioquine, and it helped. My son doesn't like ACT at all. As soon as he is given ACT, he starts watery diarrhea in a matter of minutes and loses all his energy. His eyes become completely red. So I'm still worried. I know that my son is still sick, so I go to the local private pharmacy and buy amodiaquine. *Mseto* only worsens the fever.

Although Mama Rehema was married and living with her husband at the time of this interview, her lived experience with her daughter's death was in many ways similar to the single mothers' experiences documented in the previous chapter. Her ongoing struggles with her son's illness and her continuing frustration and social misery are illustrative of how impoverished mothers experience the ravages of malaria even in an era of ACT, which promises higher levels of efficacy compared to monotherapies.

Beyond Efficacy

Very few people who participated in my research mentioned ineffective drugs or drug-resistant malaria (malaria *sugu*) as one of the main reasons for malaria's persistence in their communities. Elaborating on their responses, more than 75 percent of the mothers I interviewed mentioned poverty and bad environmental conditions as the two main reasons why there was so much malaria in their villages. Salma, a forty-year-old mother of four children explained:

> There are many reasons why there is so much malaria in this village. First, the water we drink is not safe; we rely on our wells for water. Second, children play near dirty places where mosquitoes breed. Third,

> we use bednets but then, we are poor so we don't have enough nets for everyone in the house. When our relatives come to visit us, we'll say, Ah! Alright, let the guests sleep there under the net, and I'll sleep on this side with my children without a net. Naturally the mosquitoes bite us and we get malaria. What can we do? We are poor. There are many large families in this village who have only one net, and many people sleep in places where there are no nets at all. Moreover, we live in mud houses without proper windows and doors, so mosquitoes come and go as they please.

As with Salma, Sakina Kabesa, one of the single mothers whose case was presented in chapter 6, said that living with her children's periodic episodes of malaria had, in fact, become her way of life because she had only one bednet at the time, which she used for her youngest child. As for her other three sons, they did not have a bednet to sleep under, "so we suffer, we get better, we suffer, we get better, we continue to struggle with life, that's it, we are poor, life is hard." The pressures of daily life and an overwhelming sense of helplessness in contexts of poverty compound the difficulty and suffering that many impoverished mothers experience even as they are eager to prevent their children from repeatedly falling sick. Much in accord with the WHO's call, they are keen to seek prompt, effective treatment for their sick children. In many cases they encounter disappointing experiences. Ultimately, the perceived efficacy of antimalarials constitutes only one aspect of peoples' struggles with their children's sickness.

Mothers gave various reasons why, despite the fact that they now had access to highly effective antimalarial, malaria persisted in their villages, and what needs to done about it. For example, Mama Salehe, who participated in an FGD had this to say:

> I am busy at 6:00 p.m. when I should be preparing the bed and setting up the net, but I say to myself, "wait, let me finish my work, cooking etc.," but by then the mosquitoes have entered the net and when the children get into bed, the mosquitoes bite them and they go away. I can keep my house clean, but what about the outside where mosquitoes breed in plenty? The insecticide (*ngao*) helps a bit, but then there is only so much we can do.

Mothers described their various efforts to minimize the impact of malaria on their lives. They spoke of using ITNs to prevent mosquito bites and covering the bed with an ITN early during the evening; keeping surroundings clean and making sure that children wear a sweater in the evenings before going to bed to prevent mosquitoes from biting them. For the majority of the mothers, however, the blood test offered free of cost, marked a radical departure from the SP era when children were routinely and clinically diagnosed with malaria and prescribed SP, even as the majority of the mothers deemed it a useless and/or a dangerous drug. In addition to efficacy, cost entered the evaluation of antimalarials. As note earlier, for most mothers in Mbande during the SP era, dealing with childhood malaria was usually an expensive undertaking because they had to seek treatment from more than one health facility for a malarial episode. By contrast, the introduction of subsidized ACT had radically changed the situation, as most of the mothers believed that they were spending less money on dealing with a malaria episode than before. Significantly, however, even though mothers identified ACT as cost-effective, the majority of them continued to delay in bringing their sick children to a health facility because they thought they were dealing with an ordinary fever. Most of the mothers had decided to wait and watch to see if the fever would go away following treatment with a store-bought antipyretic. Plans to provide the public with better access to ACTs must therefore be accompanied by interventions that would convince mothers to bring their sick children to a health facility for diagnosis and treatment within twenty-four hours of the onset of symptoms, and not wait for three or more days to see if the fever would subside with an antipyretic. Further, health-care providers must be trained to communicate more effectively with mothers whose children have been diagnosed with malaria. It is also important to ensure that there is no discrepancy between recommended dosage and schedule and the patient's adherence to the correct drug regimen because partially effective treatment may result in recrudescence of the infection, and in the long run, contribute to the development of antimalarial drug resistance (Fogg et al. 2004; White 2004; Yeung and White 2005).

As David Durrheim and Holly Williams note, even as major policy advances are being made in the deployment of "new" antimalarials, "delivery of effective malaria treatment will not occur unless attention is also focused on the broader, socio-cultural, economic, technical and political environments in which it is implemented" (2005:178). Clearly, demonstrating the in vivo clinical or pharmacological efficacy of various antimalarials in controlled environments is different from ensuring the effectiveness of the drugs in real-life situations (Amin et al. 2004; Mugittu et al. 2004). Generally excellent efficacy observed under controlled clinical trial conditions will not be realized as "effectiveness" until they are deployed widely under real-life conditions (Yeung and White 2005:121).

Susan Reynolds Whyte et al. (2002:23–29) have demonstrated in cross-cultural contexts that medicines have social lives. Beyond pharmaceutical efficacy—the biochemical effects of drugs on the individual body—medicines can also have social efficacy, which refers to effects on the relations between those enacting illness and treatment. Hence, documenting and monitoring the introduction of new antimalarials and their effect on people's treatment expectations, the cultural meanings they attribute to old and new drugs, their responses to uncertainty in the context of poverty, and their reckoning of the cost factor in their search for therapy, is critical.

In conclusion, I have shown why local perceptions of drugs matter and how the objective scientific efficacy of specific drugs is negotiated through experience and local knowledge. Consequently, health planners must consider community beliefs and practices when developing and implementing new drug policies, as communities must be reasonably convinced of the advantages of the new drug policy before they will accept it. Because implementing new drugs policies is a process, and not a one-time event, frequent policy changes are likely to lead to confusion among the public and the loss of credibility of the policy makers (Yeung et al. 2004:182).

Finally, it is debatable whether the underlying cause of the enormous burden of malaria in Africa is primarily drug resistance, the culture of resistance among policy maker and international funding agencies, or poverty (Attaran et al. 2004; Barat et al. 2004; Brown 1997; Caulfield, Richard, and Black 2004; Chima, Goodman, and Mills 2003; Worrall, Basu, and Hanson 2005). Throughout this book, I have emphasized that comprehending the vulnerability and the social burden of the poor requires a careful consideration of the broader socioeconomic and political contexts in which health and disease are embedded (Williams and Jones 2004; Sachs and Malaney 2002). In this regard, it is important to address how laypeople in the real-world talk about treatment decisions, alternative courses of possible action, and interpret the efficacy and side effects of antimalarials that are deployed as first-line drugs, their treatment expectations, and perceptions of medicine compatibility. As Mark Nichter notes, "Educating the community about drug resistance is a necessary but insufficient step given the political [and] economic factors that drive medication supply, sale, distribution, and consumption" (2008:93). As will become apparent in the following chapter, although SP was widely discredited in Tanzania and associated with poor clinical efficacy (resistance) and side effects, especially among young children, ironically different brands of SP were among the most popular antimalarials in the retail sector. Cost considerations, ease of access, and consumption, familiarity, and other conveniences helped retain SP's popularity even as highly subsidized over-the-counter ACTs were made available to the public through the retail sector.

CHAPTER EIGHT

Pharmaceutical Nexus and Globalizing Antimalarials

When we analyze the global production and distribution of pharmaceuticals from an ethnographic standpoint, we find areas of practice that defy standardization. A variety of distinct niches—regulatory, medical, ethical, legal, scientific, and economic—related to the anthropological study of pharmaceuticals take specific forms in local contexts and affect individual and collective experience. Enormous differences in drug pricing, for example, stand out as the most politically charged issue of the world's prescription drug market.

ADRIANA PETRYNA, ANDREW LAKOFF, AND ARTHUR KLEINMAN 2006:14

Pharmaceutical fixes of diseases often constitute the path of least resistance in contexts of underdevelopment, a strategy whereby health promotion eclipses health protection. Reliance on medications to treat diseases and conditions endemic among the poor can result in a "cycle of disease-treatment-disease" that brings profit to pharmaceutical manufacturers.

MARK NICHTER AND NANCY VUCKOVIC 1994:1512

Antimalarials Nexus

As with all pharmaceuticals, antimalarials have social lives. They are produced, marketed, prescribed, distributed through formal and informal channels, meet their death through one or another form of consumption, and have lives after death in the form of efficacy in modifying bodies (Whyte et al. 2002:13–14; see also Appadurai 1988; van der Geest, Hardon, and Whyte 1996). On August 27, 2011, I visited one of the largest "wholesale and retail" (*jumla na reja reja*) pharmaceuticals shops in a crowded street in Dar es Salaam's Kariakoo market as a starting point to research the social lives of antimalarials amid a rapidly changing antimalarials market. Four Swahili (Muslim) women, with their heads covered in a *hijab*, managed this shop. They were attending to a constant stream of customers, many of whom were buying their prescriptions on a retail basis. I had to wait for about an hour before Zainabu, one of the shop managers, took a break to enter into a conversation with me. The dialogue was about the recent initiative to roll out a 95 percent subsidy for artemisinin-based combination therapies (ACTs) in retail pharmacies. During the conversation, I asked Zainabu if I could take close-up photos of the different, freshly arrived ACTs that were in a pile of boxes behind the counter. She pulled out a sample of each of the six ACTs—three of them were made in India by CIPLA, and three of them by the French pharmaceutical company Sanofi Aventis. "The counter is very busy, you can take these . . . no need to pay, free for you . . . my gift (*zawadi*) to you," she said with a generous smile. Her co-worker, who was dressed in a long black Swahili style *bui bui* and a *hijab* head covering, was intently following my dialogue with Zainabu. She joined the conversation and asked, *Malaria itaisha*? (Will malaria finish?). After a brief pause, I posed the question to her, "What do you think?" She responded, "*You* tell me, *you* are the expert! (*wewe ni mtalaam!*)" "I don't know," I said. My research assistants, Mariam Mohamed and Robert Kihama, who had accompanied me to the shop, were sitting in two different corners inside the shop. They both gave a half-hearted smile and said, "*Haiwezekani*" (it's not possible). Both had recently treated their children for malaria with ACT.[1] While Robert had obtained an ACT prescribed at a municipal dispensary free of cost, Mariam had spent Tsh. 6,000 on an ACT she purchased from a retail pharmacy. The wholesale price of the six boxes of the highly subsidized ACTs that Zainabu had offered me as "a gift" was worth a total of Tsh. 1,500 (about $US1). These ACTs were heavily subsidized through the multi-million-dollar Affordable Medicines Facility for Malaria (AMFm) initiative,[2] and hence they were astonishingly low-priced at the wholesale shop.[3] The co-payments for the AMFm at the time were US$216 million in the pilot phase alone.[4]

This chapter examines how the complex pharmaceutical nexus involving the global pharmaceutical industry and international donors, that is driving the global antimalarials market, intersects with local pharmaceutical contexts, local practices, and concerns of those who are involved in the pharmaceuticals trade in Tanzania. In other words, I look at the global-local configurations to focus attention on three key questions: How do people involved in the procurement and marketing of antimalarials in Tanzania understand and interpret the recent efforts to make ACT the first-line drug in malaria treatment? How do pharmaceutical wholesalers and retailers explain the continuing presence and popularity of monotherapies, particularly SP, a largely discredited antimalarial vis-à-vis ACT, in the retail market? And finally, What value do pharmaceutical wholesalers and retailers see in the recent move toward expanding the Accredited Drug Dispensing Outlets—ADDOs (*duka la dawa muhimu*)[5] initiative and introducing highly subsidized ACTs and low-cost Rapid Diagnostic Tests (RDTs)[6] through registered retail pharmacies? In addressing these questions, I expand the scope of the discussion in this book, and provide an ethnographic analysis of the recent initiatives to deal with malaria in the Tanzanian context, and comment on the extent to which these initiatives are likely to achieve their goals.[7]

The chapter has two parts. The first part focuses on the pharmaceutical wholesalers' perspectives on the marketing of antimalarials in Tanzania, and the policy makers' decision to introduce subsidized ACTs through retail pharmacies. I discuss their explanations for the continuing popularity of SP and other monotherapies among the general public even when different brands of ACTs are readily available in retail pharmacies. The second part examines the policy implications of the recent initiative to scale up the ADDOs program and to sell subsidized ACTs and low-cost RDTs to the public through the retail sector. I examine whether this well-meaning initiative is likely to improve the on-the-ground situation or deflect attention and resources from developing a more sustainable, comprehensive health-care infrastructure. I conclude by arguing that the current top-down pharmaceutical humanitarianism depoliticizes malaria (i.e. not acknowledging it as a social and political problem), and responsibilizes those who suffer from malaria. Rather than providing them a reprieve from their suffering by engendering comprehensive reforms in global drug pricing and distribution, and investing in the country's health-care infrastructure, current initiatives are likely to further confirm Tanzania's status as an excessively donor-dependent country, especially in regard to its health sector.

Not Ready for Prime Time

In what became known among malaria researchers and health policy makers as the "medical malpractice debate," the authors of a provocative paper published in the *Lancet* (Attaran et al. 2004), argued that most African countries have no choice but to reluctantly cling to CQ and SP as the first-line antimalarials, despite their poor efficacy. This was because ACT, which is a much more effective therapy, was at that time at least ten times more expensive and, therefore, unaffordable to them. "When those same countries seek financial aid from the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) to purchase ACT, they are forcefully pressured out of it by governments such as the USA, whose aid officials say that ACT is too expensive and 'not ready for prime time'." The authors argued that despite the fact that the WHO had named ACT as the gold standard for treatment of uncomplicated malaria, it acquiesced to the pressure coming from the Global Fund to cut costs. Apparently, "WHO made known to the Global Fund of its approval to continue to fund cheap but ineffective antimalarials such as CQ and SP to treat *P. falciparum* malaria" (Attaran et al. 2004:238). The WHO's response to this criticism was swift but measured. Pointing to the major challenges it faced in adopting ACTs as the universal option in malaria treatment, WHO assured its critics that it was developing a new mechanism to facilitate access to ACTs and other products for malaria control, along with its global partners in the public and the private sectors, especially the Global Fund, "to make ACTs more widely available through lowered costs, increased access, and technical cooperation" (Fatoumata 2004:397).

As academics, health policy makers and funding agencies were ruminating over the immediate and long-term implications of the issues raised in these so-called medical malpractice debates, researchers were conducting some crucial randomized controlled trials in Tanzania aimed at testing the feasibility of introducing ACTs into rural communities (Kachur et al. 2004). The initial results from the field trials were encouraging, but inconclusive.[8] Buoyed by these results, however, and the promise of major funding from GFATM, and the U.S. President's Malaria Initiative, the Tanzania Ministry of Health and Social Welfare (MoHSW) formally implemented a new malaria treatment policy that came into effect in November 2006.[9] The actual introduction of ACT, in health facilities commenced in January 2007 (Alba et al. 2010).[10] The new policy called for the large-scale deployment of ACT in public health facilities to treat uncomplicated malaria. Concurrently, however, retail pharmacies and drug shops (*duka la dawa baridi*—DLDBs) in Dar es Salaam were already selling more than a dozen brands of mostly imported antimalarials with artemisinin or at least one of the components of ACT, as monotherapies.[11] Concerned researchers and health administrators called the policy makers' attention to the already widespread availability of artemisinin monotherapies in the retail market. They pointed out that the ease with which the general public is able to buy such monotherapies at retail pharmacies over the counter will eventually hinder ACT's efficacy and contribute to the

Figure 13. Qualified pharmacist giving advice to a young client. Photo by author.

further emergence and spread of antimalarials drug resistance (Bosman and Mendis 2007; Charlwood 2004; Dondorp et al. 2009; Kachur et al. 2006; Rehwagen 2006). Since then, a number of significant developments have taken place in terms of how antimalarials have "traveled" globally and locally, and how global subsidies on ACTs provided at the "top of the supply chain" have altered peoples' perceptions of malaria and antimalarials at the local level (Kamat and Nyato 2010; Sabot et al. 2009).[12] Most notable was the advent of the Affordable Medicine Facility for Malaria (AMFm), which aimed to increase consumer access to ACT and delay the development of drug resistance by subsidizing ACT at the top of the distribution chain and implanting supportive interventions such as training, regulatory strengthening, and consumer education (Patouillard, Hanson, and Goodman 2010).

Subsequent to financial and research support from the Global Fund and the Clinton Foundation, the Tanzania Food and Drugs Authority (TFDA) began experimenting (pilot studies) with methods to provide greatly subsidized ACTs through retail pharmacies (Sabot et al. 2009b; Clinton Foundation and Government of Tanzania 2008). Proponents of this strategy believed that by training as well as accrediting retail pharmacies and

Figure 14. Duka la dawa baridi in Temeke. Photo by author.

subsidizing ACTs they would be in a better position to regulate the supply of highly effective and valuable antimalarials, because retailers can only sell recommended treatments and dosages. Given the complexity of the intervention, however, it is unclear whether the on-the-ground situation in terms of equity of impact and underlying disparities in access will actually improve when highly subsidized ACTs are made available in the retail market to "crowd out monotherapies" (WHO 2008; Clinton Foundation and Government of Tanzania 2008; see also Kangwana et al. 2011). Instead, the possibility exists that it will result in some unintended, undesirable consequences,[13] such as the further medicalization and pharmaceuticalization of Tanzania's malaria control program.

The data that form the basis of this chapter were gathered from multiple sources. First, I examined pharmaceutical wholesalers (*duka la dawa jumla* or *duka la dawa jumla na reja reja*), who are mainly concentrated in Dar es Salaam's Kariakoo area and retail pharmacies and drug shops (*duka la dawa* or *duka la dawa baridi*) in Temeke district and Illala district. In light of the new initiatives that are being implemented in Tanzania to deal with malaria, namely channeling subsidized ACTs through retail pharmacies and low-cost RDTs, I expanded the scope of my research beyond the village and the ward level, to the Dar es Salaam region as a whole. My goal was to explore the extent to which malaria interventions are becoming increasingly medicalized and pharmaceuticalized. Accordingly, I also interviewed officials from the TFDA, and the NGO Management Sciences for Health, following TFDA's public announcement in 2009 of its decision to discontinue licensing small drug shops, and to upgrade many of the small retail pharmacies or drug shops in the country with ADDOs/DLDM (Kachur et al. 2006; Hetzel et al. 2007; Management Sciences for Health 2006). I describe this in some detail in a later section of this chapter.[14]

The Pharmaceutical Nexus—Importers, Wholesalers, and Retailers

The size of Tanzania's pharmaceutical market is relatively small but growing due to the high prevalence of infectious diseases like HIV/AIDS and malaria, and other co-morbidities. The demand for pharmaceuticals in Tanzania is expected to substantially increase over the next few years. However, the capacity for the local production of pharmaceuticals is very limited, with only two major manufacturers.[15] Private retail pharmacies buy 70 percent of the locally manufactured pharmaceutical products, and the Medical Stores Department (MSD) buys the remaining 30 percent. As such, the country imports nearly 70 percent of its drugs and medical supplies from India and Kenya.[16] Importers are usually agents of overseas pharmaceutical companies, sometimes contracted to act as their sole supplier for distributing their products locally, or, more rarely, integrated with overseas companies (Patouillard, Hanson, and Goodman 2010:6). Indian pharmaceutical companies usually offer cheaper prices because they profit from economies of scale. They are able to do this through negotiations with the WHO, donor-financed NGOs, or foundations such as the Clinton Foundation. Thus, most of the highly subsidized nonpediatric ACTs available through retail pharmacies across Tanzania are manufactured by three Indian pharmaceutical companies; CIPLA, IPCA, and Ajanta. The Artesunate and Amodiaquine doses are manufactured by Sanofi Aventis of France.

When asked to comment on why Tanzania has to import such large volumes of pharmaceutical products into the country, Gloria, a forty-four-year-old woman with a degree in marketing and sales who was managing a wholesale pharmacy in the Kariakoo area, said that it was simply because Tanzania was a third world country, where "what we eat is useless (*chakula unachokula hakifai*), and what we drink is useless (*maji unayokunywa hayafai*), so there are many diseases including HIV/AIDS that weaken

Figure 15. Antimalarials on display at retail pharmacy. Photo by author.

people's immunity and makes them susceptible to more diseases. . . . That is why there is an influx of drugs imported into our country." In Gloria's view, Tanzania's status as a third world country with a high disease burden, especially HIV/AIDS, an underdeveloped infrastructure for manufacturing pharmaceuticals indigenously, and a substandard quality of life, where people cannot trust the food they eat and the water they drink, is, in itself, the reason why the country has to rely on imported pharmaceuticals. In sum, the country is too poor and underdeveloped to be self-reliant. She was not only concerned about the volume of drugs imported into the country, but also the countries from where they are imported; she said she was particularly suspicious of the drugs that Tanzania imports from India, because of quality concerns.

Drug pricing is a key concern among those involved in the pharmaceuticals trade. Although there is wide variation in drug prices along the pharmaceutical nexus, in the Tanzanian context, wholesalers typically mark up the price they have paid for the imported drug by 10 percent before selling it to their retail customer.[17] Catherine, a thirty-three-year-old woman with a bachelor of science in pharmacy from the University of Nairobi who was managing a wholesale pharmaceuticals shop in the

Kariakoo area, said that it is the importers who decide the drug's actual price. If the importer decides to sell a particular drug at Tsh. 5,000, wholesalers just add 10 percent and sell it at that price to their retail customers. Importers often take advantage of the situation because they are the only ones who are importing the drug. Regardless of their concerns, wholesalers have to buy the drugs from a particular importer because there is no one else who imports the same drug (i.e., the importer has a monopoly on it). If the importer decides that a particular drug will cost "*x* Tsh" then, "we have no choice but to buy the drug, and just add 10 percent of that amount, before selling it to retailers, and that is our profit." Thus, wholesalers must acquiesce to the prices set by importers who "monopolize" the trade; wholesalers in turn pass on the cost to retailers, who in turn pass it on to their customers.

Concerns regarding the rising drug prices, monopoly, profiteering, and corruption in the pharmaceutical sector were embedded not only in the everyday discourse of ordinary people, but also in the discourse generated through interviews with those who were directly involved in the pharmaceutical business. Boniface, a thirty-eight-year-old pharmacist who was managing a wholesale pharmacy in the Kariakoo area, was very concerned about "profiteering" in the pharmaceutical market. During the interview, she posed a rhetorical question, "How is it possible that there are fifty different drugs to treat the same disease?" The intention of most people who are involved in this business, she related, was to make a profit, not offer a service to humanity. "There is no price control policy. Everyone has his or her own prices. That is why you find that the drug prices keep going up." For Boniface, the ease with which those in the pharmaceutical business are able to import drugs, and antimalarials in particular, into the country was as much a matter of concern as was the fact that Tanzania did not have a price control policy. Because the government of Tanzania does not control the price of drugs sold in the wholesale or the retail market, drug prices in the pharmaceutical market are often left to "market forces" and "market fluctuations." Not surprisingly, different sellers charge different prices for the same drug, both in the wholesale and the retail market. For example, in August 2010, when I queried the retail price of Duo-Cotexcin, an unsubsidized ACT, at four different shops in the Kariakoo area, shopkeepers gave four different prices for the same drug, with a difference of Tsh. 2,000 between the lowest and the highest priced package of the drug. On a similar note, Gloria (quoted earlier), provided a moral commentary on the manner in which the pharmaceutical business was being conducted in Tanzania:

> Drugs are a poison and not something to compete over through advertising; medicines are a service to humanity. . . . It's not like someone who opens a restaurant and starts advertising the food to attract more customers, or someone who opens a fashion clothing store and starts advertising the products. . . . You cannot do that with medicines. . . . Drugs are not like cars or clothes where today you have this design and tomorrow you have that new design, so I will buy the new design. So if the government cannot check the quality of the pharmaceuticals that are being imported into the country, then the direction in which we are heading is going to get worse.

Gloria's comments reveal her concern regarding the manner in which the pharmaceuticals are bought and sold in Tanzania, and the dangers of equating pharmaceuticals with other commodities of desire such as cars and clothes—of putting profit before service to humanity. In an extended interview, she also expressed her resentment toward South Asians (or "Indians" as they are commonly known), who dominate the pharmaceutical market or nexus in East Africa, by saying that it was the "Indians" who were responsible for distorting the pharmaceutical market.

Wholesalers and retailers were concerned about "profiteering," especially at the higher levels of the supply chain, and the dangers of putting profit before service to humanity in the pharmaceutical business. In their commentaries on the current state of affairs, most of the wholesalers and retailers emphasized that a lot more needed to be done to improve the current pharmaceutical scenario in Tanzania—if only those who are involved in the pharmaceutical business were less preoccupied with making large profits from their business, and the government would step in to regulate the situation.

Continuing Popularity of Monotherapies

Even after the government of Tanzania announced its new antimalarials policy privileging ACTs over monotherapies, a survey of eighty retail pharmacies/DLDBs I conducted in 2007 revealed that the local pharmaceutical market was flushed with conventional monotherapies such as SP and artemisinin-based monotherapies (see table 8.1). And four years following the introduction of ACT in the public health system, in August 2010, when I asked the wholesalers to list the top five fast-moving antimalarials in Tanzania, they all listed different brands of SP/monotherapies such as Orodar, Ekelfin, Leifin, and Malafin. These were the cheapest

Table 8.1 Antimalarials (Brandnames) Sold in Retail Pharmacies in Dar es Salaam (2007)

Antimalarial/ Brand Name	*No. of shops selling the product*	*Average no. of doses sold in one week*	*Price range in Tsh.*	*Median price in Tsh.*
Amobin	7	3.28	800–1000	1000
Amodar	18	3.11	400–1000	1000
Amodioquin	35	4.2	500–1000	800
Amoquin	31	3.28	500–1200	1000
Arinate	26	2.36	3000–9000	6000
Arinate wa kubwa	2	1.5	7000	7000
Artemedine	19	2.73	5000–8000	6000
Arumax*	4	2.25	10000–13500	10000
Chemoquin	22	3	600–1000	1000
Co-arinate*	14	2.35	8000–10500	8500
Coartem*	11	1.45	10000–12000	12000
Coartesunate	1	3	700	700
Co-tecxin	23	2.48	4000–8500	6000
Diornate	7	2.88	2000–3000	3000
Ekelfin	63	8.04	600–1200	800
Falcinil	5	1.6	3000–6000	4500
Halfan	5	2.4	10000–12000	11000
Laefin	60	5.38	500–2500	800
Maladar artesunate	2	1.5	4500–5000	4500
Malafin	66	6.75	500–1200	800
Malather	16	2.5	2500–4000	3000
Malaxin*	1	1	7000	7000
Maratab	17	2.29	600–1000	600
Metakelfin	62	3.8	1800–3000	2000
Orodhar	75	9.18	400–600	500
Quinaquine	1	1	1800	1800
Quinine Inj.	24	4.29	250–500	300
Quinine Sulphate	13	4.07	1000–4500	3000
Quinizen	10	2.11	1500–2000	2000
Tankelfin	37	5.10	600–1000	700
Thaitanzunate	15	2.6	2000–3500	3000

*Combination therapies (2007 data)

US$1 = 1200~1320 Tshillings in 2007

antimalarials available in the local market at the time.[18] Compared to the wholesale price of SP, which ranged from Tsh. 300 to Tsh. 800, depending on the brand and country of manufacture, the wholesale price of ACTs was significantly higher—between Tsh. 5,500 and Tsh. 12,000.[19]

Raman, a thirty-two-year-old man of South Asian descent who owned and managed one of the well-established wholesale pharmaceutical shops in one of the busiest and crowded intersections in Dar es Salaam's Kariakoo area, reflected on why he thought SP prevailed in Tanzania despite the government's decision to "ban" it or retain it as a prophylactic drug that is to be used in IPTp interventions.[20] "SP," he said, "is still popular because it is very cheap, even though it leads to the recurrence of malaria." Given that most of the people who suffer from malaria are poor and do not have enough money, they make a "rational and logical choice" by buying SP. Besides, "the dosage is very simple—it's a single dose. People are used to taking it." In other words, people's decision to opt for a monotherapy such as SP over ACT in the retail market represents not just a "rational" economic choice, but also their preference for a convenient single-dose therapy. However, Raman was also concerned that this "short cut" (as he put it) might not be in people's best long-term interest due to the problem of drug resistance.

Severine, a thirty-five-year-old trained pharmacist who was managing a large Part I (registered retailer) pharmacy, gave a more elaborate response to the question surrounding the continuing popularity of SP vis-à-vis ACT.

> Most of the people in Tanzanian are poor, and combination therapies are expensive; people cannot afford to buy them; that is the reality. Do you think an ordinary person who sells oranges or peanuts on the roadside can afford to spend Tsh. 10,000 on a bout of malaria? Even though a person knows that if he uses SP to treat malaria, he will get another bout after one or two months, he will still buy SP. What can he do? He does not have the money to buy an expensive combination therapy, so he decides to take SP and wait until he gets another bout of malaria; he will repeat the same thing the next time. On our part, we invent our own combination therapy (*dawa mseto*) and advise our patients/customers to try it. I know that amodiaquine is a monotherapy, so I add another inexpensive medicine such as tetracycline, doxycycline, and cotrimoxazole, and I know that these antibiotics will work well with amodiaquine.

Thus, notwithstanding the side effects (e.g., Stevens-Johnson syndrome and a spike in fever) that people commonly associate with SP, the reality of widespread poverty in Tanzania and the convenience of a single-dose therapy to a large extent explains why different brands of a drug that is less efficacious against malaria than ACT remain the drug of choice among the general public. Retail pharmacists stock SP because there is a demand for the drug; and there is a demand for the drug not only because it is significantly cheaper than ACTs, but also because it is readily available in retail pharmacies and drug stores. In sum, this represents an uncorrected feedback loop. In this context, pharmacists such as Severine emphasize that they are "sensitive" to the fact that they need to cater to people from different social classes, and hence they also stock expensive ACTs alongside different brands of the far cheaper SP: different drugs for different social classes. What is more, pharmacists like Severine also claimed to be sensitive to the fact that SP is not an effective monotherapy against malaria, hence they deem it incumbent upon themselves to creatively "invent" their own "combination therapy" that is geared toward their relatively poor customers who cannot afford to pay for a fixed-dose ACT.[21] Clearly, the presence of large stocks of SP in the wholesale and the retail pharmaceutical market is the result of the public demand for SP; and the public demand for SP continues because the drug is readily available in retail pharmacies and drug shops at prices that are exponentially lower than the cheapest of the ACTs (at the time of my research in 2010 and 2011).

Grace, a thirty-two-year-old medical assistant who was managing a wholesale shop in Kariakoo, said in her interview that SP continues to be more popular than ACTs because some people find that combination therapy is too powerful for them; it is not compatible with their bodily constitution, and they prefer to buy familiar medicines. She gave examples of people she knew had taken Duo-cotexin and complained about it "as if they are going to die soon because their body simply stops functioning." Thus, people's preference for SP over ACTs is not only related to the cost and the ease with which they are able to buy it over the counter at retail pharmacies and drug shops, but also their perceptions regarding the drug's compatibility with their bodily constitution. Those who have had "bad experiences" with ACTs will revert to SP, which they feel they can tolerate better than ACTs. Importantly, there is also the tendency among the public to reach for SP for symptoms that they believe are indicative of malaria, when in fact that may not be the case. This practice is believed to have contributed to the development and persistence of drug resistance—one of the factors that has rendered SP an ineffective drug against drug-resistant *P. falciparum* malaria.

Another reason why SP is significantly more popular than ACTs is that while SP is a single-dose therapy, there are just "too many tablets" (twenty-four) in an ACT package, and the full adult dose (four tablets twice a day for three days—a total of twenty-four tablets) takes three days to complete. In order to address this concern regarding "too many tablets," some pharmaceutical companies have reduced the number of tablets (in unsubsidized ACTs), while increasing the dosage of the main ingredients per tablet. This has brought down the cost of unsubsidized ACTs to some extent. As Catherine (quoted earlier) explained, "People find it easier to take six tablets rather than twenty-four tablets. . . . You take one in the morning, and one in the evening for three days, that's it." Not surprisingly, pharmaceutical companies have sought to address this issue by using creative dosage and marketing strategies.

Mzee Mwaluko, a pharmacist in his sixties at a Part I pharmacy, had a different perspective on the continuing presence of SP in the retail market. As he explained:

> SP is being legally used for IPTp. Now, how can you convince people not to use SP when it is still available in the drug shops? Do you think I should not be selling SP when people ask for it, and I have it in the shop? The government hasn't totally banned the use of SP. . . . TFDA/the government has banned the use of some imported brands of SP such as Metakelfin because of the problem with fake Metakelfin,[22] but it has continued to allow importers to bring all other brands of SP into the country. All these drugs are available in the market and people are using them. Now, should we blame the seller? Should we blame the consumer? Or should we blame the policy makers? I don't know. . . . You tell me.

According to Mzee Mwaluko, the continuing presence of SP in the retail market is justified for several reasons, including the fact that it remains a life-saving drug in many cases, and it is being legally used for IPTp.[23] He was unclear and noncommittal about blaming anyone in particular for SP's popularity in the retail market. For Mzee Mwaluko, it was ultimately a question of demand and supply. The government was cognizant of the on-the-ground situation and had therefore not completely banned and withdrawn SP, as it had done in the case of CQ in 2001 (see Ringsted et al. 2011).

Shifting Antimalarials Policy and Subsidy

THROUGH THE WHOLESALER'S EYES. As noted in the previous chapter, in 2001, when the government of mainland Tanzania decided to ban CQ due to high levels of resistance and replace it with SP as the interim, first-line antimalarial, amodioquine as second-line, and quinine as the third-line drug in the treatment of uncomplicated malaria, there was much resentment among pharmaceutical traders and manufacturers toward this shift in the antimalarials policy, mainly because they had built up huge stocks of CQ and profited from its popularity among customers (Eriksen et al. 2005; Mbuyazi et al. 2005a; Mulligan et al. 2006; Williams and Jones 2004). Thus, when asked to comment on the government's decision to change the first-line antimalarial from SP to ACT, and to roll out highly subsidized ACTs throughout the country, Raman (quoted earlier) responded by saying that the government was indeed doing the right thing. Because of all the evidence regarding drug resistance, the government had changed its antimalarials treatment policy according to the most current scientific information available. However, he added that the shifting antimalarials policy was problematic from the affordability point of view. As he explained:

> Malaria is a sensitive issue here in Tanzania because it affects the lives of so many people, so the government has to do something about it, and we (those in the pharmaceutical business) have no option but to cooperate with the government. Shifting the first-line drugs for malaria will create chaos, but that chaos is normal because there are many people in this country who are in the pharmaceutical business. . . . There are big players (importers) who stand to benefit from the growing demand for antimalarials. . . . They are making millions of TShillings in profit. . . . They are selling antimalarials at higher prices and making mega profits.

In this interview, Raman's multiple references to "chaos" reflected his concern not just regarding the effects of the government's frequent changes to the first line of treatment for malaria, but also the unbridled "mega" profiteering in the pharmaceutical sector. Nonetheless, he believed that introducing highly subsidized ACTs in the retail market was one solution to deal with pharmaceutical importers and traders' motives to make unacceptable levels of profit from antimalarials.

Mzee Matiko, a thirty-two-year-old owner of a Part I pharmacy located in front of one of the district hospitals, responded on a positive note stating that "Tsh. 5,000 is a lot of money for the ordinary people of Tanzania, but if ALu is subsidized and made available through drug shops, and providers are allowed to add Tsh. 100 as handling charges or profit, then it's a very good idea because it will increase people's access to ALu." He insisted that the subsidy would not affect his business with regard to other expensive antimalarials because people from the middle class want expensive drugs from Europe or the United States; the poor will buy subsidized ALu and the middle class will buy expensive ACTs from the retail market, and business will go on. The central message in Mzee Matiko's response is that when highly subsidized ACTs are introduced in the retail market, it is unlikely that it will have a significant effect on his pharmaceutical business because while the poor will buy subsidized ACTs, he is confident that he will still have customers who will buy nonsubsidized ACTs that cost between Tsh. 8,000 and Tsh. 12,000.[24]

Similarly, when asked if highly subsidized ACT sold through retail pharmacies will affect the market for other expensive drugs, Selina, a twenty-eight-year-old woman who managed a Part I pharmacy in Temeke, used the example of a widely used anthelmintic to provide the context for her response. She said that she was able to sell both Tanzanian-made albendazole priced at Tsh. 500 and U.K.-made albendazole for Tsh. 5,000 because there are people who are willing to pay the higher price for the one made in the U.K. "When I tell my customers that in terms of the contents, albendazole from Tanzania is the same as the one made in U.K., they don't believe me because they think that the one from the U.K. is original, more effective, and therefore more expensive, while medicines made in Tanzanian are fake (*kuna utapeli mwingi*), but that of course depends on an individual's income. Those with low income will just say 'please give me that (albendazole) which costs Tsh. 500.'"

Echoing Mzee Matiko, for Selina, the decision to introduce highly subsidized ACTs through retail pharmacies was not a matter of concern. On the contrary, if her experience with other pharmaceuticals (brands) made in Tanzania and in the U.K. was any guide, she was confident that she would stand to make better profit by stocking and selling both subsidized ACTs and the regular, more expensive brands of ACTs. In sum, she would welcome the implementation of the proposed strategy of introducing subsidized ACTs through retail pharmacies, because it would make her business all the more profitable.

However, when asked to express his thoughts on the government's decision to subsidize ALu and distribute it through private pharmacies, Severine (quoted earlier) responded with a rhetorical question, "Who would want to buy an ACT for Tsh. 12,000 when it can also be bought for Tsh. 500 or Tsh. 1,000 from the same shop?" But he was concerned that if there is no control over their sale (*pasipokuwa na utaratibu*), there is the danger that ACTs will lose their efficacy. They will become like tetracycline or CQ, which were being sold in grocery stores, eventually leading to the development of drug resistance. So increasing access to ACTs is partly beneficial, but there is always the risk of developing drug resistance. "As we say it here in Tanzania 'every Tanzanian is a malaria doctor' because of the 'I know' mentality. If someone comes here and says, 'I have malaria,' and you advise him to go to a laboratory to confirm whether he really has malaria or not, he will refuse and say, 'I know it, I know I have malaria, and I want the medicine.'" Thus, Severine saw the government's decision to introduce highly subsidized ACTs in the retail market as a double-edged sword.

Judith, a thirty-two-year-old manager of a wholesale pharmacy, in fact, saw an opportunity in the government's decision to make highly subsidized ACTs available though the retail market to increase her profit. "You can stock an expensive drug for a month, and at the end of it expect to get Tsh. 2,000, whereas if you can sell more boxes of a drug that costs Tsh. 500, you can get Tsh. 6,000 at the end of the month. So if I have a subsidized drug like Coartem, I am sure I will be able to sell twenty packs in a day instead of ten of the regular priced ACT, after a week. So it's good." Thus, contrary to concerns that wholesalers and retailers might resist any moves to persuade them to stock and sell subsidized ACTs, Judith's comments suggest that retailers are more likely to see a logic in welcoming the subsidized ACTs in their shops because they will be able to increase their overall profit. However, the sustainability of this arrangement will, to a large extent, depend on how fast the drug moves.

Overall, from the pharmaceutical wholesalers and registered retailers (Part I pharmacies) point of view, the decision to introduce highly subsidized ACTs through the retail market is a welcome strategy. However, this strategy needs to be carefully reviewed and monitored mainly to ensure that it does not backfire, leading to drug resistance due to misuse or overuse of ACTs because they would be readily, and cheaply, available in the retail market. Significantly, those involved in the pharmaceutical business were confident that this strategy would not compromise their business (profit) in any significant way. This was either because antimalarials constituted only a small portion of their overall sales, and/or because, as one of the wholesale pharmacists explained, access to subsidized ACTs would expand the pharmaceuticals market and those involved would actually stand to benefit from larger sales volumes. Finally, nearly all those interviewed expressed confidence that even if the government were to introduce highly subsidized antimalarials in the retail market, there will always be those who will continue to buy nonsubsidized antimalarials, including ACTs that cost

Tsh. 8,000 or Tsh. 12,000. This is mainly because of their higher purchasing power and their belief that drugs that are highly priced and imported from the West are more efficacious than those locally manufactured and/or available at a much lower price.[25]

DLDBs, ADDOs, ACTs, and RDTs: Acronyms and Reality

On January 16, 2009, the Ministry of Health and Social Welfare, Government of Tanzania published a gazetted notice (Government Notice No. 19 of 2009) in the national newspapers announcing a nationwide ban on DLDBs, effective January 15, 2011. The notice also made it clear that TFDA would not be issuing any new licences for DLDBs, and those already issued would not be renewed. Effectively, owners of DLDBs were given a two-year window period either to close their shops, or to upgrade them to ADDOs or DLDM. This decision was made to prevent the sale of prescription-only drugs, including antimalarials, over the counter by untrained or poorly trained personnel who own or manage the DLDBs (*uendeshaji wa maduka ya dawa baridi*).[26] The larger goal was to replace all the DLDBs with ADDOs through a major intervention program (*Kufuatia dhamira ya Serikali kuongeza udhibiti wa usalama, ubora na ufanisi wa dawa*); ADDOs in turn would sell, among other essential drugs (including a few prescription-only drugs), highly subsidized ACTs, ITNs, and pending further research, low-cost RDTs as well. A national rollout of an expanded ADDOs program was under way at the time of my research, with major funding for this project provided by the Bill and Melinda Gates Foundation and the U.S. President's Malaria Initiative.

It has been argued that despite the fact that ACTs are more expensive than monotherapy, they can be very cost effective, provided that the drugs are prescribed only to those with malaria (Wiseman et al. 2006:1849). Because ACTs are expensive and there is a danger that they would be inappropriately sold to customers who report fever, malaria researchers have suggested that RDTs be made part of the "package" and sold at highly subsidized prices through ADDOs. Charlotte Zikusooka et al. (2008:2) have argued in favor of using RDTs, stating that "misdiagnosis of malaria is costly and results in considerable morbidity and mortality, because it contributes to both a delay in treatment of the correct diagnosis and to increasing antimalarial drug pressure and thus resistance, thereby speeding up the obsolescence of affordable drugs. . . . Rapid diagnostic tests offer the possibility of accurate and accessible detection of malaria parasites, and have an important role in limiting malaria over-diagnosis and over-treatment."

Researchers have argued that this strategy would not only be cost effective, it will also likely reduce the possibility of drug resistance. This argument is based on the assumption that ACTs would be sold only to those who have a confirmed diagnosis for malaria, with the help of a RDT at the site of an ADDO. "The introduction of RDTs at drug shops therefore has the potential to make a significant contribution to targeting antimalarial drugs to those with malaria parasites" (Chandler et al. 2011:938). While some researchers have argued the RDTs and ACTs package does not make economic sense since the new generation of unsubsidized RDTs are just as expensive as ACTs, others have argued that this strategy is still the best way forward in the current circumstances. These researchers have argued that if the ultimate goal of the global malaria elimination program is to ensure that at least 90 percent of the people who are diagnosed with malaria have access to an effective antimalarial such as an ACT within twenty-four hours of the onset of fever, then RDTs and ACTs constitutes a rational economic strategy (Cohen and Dickens 2012).

Still others have argued that channelling ACTs and RDTs through ADDOs is unknown territory, and therefore a lot more research is needed before asserting the strategy's robustness, let alone scaling it up (Chandler et al. 2010; Cohen et al. 2010; Lubell et al. 2007; Lubell et al. 2008; Skarbinski et al. 2009; Zikusooka, McIntyre, and Barnes 2008).[27] For example, drawing on a study conducted in the Ugandan context, Clare Chandler et al. (2011:938) assert that "public providers may continue to overprescribe antimalarials in spite of negative RDT results . . . due to a long established mindset of presumptive treatment that has been hard to leave behind"; however, there is far less evidence about how RDTs are used when they are implemented in the private sector, with no published data on frequency of use or adherence to results.[28] Their study revealed that "mistrust of negative results combined with cost of tests in terms of finances and time were responsible for reduced appeal of malaria tests. . . . Participants were curious about parasitological diagnosis but viewed this as insufficient to make a decision to buy antimalarials and unnecessary when short of time and money" (Chandler et al. 2011:942). Clearly, while the proposal to introduce low-cost RDTs through registered retail pharmacies and drug stores may be seen by many as a bold policy decision, there is always the danger that this will result in narrowing the conceptualization of malaria to parasitaemia, without recognizing the wider social construction of "malaria" as discussed in the previous chapters (see also Koram and Molyneux 2007; Williams and Jones 2004).[29]

In light of the on-going developments in malaria control strategies, I interviewed owners of Part I shops about their opinion regarding the ADDO program, the proposal to sell highly subsidized ACTs through ADDOs, and also RDTs. While the majority of the interviewees spoke in positive terms about the ADDOs, some of them expressed their scepticism regarding the proposal to scale up, saying that the ADDO program was a short-term solution for a long-term problem, and that it will not be sustainable—the ADDOs are a fully donor-funded initiative, and, as with any donor-funded program, sustainability is often dependent on the availability of funds. "How can you teach a previously untrained person about pharmaceutical products in four weeks when it took us four years of college to understand that material?" one pharmacist argued. "Basically, you can teach shopkeepers that if a customer comes without a prescription, they should not sell him or her the drug—which means they can be trained to do the basic things that they already do, but to be more aware of the ethical and legal implications of what happens when a person buys drugs [without a prescription] as if they were vegetables." The astonishingly high turnover among shopkeepers and shop managers was also a matter of concern (Kamat and Nyato 2010). Another Part I pharmacy owner expressed his scepticism by saying that banning DLDBs will not be easy because people have started their shops by taking loans from the banks; they have to repay the loans. Thus, if the ban comes into effect, they will close their shops during the day and keep them open during the evenings, knowing fully well that nobody from the TFDA will come in the evening to check their shops. Those who were interviewed on the question about the feasibility of expanding the ADDOs program, and also introducing highly subsidized ACTs and low-cost RDTs through them, were, for the most part, supportive of the strategy. However, they were sceptical about the longevity of these programs and the practicality of the government's decision to ban DLDBs and the ability of the TFDA officials to closely monitor the drug shops' activities. In sum, even if there is evidence of good intentions behind these bold initiatives, a lot more evidence is needed in regard to their sustainability.

Paradigm Shift

The ongoing global discourses on the greater involvement of the private sector, including pharmaceutical wholesalers, retailer pharmacies, and ADDOs in malaria control, signify a paradigm shift in the policies that the WHO and many national governments (WHO 2010) have subsequently followed. This shift is largely attributable to economic globalization undergirded by the tenets of neoliberalism, with its emphasis on free market and responsibilization, and the dramatic increases in funding associated with the Global Fund, the Gates Foundation, the Clinton Foundation and the U.S. President's Initiative, which have together ushered in an era of unprecedented philanthrocapitalism—the application of business techniques to philanthropy—and pharmaceutical humanitarianism (cf. Bishop and Green 2008; Jenkins 2011; McGoey 2012). Many of those involved in global health initiatives have welcomed the unprecedented surge in international commitment for malaria control, and the millions of dollars worth of donated and subsidized pharmaceuticals that are at the disposal of various national governments in Africa and elsewhere. However, this transition has also been prompted by governments' failure to ensure citizens' basic health, which in turn has made room for market responses and a further push toward privatization of health-care services. Since the mid-1980s most African governments have introduced cuts in public spending on health as part of the structural adjustment programs. While these programs enabled the governments to maintain payment schedules on their loans, they proved catastrophic for the health of the poor (Foley 2010:60; Kim et al. 2000).

Analogous to the numerous global public-private partnerships in the domain of HIV/AIDS, which come in various forms, have multiple interests, and create new norms for institutional action, similar developments have also taken place in the domain of malaria control. These partnerships (e.g., Medicines for Malaria Venture) "have stepped in to fill public health voids in places where national systems and markets have failed or have been absent altogether." (Petryna 2009:192). As the medical anthropologist Adriana Petryna has observed, it is often the case that "the interests and concerns of donors, not recipients, tend to predominate, and the operations of international organizations tend to reinforce existing and unequal power relations between countries. For instance, the long-term sustainability of some of these initiatives remains uncertain" (Petryna 2009:193).[30] Tanzania provides an excellent case in point, as 90 percent of the country's total health development budget is funded through donor support. Public-private collaborative projects provide nearly 100 percent of the funding for interventions like ACTs, ITNs, ADDOs, and RDTs. Not surprisingly, most of these highly focused top-down complex interventions are swiftly implemented to conform to the interests and concerns of the donors, even as the living conditions of the majority of the Tanzanians have either remained unchanged or in fact worsened due to rising commodity prices. As one of my key informants in Dar es Salaam would often say to me, "*Maisha magumu* (life is hard) has become Tanzania's national anthem, everyone is singing it!"

Without romanticizing socialist health policies, medical anthropologists have consistently pointed to the dangers of increasing privatization of the public health sphere in resource-poor countries like Tanzania. As Adriana Petryna, Andrew Lakoff, and Arthur Kleinman note, "Privatization of services has introduced new experiments with decentralized healthcare delivery systems and new criteria for resource allocation. The pharmaceutical industry has filled in the services gap in some low-income contexts and has acquired preferential treatment and influence on the kinds of drugs to be included in national formularies and essential drug lists" (2006:28). Moreover, the growing emphasis on the shift from symptom-based presumptive treatment to parasite-based diagnosis and treatment of malaria, mainly by making highly subsidized ACTs and a new generation of RDTs available through the private sector, is at once radical and challenging. As Valérie D'Acremont et al. have noted, "Large-scale deployment of RDTs is a great challenge that requires theoretical and practical training, regular supervision, and sustained financial mechanisms to ensure constant availability" (2009:3).

The introduction of ACTs for treatment of malaria in many low-resource settings, and the need to target treatment to patients with parasitologically confirmed malaria in order to improve quality of care, reduce overconsumption of antimalarials, reduce drug pressure, and in turn delay the development and spread of drug resistance has prompted this shift (D'Acremont et al. 2009; English et al. 2009; Reyburn et al. 2007). While these well-intentioned initiatives are likely to achieve their goals in varying degrees in different contexts and local conditions, it is likely that in the process, strategies to deal with the malaria problem are increasingly becoming donor-driven, decontextualized, hyperindividualized, medicalized, and pharmaceuticalized. In community health terms, the individually focused "new public health" responsibilizes individuals; it locates responsibility in the life style of the individual as purely an individual decision (Peterson and Lupton 1996). "Public health is increasingly decentralized *and* pharmaceuticalized" (Biehl 2006:222–23).[31] What is presented as a choice for the consumer is an indeterminacy that reverses the role of the drug-consumer-as-patient in the expert-client treatment relationship (Lovell 2006:161). This approach deflects attention away from collective responsibilities (Nichter and Nichter 1996:300); global discourse that is hinged on the workings of the pharmaceutical magic bullet (Petryna, Lakoff, and Kleinman 2006:9) will replace malaria as a social problem and a social burden. The availability and promise of technical fixes are likely to diminish the needed interest in community-based action as alternatives to disease control (e.g., medicine-based control of malaria instead of ecological approaches) (Nichter and Vuckovic 1994:1512).

Writing in the context of the HIV/AIDS and pharmaceutical governance in the Brazilian context, Joao Biehl makes an observation that could easily be extended to the Tanzanian context, not just for HIV/AIDS but for malaria control as well. He writes, "Here, one saves lives by finding new technical tools and cost-effective means to deliver care. . . . The civil and political violations that precede disease are apparently lost sight of in this pharmaceutical humanitarianism, and the economic injustices reflected in barely functioning health care systems are depoliticized. . . . In the end, governments function on the business side, merely purchasing and distributing medicines" (2007:384). A critical examination of the pharmaceutical nexus reveals that the emphasis is increasingly on technical fixes as the way forward, rather than on the social relations of inequality and poverty that are at the core of the persistence of malaria in Africa and elsewhere.[32] The promise of technical fixes, and the potential danger of exaggerated claims of efficacy and certainty can generate a false sense of security not only among policy makers and program managers, but also among the general populace. It is a well-known fact that malarial parasites will, over time, develop resistance to the existing generation of antimalarials, albeit with varying degrees of intensity across different population groups (Dondorp et al. 2009: WHO 2010, 2011). This in turn will provide pharmaceutical companies with opportunities to develop newer generations of antimalarials, which are bound to be more expensive and accessible only to the relatively wealthy. "As drug costs escalate and access becomes hyper-individualized, pharmaceutical markets generate new distinctions based on the individual's ability to pay" (Petryna, Lakoff, and Kleinman 2006:7). We have seen this happen most clearly in the case of SP versus ACTs, where the poor continue to resort to SP and other monotherapies and the relatively wealthy and those who can afford it buy expensive ACTs from retail outlets. With a guaranteed market for millions of doses of antimalarials and RDTs every year, the pharmaceutical industry has everything to gain from such a scenario. "For the pharmaceutical industry, resistant strains means new business opportunities and markets for new generations of drugs" (Nichter 1996:302). Co-payments made at the top of the supply chain automatically translate into guaranteed business and profits for the pharmaceutical industry, an opportunity for market penetration that would not have been possible otherwise. The malaria-related pharmaceutical nexus or the pharmaceutical modus operandi provides an excellent example of how the global pharmaceutical industry has significantly influenced the neoliberal global discourses on malaria control.

As the proponents of critical medical anthropology have argued, history has taught us that health is too precious to be left in the hands of the global pharmaceutical industry (Dumit 2012). The laudable goal of malaria elimination demands global suggestions and initiatives, but local solutions. The overall perspective and approach to the problem has to be comprehensive and decidedly political, or more accurately, biopolitical. This should include not just scale up of narrow interventions and specific projects such as ITNs, indoor-residual spraying, distribution of highly subsidized ACTs, RDTs, and expanding ADDOs, but also policy decisions that will address the most fundamental factors behind the persistence of malaria: historically entrenched, widespread poverty, structural and gender inequalities, and climate change (Stratton et al. 2008). Dealing with these factors is an enormous challenge, but once again, "there is no other logical choice." This time, however, the logical choice is to render bare the realities of deepened social inequality, health disparities, insecurity, and human suffering (Pfeiffer and Nichter 2008:410).

The way forward then is to streamline and consolidate efforts in global health, global funding priorities, and keep national governments and donors accountable for how their policies and practices determine the everyday lives of ordinary people. Finally, at a time when pharmaceutical humanitarianism has taken on a life of its own, inattention to malaria as a social and political problem, and dealing with it as a disease, mainly through technical interventions, is tantamount to a missed opportunity to deal with an intractable global health problem that mirrors long-standing global structural inequalities that have been exacerbated by histories of neocolonialism and the rise of neoliberalism as a dominant political ideology.

PART FOUR

The Way Forward

CHAPTER NINE

Conclusion

From Malaria Control to Malaria Elimination

> *The anthropological tactic of attempting to expose social suffering by bringing the local worlds to the attention of global audience runs the risk of legitimating social inequality if it fails to challenge the global pretentions of elite accounts, to bring out the global critiques often found in the narratives of poor and racialized populations, and to confront the gatekeeping mechanisms that provide broad audiences for some narratives and restrict others to home.*
>
> BRIGGS AND MANTINI-BRIGGS 2003:327

Discursive Practices

This book was not written as a policy prescription for malaria control or malaria elimination but as an anthropological critique of the shifting global discourses and practices on malaria. On the basis of insights developed during my ethnographic research in Tanzania, I have argued that global efforts to deal with malaria have become overzealously hegemonic, technocentric, and oriented toward eliminating the disease. Few would question the praiseworthiness of this philanthrocapitalism-driven discursive shift in recent years—from malaria control to malaria elimination. However, malaria historians and many of those at the forefront of the global malaria elimination strategy have warned against throwing caution to the wind when dealing with a global killer that has defied humanity for centuries (Feachem et al. 2010; Najera, Gonzalez-Silva, and Alanso 2011; Packard 2007; Stephen 2011). Notwithstanding the encouraging announcements regarding some successful malaria vaccine trials, or new funding mechanisms to enable even the poorest of the poor to have access to insecticide-treated bednets and highly effective antimalarials, malaria remains an intractable problem in many parts of sub-Saharan Africa. The WHO has renewed its commitment to eliminate, if not completely eradicate, malaria. Therefore, the logical question to ask is, What are the prospects that this goal might be achieved in the next few years or decades, and what is the best way forward? While "cautious optimism" is the WHO's way forward, Richard Feachem and Oliver Sabot's reality check on the current push to eliminate malaria is noteworthy. They assert:

> Barring a magic bullet, which even the most promising vaccine candidates are not, even the most optimistic malaria experts agree that eradication is decades away . . . even with the large arsenal and war chest available today, an indiscriminate push to eliminate malaria could lead to epidemics and erosion of years of work and investment. . . . Maintenance of intensive interventions will be difficult once malaria is no longer a major public-health threat and donors and populations lose interest. A breakthrough intervention, such as a highly protective and long-lasting vaccine, will not be available for at least 20 years. (2008:1633)

The dominant public health explanation for the persistence of malaria in sub-Saharan Africa has centered on the twin problems of the parasite's resistance to antimalarials and the vector's resistance to insecticides, demanding new antimalarials, insecticides, and vaccines. This book offers a very different analysis of the problem, with its focus on the social basis of malaria. Based mainly on ethnographic research in a regional context of Tanzania, I have argued that the persistence of childhood malaria in sub-Saharan Africa can be better explained from an anthropological perspective by framing it within a critique of neoliberal global discourses on malaria control and elimination. Through case studies, illness narratives, and life history interviews, I have highlighted not just the social burden of malaria, as mothers who are single and/or previously married experience it, but the salience of the diversity of experiences within a specific sociocultural context. In analyzing illness narratives, I have tried to bring "the local life worlds," that is, people's lived experience with malaria and the local context in which malaria-related social suffering is embedded, to the attention of "the global," that is, a global audience of readers and policy makers, to demonstrate how top-down policies are locally experienced. In this regard, medical anthropologist Craig Janes's observations are worth noting:

> As anthropologists we are uniquely positioned, by virtue of our global expertise and yet local focus to advocate such reforms and, at minimum,

> challenge the dominance of economics and efficiency-based rationality in global health. The grand challenges in global health are not, as Bill Gates would have us believe, related to technological roadblocks. . . . They are instead social in character and ethical in principle. For medical anthropologists, indeed for all concerned advocates for global health, the grandest challenge of all is to bring the local back into the global. The question, of course, is how? (2004:463)

In highlighting the social suffering, abjection, and alienation in local communities and bringing it to the attention of a global audience, I acknowledge that there is the risk of indirectly legitimizing existing structural arrangements of inequality and discrimination (Briggs and Mantini-Briggs 2003). And as Henrietta Moore has recently emphasized:

> It is important to be very clear that while suffering, pain and immiseration are an all-too-overwhelming reality of daily life for many people around the globe, as are violence and forms of exclusion and neglect . . . we should not develop theories in the human and social sciences that presuppose the dominance of abjection and alienation, nor should we develop theories of the historical transformation in subjectivities and processes of subjectification that foreground these states to the exclusion of others; not least because to do so undermines our theoretical capacity to account for alienation and abjection when they do occur as salient conditions. More importantly, it excludes from analysis the ambivalent character and power of identification, recognition and subjectification, and rather than treating alienation and abjection as dynamic processes of engagement with the world—however painful and overdetermined by power—it renders them as immutable states of being that effectively cast many individuals and communities as victims. (2011:68–69)

I have attempted to address concerns such as those above by providing illustrative examples of some of the agentive decisions and practices that people in Tanzania, particularly impoverished women, engage in. In my fieldwork location, for example, single mothers did overcome overwhelming structural forces of marginalization and gendered domination and demonstrated their resilience as they pursued their livelihoods. However, there is always a danger in overestimating the agency of the people who are systematically marginalized and are subjected to structural violence, which manifests itself in various forms. I have tried to show that people do demonstrate considerable resilience in the face of vulnerabilities and this should be seen as one of the strengths that needs to be built into malaria intervention programs—as in any health intervention program (Obrist 2006). But there are limits to what people in impoverished communities can and cannot do on their own, particularly when they are caught up in "spirals of vulnerabilities" (Muela Ribera and Hausmann-Muela 2011). As Holly Wardlow has rightly asked, "if objective structures are so seamlessly internalized as *habitus*, is agency illusory?" (2006:228). In her study of agency among Huli women in Papua New Guinea, Wardlow has argued that although external structures are internalized, and fundamentally mold subjectivity and the imaginable possibilities for action, there is always room for other practices, and therefore actors can choose to act otherwise even while operating within the dominant categories that make social life meaningful. In the region of Tanzania described in this book, many single mothers preferred to engage in small businesses and earn their own livelihood rather than enter into sexual relationships with men for survival (chapter 6). Further, even mothers' acts of selective symptom-reporting to invoke the best available treatment for their children are representative of women's agency in contexts of unequal relationships between providers of health care and patients and/or mothers of sick children (chapters 4 and 5).

I began by recalling a memorable event that took place at the village dispensary in February 2001. Unbeknownst to me, due to my limited linguistic competence during the initial stages of my fieldwork, I had confused or conflated "culture as enacted," that is, the enactment of a ritual joking relationship with a quarrel between the nurse and a sick child's mother at the dispensary. Perhaps I had done so because in much of the medical anthropological and some public health literature, health centers are commonly depicted as sites of tension and conflict emanating from unequal power relations rather than cooperation between providers of health care and patients (see, for example, Brodwin 1997; Nichter and Nichter 1996). However, despite the tensions and frustrations that mothers experienced at the dispensary, overt confrontations between staff and patients were rare. The aggressive verbal exchange between the nurse and Fatuma was playful enough to ease a potentially tense situation—which is precisely the underlying value of joking relationships in the East African context (Beidelman 1986; Campbell, Mwami, and Ntukula 1995).

At the time of my year-long fieldwork in from 2000 to 2001, nearly 90 percent of those who attended the dispensary in Mbande were mothers from the main village and numerous surrounding hamlets who came to the dispensary either to get their babies immunized or to seek treatment for their fevers, which were routinely (and presumptively) diagnosed as malaria and treated with chloroquine. Since then, there have been significant changes, both locally and globally, in regard to malaria control. First, malaria is no longer indexed as a "tropical disease"; it is placed on par with HIV/AIDS and tuberculosis as a global killer, at least discursively, demanding renewed attention and enormous resources. Second, the manner in which childhood malaria is diagnosed and treated has radically changed, from presumptive diagnosis to parasite-based diagnosis, either through microscopy or more recently, with the help of RDTs. Third, if the findings of some recent studies are credible, and not just context-dependent, the actual number of people, and children in particular, who are diagnosed and treated for malaria has dropped, although the exact numbers may never be known (WHO World Malaria Report 2011). Fourth, it is becoming increasingly difficult to approach malaria as a single, isolated disease when a high proportion of the parents of children who are diagnosed with malaria are themselves being diagnosed with HIV/AIDS. In other words, the approach to dealing with malaria has to be decidedly syndemic. Medical anthropologists can play a crucial role in influencing policy debates by emphasizing the syndemic character of the illness and repeatedly calling policy makers' attention to the need to pay attention to and act on the social burden of malaria.

This realization became all too obvious to me during a visit to the village dispensary in July 2011. As soon as I pulled out a camera from my backpack, the head nurse made a hand gesture to me, from a distance, to indicate that I should not be taking any pictures inside the dispensary's premises. It was an awkward moment for me, because she was the same nurse who had for nearly a decade encouraged me to take pictures inside the dispensary, and she was particularly fond of the dozens of pictures I had given her over the years. Later on, she invited me to her office and explained that the dispensary was now an important center for HIV testing, and that photography was not allowed (or at least strongly discouraged) for reasons of confidentiality. On that day, hundreds of primary schoolchildren aged between ten and fourteen were lined up at the dispensary waiting to be tested for HIV. Confidentiality was now a key concern among the dispensary staff, and for good reason. While malaria is generally understood (from a biomedical perspective) as a disease for which one is expected to go to the nearest dispensary or hospital for diagnosis and treatment, unlike HIV/AIDS, it is not a stigmatized condition. Arguably, and ironically perhaps, the fact that malaria is not a stigmatized illness, and mainly affects infants and young children rather than adults in the economically productive age groups, has contributed to reduced levels of awareness, funding, and research in comparison to other exceptional infectious diseases such as HIV/AIDS and tuberculosis. The general neglect of structural factors, such as poverty, gender, and structural inequalities in public health discourses on malaria has prompted me and other scholars (see Packard 2007, in particular) to term the persistence of malaria and the high levels of morbidities and mortalities associated with it as "silent violence."

Through stories and illness narratives, my goal has been to bring the ongoing "silent violence" to the attention of a global audience. Despite the enormous resources that are being committed toward malaria elimination, there is ample evidence to remind us that malaria is a notoriously resilient disease. It can resurge with devastating effects in a very short period. The failure of the Global Malaria Eradication Program in the 1960s stands testimony to how the initial overoptimism belied the imminent failure of one of the boldest global health initiatives undertaken by the global health community under the auspices of the WHO.

In Tanzania, in the late 1980s and 1990s, for example, even after millions of donor dollars (mainly from the Japanese government) were spent on controlling malaria in Dar es Salaam, due to the lack of a comprehensive monitoring and surveillance system for all aspects of the program, initial successes in controlling malaria cases ultimately led to a dramatic rise in new malaria cases in the city (Caldas de Castro et al. 2004). From an anthropological and ethnographic perspective, the failure of such programs may be attributed not to the lack of attention to detail or any limitations in the expert epidemiological knowledge that hampered efforts, but perhaps more troubling to the lack of attention given to how people experience malaria as an illness within its social, cultural, and structural context.

In the course of this book I have discussed how the global economy, structures of the state, and local structural conditions, especially gender-related inequalities and social relations and other powerful processes, predispose single mothers in particular to disproportionately experience both the biological and social vulnerabilities of childhood malaria. My analysis of these interconnected issues emerges from a concern with top-down, hegemonic discourses on the way forward in malaria control and/or elimination, and the accompanying overemphasis on the biomedically based, hyperindividualized, and pharmaceuticalized interventions that undermine people's efforts to assert their own agency. Within anthropology, and particularly among those commenting on the global health policy, it has become commonplace and perhaps politically correct to assert and illustrate how the neoliberal trend of market-based reforms has had devastating effects on the lives of those who live on the margins of the society. Ellen Foley has dubbed this as "the neoliberalization of just about everything" (2010:9; see also Janes 2004; Schoepf, Schoepf, and Millen 2000; Turshen 1999). Still, local stories of people who are caught up in the everyday challenges of survival and coping with ill health in a rapidly changing sociocultural, economic, and political environment are indeed relevant to the arguments and analyses developed herein. I have tried to specify the implications of the discursive shift in dealing with malaria, with an emphasis on medicalized and technocentric interventions, rather than on the social conditions in which people lead their everyday lives. To reiterate a key point made in this book, malaria is increasingly being cast as a bureaucratic, managerial problem and interventions are being privatized and the core of the problem depoliticized.

At a time when a pharmaceutically centered model of public health is being consolidated worldwide, and medicines have become increasingly equated with health care for afflicted people (Biehl 2007:382), there are important lessons to be drawn from the arguments and analyses of malaria developed here. These arguments are relevant to the malaria situation in other countries in East Africa, especially Tanzania's neighbors Kenya and Uganda. These include the problems associated with overreliance on external funding agencies and philanthropic organizations, and the vagaries of the global economy, discourses, and practices to deal with problems that should be the primary responsibility of national governments, and not NGOs or civil societies. In November 2011, for example, the Global Fund Board's decision to cancel its eleventh round of funding because of inadequate resources from its donors revealed the vulnerabilities of donor-dependency in global health programs. Notwithstanding the very different political and economic histories of these three countries (Tanzania's disposition toward socialism and Kenya's toward a capitalist economy), they share many of the same concerns with regard to the nature of the malaria problem: poverty, social and economic inequalities, high levels of malaria morbidity and mortalities, poor health infrastructure, drug resistance, shortage of drugs and funding, and corruption. For one thing, the global discursive shifts in the treatment of malaria and the shifting policies with regard to the first-line antimalarials—from SP to ACT—from changing funding patterns, pharmaceutical humanitarianism, and research priorities are relevant to all three countries.

Recent theoretical and methodological advances in medical anthropology have reemphasized the link between wider social, economic, and political forces and local experiences of sickness and suffering. In that vein, this book has shown the critical importance of acknowledging the larger socioeconomic and political matrix in which malaria-related social suffering is embedded. By documenting and analyzing the lived experience and practices of those who are most deeply affected by malaria, I have illustrated the relevance of examining the persistence of childhood malaria as a form of structural violence, and the resultant misery in poor communities as social suffering. In doing so, I have presented the reader with a critique of the processes that are closely tied to structural inequalities and hegemonic global discourses on malaria control that are increasingly becoming biomedicine-based, technical fixes. This book, then, is a contribution to current anthropological theories on globalization, neoliberalism, and social inequalities and illustrates the evolving nature of local responses to global discourses on malaria control. Chapters 4 and 5 in particular demonstrate the theoretical and methodological importance of eliciting and analyzing illness narratives in poor communities as one of the effective means to comprehend the impact of large-scale processes, including the shifting global health funding strategies on subjectivities in communities that are most deeply affected by malaria. I have illustrated how the absence of social safety nets predispose certain people in poor communities to experience the devastating effects of childhood malaria more intensely than others. An ethnographic analysis of this sort provides a critical anthropological perspective on the limitations of the bureaucratic, technological, institutional, medical, and political practices that are determining local life worlds (Petryna, Lakoff, and Kleinman 2006). Through contextualized stories I have shown how health-care-seeking for childhood malaria is often mediated by cultural meanings associated with certain illnesses, structural disadvantages affecting women's access to societal resources, and the micropolitics of patterns of communication between mothers and health-care providers. Ultimately, this book is an ethnographically grounded story of the broader political economic context within which the particularities of lives are lived, and how these lives are linked to global forces of neoliberalism.

CHAPTER TEN

Epilogue

The End of Malaria?

On June 25, 2011, I visited Mbande along with three graduate students from North America and the U.K. who had read my work and wanted to see it for themselves. Prior to this visit, I had decided that this would be my last research-related visit to the village because I had initiated fieldwork on food security in the Mtwara region on the Tanzania-Mozambique border. I was struck by how much the small village with mostly wattle and daub houses, that once enticed me to do my ethnographic fieldwork in 2000, had changed in the last three or four years since the arrival of electricity in 2007. I found myself repeating to the students, "This is not the Mbande village I've described in my research!" And they agreed. As we meandered through the streets, many of the young children and teenagers who once lived in my neighborhood, who had posed for the hundreds of photographs I took of them, and had worked the farms, were now driving two-wheel motorbikes as taxis (*boda boda*) in the village. Many of the people whose narratives I have included in this book had died recently. My long-term research assistant, Mzee Ali Mtangenange, had returned to his native village in Kilwa, following a stroke that had left him half-paralyzed. Mzee Chautundu, the village executive officer told me that Mbande's local population had grown over five times in size in the last three or four years. Mzee Musa, my neighbor and former municipal counselor, asserted that the real estate price in Mbande (land price) had gone up multiple times and that it was impossible to find a plot of land in Mbande to build a house. Now one has to go into the interiors, about a mile away from Mbande's marketplace, into what were the hamlets that I have described in this book. Once the proposed highway between Mbagala and the international airport through Mbande is complete, life will never be the same for the people of Mbande; it will become a big town—it was already becoming one. The dispensary, where I had spent hundreds of hours, was dwarfed by larger structures built around it within the same compound. When I visited the dispensary, an immaculately dressed doctor, who spoke fluent English, said that he had only recently taken up his post in Mbande. He proudly showed the students and me the upgraded mother and child center and the HIV/AIDS testing and counseling center. During the twenty-minute walkabout inside the compound, and through all the rooms, including the delivery room and the drug store, the doctor did not once utter the word "malaria." Given the global funding structure, the discursive practice had shifted to HIV/AIDS while the silent violence of malaria continues.

Glossary of Kiswahili Terms

aibu	shame
akili	intelligence
arusi	weddings
baba wa taifa	father of the nation
bado	not yet/also too young
bahati	luck/fortune
bahati mbaya	misfortune
bamia	okra
baraza	hang out
baridi	cold
barua	letter
bazi	legumes
biashara ndogo	small business
binadamu	human being
bomba	pipe/syringe/also a bore well
bondeni	valley
chakula	food
chango	cramps
choo	latrine
chui	leopard or cheetah
chunguzi	curious
dagaa	dried/fried sardines
daladala	mini buses
damu	blood

dawa	medicine
degedege	cerebral malaria (biomedical equivalent)
deni	debt
dhambi	sin
duka la dawa	pharmacy
fundi (pl. *mafundi*)	mason; also traditional teacher/mentor
gani	kind, type
halali	approved
haramu	forbidden, prohibited
hatari	dangerous
hawara	lover, mistress, concubine
hela	money
hitima	burial ceremony
homa kali	high fever
homa ya kawaida	ordinary fever
homa ya kifua	chest congestion
jando	circumcision ceremony
jembe	hoe
jumla	wholesale
kabila	tribe/ethnic group
karibu	"welcome"
kazi	work
kanga	colorful two-piece piece of cloth
kibarua/kipande	wage labor
kidogo	little
kilinge	place for divination
kisamvu	cassava leaves
kitabu	book
korosho	cashew
kuchangia	contribute
kuharisha	diarrhea
kuhudumia	to provide for
kunde	beans
kupata	to get
kupunguza	to reduce
kushtukashtuka	to wake up startled/convulsions
labda	perhaps
maabara	pathology laboratory
maandazi	buns
mabati	corrugated iron sheets

machimbo	sand mines
madafu	tender coconut
madhara	side effects
maembe	mango
maendeleo	development
mafiga	cooking stones (hearth)
mafundo	lesson
magenge	kiosks in the markeplace
mageuzi	complete turnaround
mahali	place
maharagwe	red kidney beans
mahari	bride price
maisha magumu	life is hard
maisha ya kawaida	ordinary life
maji	water
makabila	ethnic groups
makuti	thatched roof
malaya	prostitutes, promiscuous
mambo ya akili	mental health problem
mapacha	twins
mapenzi	love, sex
msaada	support
mashaitani	evil spirits
mashughuli	ceremonies
maskini	poor
matatizo	problem/predicament
matofali	cement bricks/blocks
matumizi	expenses
maulidi	Islamic festival
mayayi	eggs
mazingira	environment, surroundings
mbaazi	long beans
mbao	board game
mbaya	bad
mchele	rice
mchumba	fiancé, lover
mchuzi	gravy with vegetables
mdomo	mouth
mdudu	bug, living being
meno	teeth

mfuko	bag
mgahawa	small tea shops
mganga	traditional healer
mimba	pregnancy
misingi	foundation, starting capital
mitumba	secondhand clothing
mkanda ya maji	tepid sponging
mkeka/jamvi	mats
mkoa	region, province
mnyonge	lethargic
moto	hot
mpunga	rice
mtama	millet
mtendaji	village or ward executive officer
mtoto	child
mtu	person
muhindi	corn
muhimu	important
muhogo	cassava
mwali	a female initiate
mwalim (pl. *walimu*)	teacher
mwanangu	my child
mwenyekiti	chairman
mwenyezi ya mungu	God's wish
mwili	body
nafuu	cheap
nazi	coconut
ndoa	marriage
ngiri	hernia, intestines
ngoma	dance
nguzo	pillar
nguvu	strength
nimechoka	tired
nisamehe	excuse oneself
njaa	hungry
njia	way
nyama	beef
nyumba ndogo	small house, mistress
nzuri	good
ongopea	bluff

pole sana	very sorry (apology)
pombe/gonga	beer
porini	in the jungle
povu	froth
raha	ease, relaxation
ramli	divination
reja reja	retail
riziki	livelihood
roho	soul
ruksa	"do your own thing" or carte blanche
rungu	divination
sabuni	soap
safura	worms
sana	a lot
sawa	okay
sehemu ya	the area of
shamba	farm/field
shehe	qur'anic teacher
shingo	neck
soko	market
starehe	relaxation
sugu	resistant
tabia	character
tajiri	owner, rich person
tamaa	greed/lust
taratibu	gradually
tofouti	different
tonge za wali	rice dumplings
tui	coconut milk
tundu la choo	toilet, latrine
ubinafsishaji	privatization
uchawi	sorcery/witchcraft
udongo	mud-sticks-fronds with a thatched roof
ugali	thick porridge made from maize flour
ugonjwa	illness
uhuni	wayward, vagabond
uhuru	freedom
ujamaa	socialism
uji	porridge
ukumbi	hearth

umoja	united
upele (pl. *vipele*)	boils on skin
upesi	soon
utamaduni	culture
utani	joke
utapiamlo	malnutrition
uvimbe	swelling
viazi	potatoes
vidonda	ulcer
vipodozi	cosmetics
waganga	traditional healers (pl.)
wanyama	wild life
wanyonge	marginalized people
watani	joking partners
watumwa wa shamba	agricultural slaves
watu wa porini	jungle people
wengi	many
wenyeji wa hapa	long-term local residents
wilaya	district
yangu	mine
yetu	ours
zahanati	dispensary
zawadi	gift

Notes

Chapter 1

1. Swahili or Kiswahili (lit. language of the Swahili people) is spoken throughout East Africa. While Kiswahili is Tanzania's official language, it is widely used as a business language in East Africa and parts of Central Africa.

2. Mzee Ali Mtangenange was in his early fifties when I first met him in August 2000. During my main fieldwork in 2000–2001, he was probably the only person in the village who could read, write, and speak English at a level that I needed. He was living with his wife and five young children on a borrowed piece of land on the edge of the village and leading a life of penury.

3. In East Africa, joking relationships play an important role in people's everyday lives. T. O. Beidelman (1986:121–137), who has written extensively on this topic, notes that a member of the Kaguru "tribe" or *kabila*, for example, stands in a relation of *utani* toward persons called *watani*—or joking partners from another *kabila*; "persons who stand in reciprocal 'joking relations' with one another, though jocularity is only one aspect of the relationship, and not even the most significant. *Watani* partners exchange abuse and insults, without taking them seriously or personally."

4. Malaria is a haematoprotozoan parasitic infection caused by the *Plasmodium* parasite and is mainly transmitted by the bite of a female *Anopheles* mosquito, which acts as the vector for the disease. In humans, the typical symptoms of uncomplicated malaria include fever, chills, rigors, headache, and joint paints, and those of severe malaria include repeated fits or vomiting, altered consciousness, and severe anaemia. The clinical manifestations of malaria depend on the previous exposure of the individual and the degree of immunity acquired as well as other poorly understood parasite factors. Chronic infection may lead to anaemia, clinical relapses (recrudescence), and splenomegaly. In high-transmission areas, malaria in pregnancy causes maternal anaemia, prematurity, and low birth weight, which is a major risk factor for infantile death. In low-transmission areas and in nonimmune individuals, malaria in pregnancy

is associated with the development of severe disease (Bell and Winstanley 2004:29–30). For an excellent description of the life cycle of the malaria plasmodium, and the origins of malaria, see Packard (2007: chap. 1), chapter 1 titled Beginnings.

5. At the time of this incident, chloroquine was the first-line antimalarial in Tanzania. However, following numerous studies, which demonstrated chloroquine's diminishing efficacy against Plasmodium *falciparum* in East Africa, the government banned it from being used in the country starting August 2001.

6. Elsewhere in this book, I use Fatuma's life history to illustrate some of the travails that single mothers in particular experience as they go in search of therapy for their sick children, many of whom suffer from frequent bouts of malaria.

7. Drawing on their extensive ethnographic research in the Kilombero Valley in southeastern Tanzania in the mid-1990s, Muela Ribera and Hausmann-Muela (2011) provide poignant case studies to illustrate the cumulative effects of poverty, inequalities, malnutrition, re-infections, and rebound malaria among vulnerable populations, leading to spirals of vulnerabilities.

8. Many scholars have discussed the large-scale historical, political, and economic factors that determine the persistence of malaria as a global health problem (Dobson, Malowany, and Snow 2000; Malowany 2000; Packard and Brown 1997), while others have called attention to context-specific problems that are related to malaria and child mortality. These include the lack of protection from infective mosquito bites, poor diagnosis and quality of health care, antimalarial drug resistance, delays in seeking appropriate medical attention, poor adherence to recommended therapy, and chronic anemia (Bloland, Ettling, and Meek 2000; Comoro et al. 2003; Crawley 2004; Kachur et al. 2006; Mwenesi et al. 1995; Nsimba et al. 2002; Plowe 2003; Snow, Trape, and Marsh 2001; White 2004).

9. I draw on some of the key elements of an approach commonly known among medical anthropologists as critical medical anthropology (CMA), popularized by medical anthropologists such as Baer, Singer, and Johnsen (1986); Baer, Singer, and Susser (1997); Farmer (1992, 1997, 2004); Scheper-Hughes and Lock (1987); Pfeiffer and Nichter (2008); and many others. CMA insists on locating sociocultural and health phenomena in the context of historical, political, economic, and social forces that shape and constrain individual agency (Singer and Baer 1995). Typically, this approach draws on "Marxian political economy or Foucauldian notions of biopower and biopolitics. The structural violence analytic, popular among CMA adherents, offers an alternative lens to reinterpret disease and mortality among the poor as a form of violence that derives from structured inequality (Farmer 1999). CMA provides a corrective to mainstream international public health still rooted in narrow behaviorist and cognitive models of health disparities" (Pfeiffer and Chapman 2010:153). Critics, however, have faulted the CMA approach for its inattention to human agency in health decision making.

10. As my fieldwork progressed, I focused my research mainly on two of these four villages. I have described one of them, the main village, which I used at my home base, in detail in chapter 2.

11. In public health narratives and health education messages, *degedege* is commonly equated with cerebral malaria. It collectively involves the clinical manifestations of Plasmodium *falciparum* malaria that induce changes in mental status and coma (Maitland and Marsh 2004). See Langwick (2011) for an insightful ethnographic

assessment of the politics of drawing equivalence between *degedege* and malaria in the Tanzanian context.

12. For a useful discussion on the conceptual and strategic differences between malaria control, elimination, and eradication, see Das and Horton (2010).

13. Worrall, Basu, and Hanson (2005:1055) have commented on the endogeneity of the relationship between malaria and poverty, and the difficulties of relying on self-reported morbidity when there may be systematic differences among socioeconomic groups in the propensity to report ill-health. They have identified the difficulties with demonstrating a clear link between poverty and malaria (see also Somi et al. 2007). However, as Randall Packard has demonstrated "malaria retards economic growth and causes poverty. There is clear evidence that the causation runs both ways and that, for individuals and nations, poverty contributes to malaria by exposing people to infection and undermining efforts to control the disease" (2007: 201).

14. By contrast, in the most developed countries, maternal mortality ratios average around ten deaths per 100,000 deaths. World Bank data show declining child mortality trends in Tanzania between 2000 (130/1000) and 2010 (78/1000) (The US President's Malaria Initiative 2011).

15. This is not to suggest in any way that HIV/AIDS is less of a problem in Tanzania than malaria. Indeed, the devastating effects of HIV/AIDS on Tanzania as a nation has been well documented (http://www.tacaids.go.tz), and much is being done to deal with the problem. In this book, however, my goal is to call attention to the problem of malaria in Tanzania, which is a disease that "silently" kills mainly young children and does not carry with it the same kind of stigma as HIV/AIDS and tuberculosis.

16. Recent studies have suggested that in Tanzania, malaria is commonly overdiagnosed in people presenting with severe febrile illness, especially in those living in areas with low or moderate transmission in adults (Chandler et al. 2008; Cohen, Dupas, and Schaner 2011; Reyburn et al. 2006:1212).

17. Dodoma is Tanzania's political capital; it is located 302 miles west of the port city of Dar es Salaam, which is the country's commercial capital.

18. The history of malaria control in Tanzania and in Dar es Salaam in particular dates back more than 100 years. Tanzania (formerly Tanganyika, the mainland part of present Tanzania) was a German colony from 1885–1918. The Germans in the late 1890s saw malaria as a major threat to development in places where the disease was endemic. In 1891, quinine administration was initiated for nonimmune whites, Asians (mostly South Asians), and Africans, and at the turn of the century the first environmental management intervention was introduced, consisting of direct soil work targeted to the larval stages of malaria vectors. Larvicidal aerial spraying was first used in 1945 (when Tanganyika was part of the British colonial empire), and the application of DDT to the walls inside houses started in 1946. After World War II, chloroquine was introduced and rapidly became the drug of choice for malaria treatment. The early success of these innovations in chemical vector control and human treatment had the unfortunate negative consequences of diverting attention away from other interventions that had been part of previous integrated malaria control programs (for details see Caldas de Castro et al. 2004). Reliable historical, epidemiological data on malaria morbidity and mortality in Dar es Salaam are difficult to obtain. At the time of my fieldwork, some sources estimated that as many as one million cases of malaria were reported at public health facilities in this region each year. More recently, researchers

have argued that the number of malaria cases has been grossly overestimated. These disagreements and debates have important implications for the management of severe febrile illness, including the unnecessary treatment and consequent neglect of alternative diagnoses that could lead to avoidable morbidity and mortality (Caldas de Castro et al. 2004; Chandler et al. 2008; Wang et al. 2006; Whitty et al. 2004). Regardless of the concerns surrounding the exact number of malaria cases in the region, and throughout Tanzania, more than two-thirds of malaria-attributable febrile illnesses are dealt with outside of the formal medical system. It is a well-known fact among public health officials and policy makers that these cases are frequently unrecorded in the official vital statistics on malaria morbidity and mortality (Breman, Martin, and Mills 2004; Williams and Jones 2004). During my fieldwork, none of the childhood malaria–related deaths that I documented were recorded either at the village dispensary/health facility or the local government office.

19. As Nichter (2008:14) has explained, "The term *illness* denotes the subjective experience of being unwell—a personal, phenomenological experience that may or may not correspond to a clinically identifiable disorder and that can be experienced in a multitude of ways within one's personal, social, and cultural context" (see also Good 1994).

20. Many anthropologists, such as Paul Farmer, Charles Briggs, and Merrill Singer, have provided ethnographic evidence to demonstrate how issues of power relationships, inequity, marginalization, and racism affect how diseases are created, distributed, and treated. See William and Jones (2004) for an excellent review of how these factors impinge on malaria in particular.

21. In 1998, the WHO concluded that poverty is the greatest risk factor for malaria (Lucas and McMichael 2005). Over two-thirds of malaria cases occur in the poorest fifth of the world's population. In Tanzania, for example, children in the poorest quintile had a 39 percent higher rate of death following fever, which in most cases would be expected to be due to malaria, than the richest quintile. Studies have also shown that the poorest children in sub-Saharan Africa are typically half as likely to sleep under a bednet and less likely overall to use antimalarials (WHO/UNICEF, 2003).

22. Randall Packard has aptly described the correlation between poverty and malaria as "silent violence" (2007: 201). In my analysis of childhood malaria and its manifestations in peoples' everyday lives, I take an approach informed by the processes of structural violence and social suffering. I have elaborated on these two concepts in chapter 6.

23. Anthropological studies that draw on a critical global health theoretical framework characteristically examine the direct and indirect impact of large-scale processes such as structural adjustment policies, globalization, and privatization on health services at the national level, and on the social and cultural lives of people at the community level. Such studies also examine the ways in which these processes affect public health and describe processes of policy development and resistance (Pfeiffer and Chapman 2010).

24. The malaria prevalence and incidence rates in many countries dropped to a record low. In India, for example, by 1965, the annual malaria incidence fell from 75 million cases to an all time low of 0.1 million cases. No deaths were recorded (Sharma 1996).

25. Given that nearly a million children in sub-Saharan Africa were dying from malaria each year (Snow et al. 2005), scholars and health policy makers characterized

this burden of malaria-related deaths as "intolerable." They mobilized efforts to halve rates of mortality and morbidity due to malaria by 2010 (WHO 2005). The World Health Organization has responded to this situation, by emphasizing early identification and prompt, effective *biomedical* treatment as one of the key factors in preventing the high levels of malaria-related deaths in sub-Saharan Africa.

26. Tanner and de Savigny (2007:82) have observed that the post-eradication era from 1969 to 1991 focused on technical issues and research and development for new tools, leading to advances in drug and vaccine development, vector control, and insecticide-treated nets. These decades also brought a better understanding of the social, economic, and cultural dimensions of malaria. There was little global support provided specifically for malaria control in the newly independent states of Africa that were struggling to establish broad-based health systems and primary health care. By 1992, the combination of a worsening malaria situation and promising technical developments led to a renewed global focus on malaria control.

27. The Roll Back Malaria initiative, launched by WHO in 1998, led to the Abuja Declaration in 2000, which defined progressive intervention coverage targets for control designated to eliminate malaria as a public health problem, while emphasizing that this could be achieved through vastly strengthened local health systems (Tanner and de Savigny 2008:82). See also the Abuja declaration and the plan of action; African Summit on Roll Back Malaria, April 25, 2000, Abuja; WHO 2007. The UN declared 2001–2010 the "Decade to Roll Back Malaria" in developing countries, particularly in Africa, and set malaria as a high priority within the United Nations Millennium Development Goals. In 2005, both the World Bank's Malaria Control Booster Program and the U.S. President's Malaria Initiative (PMI) were established.

28. Artemesinin (qinghaosu) is the antimalarial extract of *Artemesia annua* (sweet wormwood) that has been used for centuries in traditional Chinese medicine to cure fevers. Artemisinin-based combination therapies are the only antimalarials currently available that rapidly reduce both asexual and gametocyte stages of the *P. falciparum* lifecycle (Barnes and White 2005:230). For a helpful review of treatment principles, essential drugs, and current recommendations for malaria treatment, see Deen, von Seidlein, and Dondorp 2008.

29. For an excellent overview of the difficulties involved in developing the elusive malaria vaccine, see http://malaria.wellcome.ac.uk/doc_WTX033040.html.

30. Bill and Melinda Gates Foundation Malaria Forum—Day, 2, October 17, 2007 [Transcript]. See also Roberts and Enserink (2007).

31. The estimate presented at the Malaria Forum in Seattle was US$6 billion annually for implementation costs of 80 percent coverage in 107 countries covering 3.2 billion people at risk of *falciparum* and *vivax* malaria (US$1.88 per case). RBM's Global Malaria Action Plan estimated the costs of country implementation of malaria control and elimination strategies to be $5.3 and $6.2 billion in 2009 and 2010, respectively, and $5.1 billion per year from 2011 to 2020, for 109 countries and 3.3 billion people at risk, suggesting roughly US$1.55 per person (Mills, Lubell, and Hanson 2008:7).

32. Generally, cessation of malaria transmission in a defined geographic area, such as an island or an entire country, is now called elimination. While WHO defines malaria control as "reducing the disease burden to a level at which it is no longer a public health problem" it defines malaria elimination as "interrupting local mosquito-borne malaria transmission in a defined geographical areas—i.e., zero incidence of locally contracted cases, although imported cases will continue to occur" (WHO

2008). Elimination means interrupting malaria transmission at a national or regional level (Das and Horton 2010:1515).

33. By the end of 2009, international donor agencies had committed more than US$9.9 billion for malaria control in eighty-one countries where populations were exposed to stable P *vivax* or P *falciparum* transmission (Snow et al. 2010:1412).

34. Antimalarial drug resistance has often been identified as the predominant factor contributing to the immense global burden of malaria, particularly in sub-Saharan Africa. However, according to Whitty et al. (2008:1), malaria incidence appears to be decreasing in a number of countries in Africa. The deployment of ACT is likely to have played a part in this, especially in moving from low to very low transmission, due to the drugs' gametocidal activity (O'Meara 2010; WHO/World Malaria Report, 2011). I am grateful to Clare Chandler for pointing out that this declining incidence is not long enough to be a trend.

35. Structural adjustment programs (or SAPs) are the practical tools used by international financial institutions (IFIs) such as the International Monetary Fund (IMF) and the World Bank at country level to promote the market fundamentalism that constitutes the core of neoliberalism (Pfeiffer and Chapman 2010:150). According to Pfeiffer and Nichter (2008:411), SAPs, recently repackaged euphemistically as "Poverty Reduction Strategy Papers" or PRSPs, have emphasized major cutbacks in public sector spending, including health and education, while promoting economic privatization to stimulate economic growth and repay debt.

36. See Ortner (1984) for an overview of Giddens on structure and agency and Bourdieu on practice theory.

37. The term "Washington Consensus" was coined in 1989 to refer to the Washington, DC–based IMF, World Bank, and U.S. Treasury consortium, and came to signify the austerity economies that SAPs produced (Pfeiffer and Chapman 2010:151). The "Washington Consensus" was developed specifically in response to Latin America's problems. By 1991, seventy-five of the poorest countries in the world had received adjustment loans, thirty in Africa and at least eighteen in Latin America.

38. The SAP reforms, first implemented in the 1980s, often brought widespread cuts in public spending on health and education. Such measures were designed to free national resources for servicing debt and reflected the IMF's primary interest in ensuring loan recovery for major creditors like the World Bank. Within the first decade of implementation, household and community resource constraints, engendered or exacerbated by austerity programs, led to rising infant mortality rates and worsening health, overall, in sub-Saharan African countries under adjustment (Manfredi 1999; Packard 2007).

Chapter 2

1. Tanzania has more than 120 ethnic groups and as many languages, but Kiswahili is the nation's lingua franca. For an excellent analysis of how Kiswahili became Tanzania's official language, see Topan 2008.

2. It was a "chance happening," a serendipitous event that led me to Mbande, the specific village setting for my fieldwork. On a more practical note, however, my research and residence permit required me to delimit my research to Temeke district

and my movements within Dar es Salaam. Thus, Mbande was the furthest I could legally venture out to do my fieldwork. I remain most grateful to the leaders of Mbande for supporting my research through the years. Gupta and Ferguson (1997) have commented on the recurrence of anecdotes in which experienced fieldworkers related how they "stumbled" on to their field sites entirely by chance. They express concern that the repeated narratives of discovering field sites by chance prevent any systematic inquiry into how those field sites came to be good places of doing fieldwork in the first instance.

3. According to Gupta and Ferguson (1997:12–13), the function of narratives of entry and exit is to authenticate and authorize the material that follows, most of which used to be written from the standpoint of an objective, distanced, observer. Such stories also form a key piece of the informal lore of fieldwork that is so much a part of socialization into the discipline.

4. Before I embarked on my fieldwork, I completed an intensive eight-week training program in Kiswahili at a language training institute in Dar es Salaam. I developed much of my communicative competence in Kiswahili during the course of my fieldwork in the villages, however, where I was forced to converse only in Kiswahili. I initially spent sixteen months, from May 2000 to September 2001, doing continuous fieldwork in the Dar es Salaam region, mainly for my doctoral dissertation. As part of my fieldwork, I conducted household surveys and in-depth interviews and spent hundreds of hours at the village dispensary and with one of the well-known traditional healers (*mganga*) in the main village, Mbande. I participated in everyday life, attended weddings, *ngoma*, funerals, and hung out with neighbors, acquaintances, and field assistants, who provided me access to stories and cases that I could follow for my research. Subsequently, I spent two to three months every summer, from 2004 to 2011, conducting research in the Dar es Salaam region. In 2005, when I built a small house on the same spot where I had built a hut for myself during my dissertation fieldwork in 2000–2001, children would often gather in the front yard, and while their mothers prepared food, they would share with me stories of everyday life, including some joyful events and also their troubles with sick children. They often approached me for financial assistance, and in the process shared with me their woes and stories of hardship. I should make clear, however, that my interactions with my neighbors and the people in the village did not involve mainly stories of woe and anecdotes and events of pain, hurt, insecurity, and suffering. Quite the contrary, I often wondered at the amount of laughter, teasing, joking, humor, the mundane, and resilience that characterized everyday life in the village. This could be the subject of a different book.

5. Many elderly men and women in the village routinely expressed their disappointment by reminiscing and telling stories to one another about the "good old days" when the socialist government under the leadership of the late president Julius Nyerere had provided households and individuals with free health care, subsidized food, and social security. By reminiscing, these elderly people reconstructed and reaffirmed their shared experiences and cultural memories—memories of the past that are socially reconstructed to make sense of and negotiate the present.

6. During the Operation people from all over Tanzania were moved, often forcibly, from their original settlements to start new villages or to merge with existing and/or neighboring larger villages. The villagization program involved the largest number of people in the history of African resettlements, relocating between five and nine million rural Tanzanians (von Freyhold 1979).

7. In her ethnography of reproductive health among the Sukuma people of West Central Tanzania, anthropologist Denise Allen (2002) describes her initial anxiety about the cultural heterogeneity of her chosen fieldwork setting. Similarly, I had initially assumed that I was working among the Zaramo people; the range of people I interacted with and interviewed, with diverse ethnic identities, soon dispelled this assumption. The household survey also revealed that the people of Mbande belonged to as many as forty-two different ethnic identities, but for all practical purposes, the Zaramo culture provided the cultural backdrop or the historical background to this ethnography.

8. In 2000–2001, the US$ exchange rate was about 800 Tanzanian shillings against one US$; in 2012, it had almost doubled, to 1,585 Tanzanian shillings against one US$.

9. Briefly, the Zaramo were elephant hunters of the inland hills. For more than 150 years, the Zaramo traded their ivory for the salt and cloth of the coastal Swahili and Shomvi. Over the years, they have gradually taken on the lifestyle of subsistence farmers and moved closer to the coast (Swantz 1995:9).

10. The Kilwa-Lindi-Mtwara region is commonly described in the literature as the Cinderella region because it is believed that no economic development will emerge from there (Seppala 1998:56).

11. The Muslim festivities had high participation rates at the local level. While most Muslim residents claimed to observe the rules of fasting during the Ramadhan period, which ends with *Id el fetri*, there were many in Mbande who observed the fasting only symbolically. Maulidi was another one-day festival that the people of Mbande celebrated with much reverence and communality. Significantly, it was Mzee Tinyango, the local *mganga*, who sponsored the Maulidi festival. Considering his "marginal" status, it is quite possible that elsewhere this would be seen as incommensurate with Islam. However, Mzee Tinyango was not only one of the oldest persons alive in Mbande, but also one of the wealthiest who could afford to cover the cost of the Maulidi festival. The other event that brought large numbers of people together was the *hitima*—a burial ceremony. Funeral ceremonies were frequent and always a major occasion in the village. Participation at a *hitima* was a common social gathering. Participation was high and the ceremony was well-organized. The number of people visibly mourning the death of a member in someone's family varied according to whether the dead person was an adult or a child. Typically, the number of people who attended the mourning and the burial ceremony of a dead child was a mere fraction of the number of people who attended the mourning and the burial ceremony of an adult dead person—regardless of whether the adult was a male or a female. When women showed up to mourn the dead, they wore their best *kangas* and partook in consuming the customary *chai* (tea) and/or *kahawa* (coffee) or *uji* (porridge) that was served to all those present. When Salama, a two-year-old Zaramo girl (whose case I describe in detail in chapter 5) died, there were less than thirty women and twenty men at Mzee Tinyango's residence where the mourning and burial ceremony was held. In contrast, when Mzee Mohamed, a coconut vendor in his late twenties, unexpectedly died due to severe diarrhea and vomiting, the entire village came to a complete standstill. Shops were closed, and all vendors closed their business for four to five hours during the *hitima* proceedings. There were more than 400 people who participated in the funeral procession. The same was true when my neighbor's sister, who lived elsewhere, died

in Mbande; the village came to a complete halt, and the *hitima* ceremony, which I documented in detail, was very elaborate.

12. When the non-Zaramo talk of promiscuity among the Zaramo people, they do so in metaphorical terms, invoking the term *mafagi matatu*—a hearth made of three stones. According to some of my Zaramo informants, when imparting lessons about life and sexuality to a *mwali* (a female initiate) during the puberty rites (i.e., when the *mwali* is in seclusion/confinement (*kualikwa*) the *fundi* (the traditional teacher/mentor) makes metaphorical reference to a hearth made of three stones to underscore the importance of loyalty to one's husband, parents in-law, and brothers- and sisters-in-law. The moral of the lesson (*mafundo*) is that one needs all three stones to be firmly in place if the family's cooking pot is to remain stable. Non-Zaramos who want to "pick on" the Zaramo argue that the hearth metaphor is actually used to educate the *mwali* in the art of survival by maximizing her sexuality—each hearth stone stands for a male who could be a potential provider. A *mwali* is advised in symbolic and metaphorical terms that, in order to survive, she must be pragmatic enough to establish a liaison with at least three men: these liaison's are an insurance of her own survival and the survival of her children. Thus, every time I mentioned the phrase *mafiga matatu*, my key informants would express amusement and surprise, as though I had unlocked one of the deepest secrets of the local culture's discourse on sexuality. At the same time, my Zaramo hosts and key informants would go to great lengths to refute the interpretation given by non-Zaramo about *mafiga matatu*.

13. See Seppala (1998) for a discussion on diversification as a strategy where a household accommodates several types of resources and employs multiple means to generate income.

Chapter 3

1. The United Republic of Tanzania is composed of two formerly independent entities, Tanganyika and Zanzibar. While Tanzania achieved its independence from Great Britain in 1961, Zanzibar became independent in 1963. Tanzania was formed in April 1964 by the union of Tanganyika and Zanzibar. There is substantial documentation on the political machinations and the geopolitics that brought these two independent entities together to form one nation, one republic. According to Askew (2002: 5–6), on April 26, 1964, Julius Nyerere (first president of Tanganyika and subsequently Tanzania) and Abeid Karume (who assumed control over Zanzibar following the violent January 1964 revolution) surreptitiously signed the union into existence.

2. The Tanzanian economy depends heavily on agriculture, which accounts for more than 25 percent of GDP, provides 85 percent of exports, and employs 80 percent of the work force. Tanzania remains an overwhelmingly donor-dependent country. In 2006, its external debt stood at $7.1 billion or 57.3 percent of its GDP. Servicing this debt absorbed about 40 percent of total government expenditures. Tanzania was one of the African countries that benefited from extensive debt relief under the enhanced Heavily Indebted Poor Countries (HIPC) initiative. Over $6 billion of debt was canceled following implementation of the Paris Club 7 Agreement. More recently, despite benefiting from the Multilateral Debt Relief Initiative to further lower its external debt,

Tanzania's total external debt increased to $4.5 billion or 25.6 percent of the GDP by end of June 2009 (World Bank/IMF 2009).

3. Neoliberal economics insists that markets can spontaneously create a new world if the old can first be destroyed. "Shock therapy's package of price liberalization, stabilization, and privatization aims to dissolve the past by the fastest means possible. . . . It is neoliberalism's pious hope that destruction is the vehicle for genesis" (Burawoy and Verdery 1999:5). Shock therapy, based on the economic theories of neoliberalism, and promoted by the IMF and the World Bank, "were first aimed to jolt Eastern economies out of their socialist rigidity and degeneration; it would miraculously rectify the inherited pathologies of planning. Shock therapy was to be the "big bang" that would eclipse the old order and set in motion an irreversible expansion of a market economy" (Burawoy and Verdery 1999:302; see also Murrell 1993).

4. The politics surrounding the Arusha Declaration of 1967 is discussed in some detail later in this chapter.

5. As noted in the previous chapters, the basic assumption underlying structural adjustment is that appropriate changes in policy can lead to sustainable economic growth, which in time will alleviate poverty and increase development (Peabody 1996:824). Sanders (2001:163) notes that structural adjustment in the Tanzanian context is about market reform, and "getting the price right." It operates on the principle that less government intervention in the economy is better; that economies will work best, and most efficiently, if propelled by market forces rather than bureaucrats. Structural adjustment, then, is a move "away from more autonomous, nationalistic, inward-oriented, import-substitution, state interventionist, and socialist models towards *laissez-faire* capitalism" (Sparr 1994:2; see also Hydén and Karlstorm 1993).

6. In February 1991, the National Executive Committee of the ruling Chama Cha Mapinduzi (CCM) party repealed the Leadership Code of the 1967 Arusha Declaration and challenged the document's original objectives. The committee's statement, which became known as the Zanzibar Declaration, stressed that party members were allowed to engage in capitalist activities as a means to earn an additional income. Thus, party members could farm, fish, and carry out petty trade, or be a board member of a private company. The Zanzibar Declaration effectively undid the Arusha Declaration, which had been promulgated by the then-ruling party, Tanganyika African National Union (TANU), in 1967. TANU had sought through the Arusha Declaration to eliminate class inequality by discouraging foreign investment and by forbidding capitalist practices of party members, middle- and higher-ranking civil servants, and government officials (Tripp 1997:xiv and 175–189).

7. The most consistent explanation for why the state had decided to reject the Arusha Declaration seems to be that the leadership at that time simply had no other logical choice but to yield to both internal and external pressures, especially the ones exerted by the World Bank, IMF, and donor countries. However, in a study of the informal economy in Dar es Salaam, Tripp (1997) argues that while the IMF and the World Bank and foreign donors no doubt played a major role in inducing economic and political reforms in Tanzania, external pressures do not entirely explain the mechanisms of change and cannot account for the internal conditions that permitted these policies to be carried out. Moreover, many reforms were not tied to donor conditionality. Instead, the change came about because the state was unable to meet the needs of the people and the people had to take matters into their own hands (Tripp 1997:60; see also Biermann and Wagao 1986; Snyder 2001:142; Spalding 1996).

8. Burawoy and Verdery (1999:308) have defined capitalism as an economic system based on private property and constrained by demand, whereas the socialist system is based on public ownership and constrained by supply.

9. Nyerere first used the concept of *ujamaa* as a principle of social organization in his pamphlet called "Socialism and Rural Development" and later articulated it in detail in the Arusha Declaration of 1967. It is believe that he was searching for a word to describe his particular interpretation of socialism. He rejected *jamii* and *ujima*, since both had been used to translate the English "communism," and instead chose the abstract noun that comes directly from the word for a extended family; Nyerere translated *ujamaa* as "familyhood" (Coulson 1982:235). Whereas Marx and Engel's understandings of social evolution were based on presumptions about "primitive" social organization in the non-Western world, Nyerere's philosophy drew in turn upon socialist ideologies formulated by European intellectuals. His goal, however, was to create a variant of socialism that was distinctly African. In Nyerere's formulation, *ujamaa* was a philosophy of community drawn from ideas of familyhood that he saw as characteristic of African "tradition." He wrote, "In our traditional African society we were individuals within a community. We took care of the community, and the community took care of us. We neither needed nor wished to exploit our fellow men" (1966:166). In short, "Nyerere espoused the romanticized ideas of communalism found in Marx's and Engels's ideas of "primitive communism," yet he appropriated it as a characteristically "African" and found within it a source of superiority to European-based ideas of socialism that portray class struggle and conflict as intrinsic social processes" (Walley 2004:109). In other words, Nyerere completely rejected class struggle as the basis of his *ujamaa* philosophy and instead emphasized the traditional African institution of the extended family system. Nyerere was, of course, fully aware that with more than 120 distinct ethnic groups, his nation had much to fear from processes such as ethnic stratification that characterized the neighboring states of Kenya and Uganda. As Kelly Askew notes, "In an attempt to dull the edges of differences, he instituted social policies of unification such as the single-language policy that formalized Kiswahili's prevalence throughout the country by requiring it as the medium of instruction at the primary school level and the sole mode of political discourse. A second strategy was to systematically weaken localized social bonds and simultaneously strengthen national ones by moving and shuffling people throughout the country" (2002: 47).

10. When Tanganyika (Tanzania since 1964) became independent in 1961, there were at least three political parties. The Tanganyika African National Union (TANU) was the dominant political party. The African National Congress (ANC) and the United Tanganyika Party (UTP) contested unsuccessfully in the 1960, quasi-free, preindependence elections in which TANU won all the seats. On that basis, TANU claimed that it had obtained an exclusive popular mandate (Baregu 1994:160). In 1968, when a handful of parliamentarians challenged the concept of party supremacy, they were silenced and stripped of their party membership by the party's National Executive Committee (NEC). Party supremacy achieved a de jure status through an amendment to the constitution in 1975 (Bryceson 1993:13). Thus, until 1977, TANU was the only legal political party on the mainland. That year, in combination with Afro-Shirazi Party (ASP), the ruling party in Zanzibar, it assumed a new identity, calling itself Chama cha Mapinduzi (Party of the Revolution; CCM). This, however, did not fundamentally alter the characteristics of the party that evolved over nearly a quarter century (McHenry 1979:61). The amalgamation was a formality undertaken to

remove the anomaly of having two parties in a constitutional one-party state. The birth of CCM was also intended to seal party supremacy over the union (Baregu 1994:164). The creation of the Chama cha Mapinduzi crowned Nyerere's effort to bring the two countries together not only in name but also in a series of efforts to regulate the political marketplace that followed after the Arusha Declaration and Tanzania's decision to become socialist (Hydén 1980:137). The CCM party continues into 2013 to rule the republic, against a weak opposition with hardly any resources.

11. According to Baregu (1994:163), by promising a socialist utopia (*ujamaaland*) and focusing attention on a hostile international environment, the Arusha Declaration was a mobilizational and diversionary mechanism for political adaptation and system maintenance in the face of growing social discontent.

12. At the end of 1962, Tanzania adopted a republican constitution with a strong presidency. On January 14, 1963, nearly one month after becoming president, Nyerere announced that TANU's Executive Committee had decided that, in the interest of national unity and economic development, Tanganyika should become a constitutional one-party state. By July 1965, Tanzania was a constitutional one-party state, and Nyerere had significantly consolidated his power (Baregu 1994).

13. In all of these cases, the government made the commitment that it would honor all existing commitments and that it would pay "full and fair compensation for the assets acquired." In its entirety, the 1967 nationalizations probably did not involve more than 20 million pounds in compensation (Coulson 1982:178–179).

14. The Tanzanian economic situation was consistently described by the word "crisis" from the mid-1970s to the late 1980s. After that period, the official figures show that the economy had strengthened. However, economists have raised doubts about whether official figures reflect the truth. According to Sarris and van der Brink (1993:57) the so-called crisis can be interpreted as a crisis of the formal economy.

15. In the 1960s Tanzania had the highest rate of increase in food production out of all African countries and it was exporting to neighboring countries. By the mid-1970s the country was importing food, and by the mid-1980s food accounted for 20 percent of all imports (Lofchie 1988:144–47 cited in Tripp 1997:62–62).

In 1977, the breakup of the East African Community (originally established in 1967) added further impetus to a policy of self-reliance that necessitated heavy investment with regard to infrastructure, such as transportation and communications (Sarris and van den Brink 1993:14).

16. The war with Idi Amin's Uganda, which started at the end of 1978 and lasted for most of 1979, only exacerbated Tanzania's economic troubles and caused major disruptions in production. The government had to import substantial amounts of arms and war-related supplies that are estimated to have cost about US$300 million, equivalent to more than half of Tanzania's 1977 export earnings (Sarris and van den Brink 1993:14). After the war, however, military expenditure continued to increase, in part due to Tanzania's support of Mozambique's battle against the South African-backed RENAMO guerrilla forces (Tripp 1997:64). Apparently, Tanzanian authorities had expected donors to carry the cost of that war, an expectation that remained largely unfulfilled (Bigsten and Danielson 2001:47).

17. Proponents of political liberalization argued that Tanzania's economic decline could be explained, at least in part, by the monolithic one-party system. They stressed that, apart from suppressing open political dissent, the system stifled innovative

thinking and nurtured conformity, mediocrity, and sycophancy among a self-serving party-state oligarchy, which did not permit criticism (Baregu 1994:175).

18. The "take-it or leave it" attitude of the IMF exacerbated the situation and negotiations broke down in 1980 and again in 1983. An important reason for Tanzania's resistance to the externally set conditions was to "maintain equity in income distribution as well as the provision of social services and other basic needs to the majority of the population" (Swantz 1997:4). The conditions set by the IMF threatened these objectives.

19. According to Goran Hydén, Ali Hassan Mwinyi was in many respects Nyerere's opposite. He had no political vision of his own, was not really committed to socialism, and lacked the predisposition and capacity to enforce social discipline. He may have been the right person to bring laissez-faire to the Tanzanian economy, but unfortunately, during his ten years in office (1985–1995), this concept was allowed to permeate all spheres of society. The result was an epidemic of corruption, land grabbing, and lawlessness. In Tanzania, Mwinyi's rule is remembered as a period of *ruksa*, a Swahili word perhaps best translated as "do your own thing" (Hydén 1999:144).

20. Multiparty elections were to happen first, however, at the civil level on October 30, 1994, on the mainland. On Zanzibar civic elections were postponed until October 22, 1995, just before the national elections—the key contest being between CCM and the Zanzibar-based opposition party CUF, an organization with overtones of Islamic reformism, Zanzibar separatism, and financial backing from the Middle East (Askew 2002:48).

21. The reelection of President Mkapa for the second time was predictable given the basic logic of African politics. As Hydén explains, the party system in Tanzania resembles the systems in most other African countries. There is a dominant ruling party and a smattering of small parties that do not constitute a real or potential threat to its hegemony. This is part of the neopatrimonialist order that permeates African politics. With patronage rather than policy making the difference, it is not surprising that the benefits of being an insider outweigh those of being in the opposition (Hydén 1999:148–149; see also Sanders 2001:164, 2003).

22. In 1960, just before political independence, there were 425 physicians, including 12 Tanzanians, 99 hospitals with a combined 11,160 beds, 22 rural health centers, and 990 dispensaries. By 1977, there were 727 physicians, including 400 Tanzanians, 141 hospitals with 19,970 beds, 161 rural health centers, and 2,088 dispensaries. By 1977, the ratio was 1 physician in private practice per 1,500 persons in urban areas, whereas in 1960 for the whole country the ratio was one physician in private practice or government service per 22,000 people (Turshen 1984:143).

23. Significantly, Chinese clinics and health facilities were among the most numerous and fastest growing of all for-profit health facilities in postsocialist Tanzania. In Dar es Salaam, in 1998, while there were only two health facilities offering Chinese medicines, in the year 2000 when I started my fieldwork, there were more than twenty-five such facilities—all offering for-profit health services and Chinese pharmaceuticals to local Tanzanians. After 2001, however, the government of Tanzania did not reissue licenses to any Chinese medical doctor practicing in Tanzania (see Hsu 2002).

24. By the end of 1975 there were 160 health centers, with medical assistants in charge, and nearly 1,800 dispensaries, distributed so that 90 percent of the population was within ten kilometers of some health facility (Coulson 1982:208–209). By 1980

about 72 percent of the people lived within a radius of five kilometers from a health facility and another 20 percent were five to ten kilometers away. All services were free of charge and four to five health service contacts were made per person per year (Swantz 1997:10). However, as Harrington (1999:217) has noted, although there was a remarkable extension of primary health care in the 1970s, commitments to curative, hospital-based medicine were not reduced, but merely increased at a slower pace than before.

25. The government classifies missionary medical services as businesses that must conform to regulations for the private sector (Turshen 1999:43; see also Munishi 1997).

26. User charges were inspired by the new policy of cost sharing for African health-care systems, expounded by the World Bank in its document Financing Health Services in Developing Countries (World Bank. 1987. Financing Health Services in Developing Countries: An Agenda for Reform. Washington, DC), and by the WHO in the Bamako Initiative of 1987.

Chapter 4

1. There are two well-known models that inform the user fees mechanism. The first is the standard system, which is based on the assumption that user fees generate the necessary resources and they also enhance efficiency by creating appropriate referral mechanisms and encouraging the reallocation of resources to the primary level. The second is the Bamako model, which is based on the Bamako initiative, and implemented at the PHC level. It aims to raise and control funds at the local level through community-based activities that could also be national in scope. Its intent is to ensure that local communities spend revenues to improve quality shortfalls (Beattie et al. 1996:10; see also Gilson 1997:274). More recently, there is a user fees removal momentum at country level across Africa. User fee removal in other countries and the evidence that the policy led to higher utilization of curative services have consolidated the momentum (Messen et al. 2011).

2. The doctor was in his early fifties when I started my fieldwork at the dispensary in January 2001. He had trained for four years to qualify as a medical officer, but he did not pursue an MBBS degree. Over the years, he had developed a reputation for not treating his patients well and implementing the user fees policy to the book. While the local people did not hesitate to voice their disappointment with his general disposition toward his patients (of being insensitive and unsympathetic), they also praised him for his knowledge and expertise in diagnosing their illnesses.

3. The Ministry of Health and Family Welfare's cost sharing implementation manual clearly states that children under the age of five years and pregnant women are statutorily exempted from user fees for basic services (Mushi 2007).

4. I used a stringent set of inclusion and exclusion criteria to recruit mothers at the dispensary for the interviews. I did this mainly to limit the sample size to a manageable level. As such, I interviewed only those mothers who had brought their child, who was less than five years of age, to the dispensary, and who had a high-grade fever (an axillary temperature of 103° Fahrenheit was used as the cutoff point), and the child was diagnosed with malaria and treated at the dispensary. Finally, the doctor or one of the nurses must have advised the mother to sponge the child with a wet cloth before being given any medicines.

5. I conducted all the in-depth interviews with the forty-five mothers in Kiswahili in their homes with the help of Mariam Mohamed, my research assistant. I audiotaped the interviews, which lasted between fifty and ninety minutes, and later transcribed and translated them for analysis. I interviewed at least half of these mothers again at a later date in more detail to elicit their life histories.

6. Because the bulk of the data discussed in this chapter were collected during a period when chloroquine was still the first-line drug in the treatment of malaria in Tanzania, the discussion will be mainly concerned with chloroquine therapy. I take up the topic of politics of Tanzania's changing malaria treatment policies in greater detail in chapter 7.

7. The symptomatology of malaria is ambiguous and diffuse, making a differential diagnosis based on the clinical presentation difficult. In clinical settings, malarial symptoms are often conflated with pneumonia (Kallander, Nsungwa-Sabiti and Peterson 2004).

8. Aziza was two years old at the time. She was one of my favorite children in the village, as she would spend many hours playing in the front yard of my house in Mbande, along with dozens of other children. Unfortunately, Aziza died in 2008, following a complicated illness, leaving her mother completely shattered and withdrawn from social life.

9. Epidemiologists refer to burden in terms of morbidity and mortality, while economists refer to a quantification of the costs (direct and indirect), and effects on levels of productivity, national growth, and development (Williams and Jones 2004:156). By contrast, social burden represents the process through which social and cultural factors affect the biomedical burden of malaria—it represents the other burdens (social, political, and economic) that people suffer in their day-to-day lives that in turn affect their prevention and treatment-seeking activities.

10. I provide a more detailed discussion on the recent introduction of RDTs in public and private health facilities in Tanzania in chapter 8.

Chapter 5

1. This was my first encounter with a child's death in the village, and it was very early in the course of my fieldwork. I was unsure about my own demeanor during the mourning and therefore I hesitantly accompanied the men to the graveyard. Although I decided to go to the burial, I did not have the courage to meet with Salama's mother while she was experiencing intense grief. The following day, however, I visited the family to express my sadness.

2. Narratives are typically generated in an interactional context, i.e., through intersubjective dialogue. This has been extensively documented in the anthropological literature (see Garro and Mattingly 2000; Hunt 2000; Ochs and Capps 1996). Thus, my presence and the presence of my research assistant during the rendition of the narratives influenced what was narrated and the manner in which the narratives unfolded.

I recorded several deaths among children that were attributed to malaria, and particularly to *degedege*, during my fieldwork in Temeke district. However, in this chapter, I have presented and analyzed three cases that I was able to document most closely because of my physical presence around the time the critical events were unfolding, and also because of my previous knowledge of, and interactions with the mothers and/or fathers, that greatly facilitated the narratives' production.

3. A bulk of the literature dealing with malaria-related mortality has focused on causative factors such as ineffective antimalarials, malnutrition leading to greater susceptibility to contracting the disease, and the lowered immunity that further lowers the body's ability to fight off the infection. In sum, such explanations have derived from a biomedical explanatory framework. However, my goal in this chapter is to call attention to the broader contextual, cultural, and circumstantial factors that often result in what Farmer (2003) has called "stupid deaths" or unnecessary deaths; deaths that are completely preventable with the tools that are already available to the fortunate few.

4. Duranti and Goodwin have lucidly explained the notion of context as follows:

> "When the issue of context is raised it is typically argued that the focal event cannot be properly understood, interpreted appropriately, or described in a relevant fashion, unless one looks beyond the event itself to other phenomena (for example, cultural setting, speech situation, shared background assumptions) within which the event it embedded. . . . The context is thus a frame that surrounds the event being examined and provides resources for its appropriate interpretation. The notion of context thus involves a fundamental juxtaposition of two entities: (1) a focal event; and (2) a field of action within which that event is embedded" (1992:3).

5. In their study on treatment-seeking for childhood malaria in the Rufiji region, de Savigny et al. (2004) found that in nearly 90 percent of cases, the patient had made contact with a biomedical facility.

6. Langwick has queried and analyzed the assertion commonly made in Tanzania, especially in biomedical circles, that *degedege* is malaria. Langwick problematizes the equivalence between *degedege* and malaria and argues that "the translation of *degedege* as malaria masks the possibility that there is another set of relationships, another network of actors, institutions, and propositions in which to locate experience" (2011:175).

7. Hausmann-Muela and Muela Ribera (2003) report that in southeastern Tanzania, people believe that *degedege* is caused by a large nocturnal moth that sprinkles powder from its wings onto a vulnerable child, causing the child to become seriously ill. This etiological explanation, whereby a mythic bird or a pathogenic insect is associated with an illness involving febrile seizures, is not unique to the Tanzanian context. In Mali, West Africa, Castle (1994) describes the illness *foondu*, which is akin to *degedege* in its presentation of symptoms, cultural interpretation, and also in its association with a bird—an owl that flies at night over the village.

8. People from the Zaramo ethnic community in particular make a taxonomic distinction between *degedege* and another illness called *kiarusi*, a similar illness that affects adults. While the symptoms of both illnesses are similar, *kiarusi* is believed to be the result of sorcery or witchcraft. It is brought upon a person because another person wishes evil on the victim for reasons that may remain unknown until the patient has consulted a *mganga*.

9. Zaituni Upepo, an elderly woman who was in her mid-seventies when I interviewed her in August 2000, described one of the treatment options that was popular

among the Zaramo people until a few years ago. Zaituni emphasized that people did not send a child who had *degedege* directly to the hospital. Instead, if the child was rolling his eyes and convulsing, the parents would immediately take him to a *mganga* along with a hen. The *mganga* would put some medicines on the hen and start slapping the child with it. He would then throw the hen on the rooftop and as soon as it had squawked, the patient would recover. The child's parents would then give the hen to the *mganga* who would tell them that the next time their child got *degedege*, they could do exactly what he had done, in their own homes. Only if the child were to start vomiting, they were advised to bring him or her again to the *mganga*.

10. Swahili from the Arabic Khatt-ar-raml, a system of divination by calculation and examination of Arabic books that is widespread in East Africa (see Whyte 1997:64).

11. Most people I interviewed said that they were not aware of any particular medicine or any specific procedure that would protect a child from *degedege*. However, some of them mentioned that subsequent attacks of *degedege* in children could be prevented by using the medicinal bark of a particular tree in the form of a *hirizi* (talisman) that is tied around the child's hip. Another particularly powerful preventative talisman is made from the bones of a rare bird that only a skilled *mganga* can identify. This talisman is believed to offer permanent protection against *degedege*. If a child has been treated by a *mganga* and has recovered, parents are told to avoid certain kinds of food, such as a chicken's neck (*shingo*). Bi Bwatu (my host's sister-in-law) explained to me that there is no way of knowing if a particular child is likely to get *degedege* or not. Hence there is no known measure that parents can take to protect a child from getting the illness in the first place. Protection can be thought of only as a post facto intervention, that is, "after" the child has initially developed *degedege* and has survived the illness. One such practice entails the mother and her sister to make a small hole at the intersection of a road (a space that is believed to be liminal), and to cook some food on that spot. The *mganga* who is being consulted partakes in the process, takes the container in which the food has been cooked, and gives it to the child to eat and drink. Until these actions have been carried out, the child is still deemed vulnerable to a *degedege* attack. However, none of the people in Mbande with whom I queried about this practice mentioned that they had followed it at any time in their living memory.

12. A therapy management group (TMG) is comprised chiefly of the family members who piece together the picture of therapeutic process and decide the next step of action. The process of therapy management involves diagnosis and the negotiation of illness identities, the selection and evaluation of therapeutic options, and the lending of support to the afflicted (Janzen 1978; see also Nichter 2002).

13. In this particular case, it was Mzee Omary, and not his wife, who was the primary decision maker in matters related to children's health and the everyday management of household matters. This was an exceptional case. The cultural norm was for fathers to play a minimum role with regard to health matters. Mothers made most of the health-related decisions, especially when dealing with a child's sickness.

14. For a discussion on the interaction between malnutrition and children's vulnerability to malaria, see Caulfield, Richard, and Black (2004) and Dettwyler (1992).

15. Maitland and Marsh (2004) have discussed the spectrum of pathophysiological disorders associated with cerebral malaria, especially metabolic acidosis,

and subsequent death in young children in Africa. They observed that most children admitted to the hospital with severe malaria die within the first twenty-four hours. They conclude that the majority of the children die of complications of severe malaria before they can benefit from the full benefits of an effective antimalarial.

16. I was aware of Rehema's sister's therapy-seeking for her child. Importantly, on the day that she had taken her child to Mzee Pugu to deal with *degedege*, she had also brought her to the dispensary where she was given a chloroquine injection. I was able to extrapolate the details from the conversation I had with Rehema's sister that morning at the dispensary and also the photographs that I had taken of her sponging her child on the dispensary's verandah. One could, of course, argue that Rehema's sister's child had recovered from *degedege* not because of Mzee Pugu's intervention, but due to the delayed effect of the chloroquine that was injected into her body earlier during the day.

17. At this point, the emotions in the room were so charged that I decided it would be inappropriate of me to continue with the dialogue. Moreover, Rehema's mother had started stepping in and out of the room to check on what was going on and also to send me an indirect signal indicating that Rehema and her friends may want to be left alone. Later that afternoon, I met Rehema's *mchumba* outside in the marketplace. This was the first time I had seen him so we did not have much of a conversation. I said "*pole sana*" (very sorry for the loss) to him and he responded by saying "*bahati mbaya*" (bad luck) and went about his way.

18. One can only speculate why Rehema did not rush her child to a private health facility or the district hospital immediately following the *mganga*'s treatment. Her narrative does not suggest that she was either persuaded or dissuaded by members of her TMG to take Mburuane to a private health facility, or the district hospital. The circumstances surrounding Mburuane's death, then, raise a number of questions, especially whether or not the participation of a TMG in dealing with childhood illnesses necessarily leads to positive outcomes in terms of child survival. For example, in the context of Mali, West Africa, Adams, Madhavan, and Simon (2002:175) have argued that social networks might in fact exert a negative impact in circumstances when dangerous health advice is dispensed, and preventive action is discouraged by influential others. In the present case, on the one hand, the participation of the TMG, especially in the final hours of Mburuane's life, did lead to further delays. On the other hand, the community TMG had helped to absolve Rehema and the child's father of any direct responsibility for the child's death. This was made possible by the very public nature of the diagnosis and labeling of the illness—an illness for which no one can be held responsible. Thus, elderly women in the village with whom I subsequently conducted focus group discussions on the topic of *degedege*, indexed Rehema's personal tragedy to highlight their sentiments by stating, "What could she have done? It was just bad luck. It was all God's wish that she lost her child."

19. Nasla was among the first few women I became acquainted with in Mbande village. On one occasion, during the initial stages of my fieldwork, my research assistants and I were meandering through the village. We were lost and Nasla helped us find our way back to the main road. Nasla had a bright face and she looked at least five years younger than her actual age. She had little difficulty in letting out a hearty laugh, and it was also hard for her to stop laughing. In contrast, her husband Hassani was very quiet. He was conscientious and hard working, and he worked primarily as a

subsistence farmer. However, during the noncropping season, he sold *madafu* (tender coconut) in downtown Dar es Salaam, and earned about Tsh. 2,000 (about US$2.50) per day.

20. Marsh et al. (1999) have examined the role of private pharmacies in malaria control in the East African context, and concluded that there is a need for better supervision and monitoring of prescribing practices in private sector health facilities. Alongside, researchers have made a case to include private pharmaceutical dealers in control strategies and to provide health education through shopkeepers as a means to improve prompt effective treatment for malaria. Accordingly, the Tanzania Food and Drug Authority (TFDA) initiated a program to replace small private pharmacies with accredited drug dispensing outlets (ADDOs) (for details see Kachur et al. 2006). Chapter 8 in this book deals with the subject of pharmaceutical marketing in Tanzania in greater detail.

Chapter 6

1. A typical Swahili house in the Dar es Salaam region consists of a large structure with several single rooms, each occupied by a tenant on both sides of a long corridor. Occupants or tenants use the corridor as a public space to sit and chat, and also to prepare their meals over individual charcoal stoves. The mud walls of a Swahili house are usually thick, and the roofing is corrugated metal sheet.

2. At this point, I had lived in Mbande and had done more than sixteen months of fieldwork in the region. Therefore, this was not the first time I had encountered an incidence of gender-based violence. However, the visibility of the violence, and the very public display of verbal and physical aggression, had left me with a visceral experience of the kind of violence I had not previously experienced during fieldwork.

3. In much of sub-Saharan Africa, in both patrilineal and matrilineal societies, the male ideal is that of the breadwinner. This ideal defines men who can provide economically for their female partners and families and who earn their male authority through this practice (Groes-Green 2009:289; Silberschmidt 2001).

4. I was fully aware of the social stigma that is generally attached to women who are single mothers, including those who have been previously married, and young girls with illegitimate children, in the Tanzanian context (Lockhart 2005; Seppala 1998), and elsewhere in Africa (Calves 1999). Therefore, I first conducted a survey of 360 single mothers or *mama ambao wanaishi peke yao* (mothers who live on their own), with the help of two of my field assistants, who were also single mothers. They identified the single mothers mainly through their social network by asking a few single mothers if they knew of other single mothers in their social network. For the purpose of the survey, a single mother was defined as a woman who is currently living on her own, without a husband, a partner, or a boyfriend, continuously for at least one year prior to the interview, and with at least one child who is less than five years of age. The status of single mothers is often mutable. The methodological limitations of verifying the authenticity of the status of women as "single mothers" became evident in some of the everyday discourse that I documented during my fieldwork. For example, Husna Ali, one of my long-term key informants, explained to me, "the same woman who complains about men during the day time, will be sleeping with a man during the night!"

(*kumbe saa nyingine ana mtu pembeni anayemsaidia!*). Of the 360 mothers who participated in the preliminary survey, which involved asking only 12 basic background questions, every third mother in the list was selected for detailed interviews. Of these 120 mothers who were interviewed, 52 were from Mbande, 24 were from Kisewe village, another 24 were from Mwembebamia, and the remaining 20 were from Kiponza village. Additionally, I conducted two focus group discussions with the help of my research assistant with 12 (6 x 2) respondents, and one with 6 older women, mainly to get a historical perspective on the phenomenon of single mothers in the study area. All in-depth interviews were conducted in the individual life histories format.

5. In the Melanesian-Huli context, Wardlow (2006:14) has argued that "female agency is often atomistic rather than a collective activity. . . . This is not to say that women are never recognized as persuasive speakers, only that dominant discourses make it is easy for others to trivialize what women say."

6. In the Tanzanian context, for example, Lockhart has observed, "As a practice rooted in social and economic impoverishment, engendered power disparities, and the lack of choice, survival sex is both a form and consequence of everyday violence. The ways in which survival sex obscures the line between sexual practices and meanings and various forms of symbolic, sexual, and physical abuse give it a particular hegemonic quality" (2008:110).

7. Drawing on her research in Kenya and Tanzania, Silberschmidt (2001) has argued that the socioeconomic changes in rural and urban East Africa have brought in increasing economic hardship and these in turn have increasingly disempowered men and led to their lack of social value and self-esteem; with unemployment and lack of income earning opportunities and problems fulfilling social roles and expectations, male identity and self-esteem have become increasingly linked to sexuality and sexual manifestations—in their frustrating situations, multipartnered ("extramarital")—often casual sexual relations—have become essential for masculinity and self-esteem (Silberschmidt 2001:657).

8. Smith (2008:119) reports that 80 percent of the households among the wataita of Kenya that he surveyed in 1998 were either entirely headed by women or headed by women with men in absentia. This is indeed a striking statistic. While it has been suggested that young women in Africa sometimes use their sexuality and childbearing as a strategy to favor or accelerate transition to marriage, researchers have observed that this strategy often does not succeed or result in a marriage (Clark, Karibu, and Mathur 2010). Consequently, this strategy increases single mothers' burden to take care of their children and it also jeopardizes marriage opportunities in the long run (Hattori and Larsen 2007). Additionally, high mortality rates and health problems among children born out of wedlock are examples of increasingly visible health and socioeconomic risks associated with premarital pregnancies and births (Calves 1999:192).

9. In August 2010, there were more than a dozen bars and "guest houses" (bars with sleeping rooms attached) in the village. All of them served beers of different popular brands alongside the locally brewed gin (*gonga*) to hundreds of adults who live in Mbande and the neighboring villages, or who visit these villages.

10. Among sociolinguistic anthropologists in particular, it is well known that people do not ordinarily tell all that they have to tell about themselves to a listener all in one sitting; instead they often narrate aspects of their life history in "snippets at a time." In the telling of life histories, people tell stories often as a means to express their sense

of self, and these stories "are central to their ongoing efforts to create coherence out of their lives. As such, they are always being updated and revised" (Quinn 2005:42). And as Holly Wardlow reminds us, "one can read life history interviews not only as factual statements (once the facts asserted are cross-checked with others) about an actor's social efficacy, but also as social critiques and as examples of a particular narrative genre" (2006:90).

11. Kleinman (1997) has termed this process "the violence of everyday life."

12. Single mothers or female-headed households are often assumed to be worse off than two-parent households because, in lacking a "breadwinning" partner they are not only deprived of an adult male's earnings, but have relatively more dependents to support (Chant 2007:20).

13. This situation is not unique to Tanzania. Other anthropologists have documented similar scenarios in their ethnographic context. Foley, for example, notes in the Senegalese context that "men's selfish behaviour was a frequent topic of female conversation. " "They wait until they have some money, and then they go and marry a wife. . . . If men could have their way, they would just go and marry more wives. Cement and wives, that's it" (2010:120). In the Mozambican context, Groes-Green has argued that "massive unemployment caused by neoliberal reforms have led to a growing number of young men basing their authority vis-à-vis women on bodily powers, understood as abilities and physique of the male body, rather than on economic powers and social status" (2009:286). Groes-Green's representation of the Mozambican situation can also be applied to the Tanzanian context, where neoliberal reforms have hugely contributed to the widening gap between the well-to-do and the poor.

14. A number of scholars and anthropologists, particularly from the Chicago School have forcefully argued that the rise of the occult, witchcraft accusations, witch hunts, and the recent killings of albino men, women, and children in Tanzania, and the unacceptable trade in their body parts, can be directly attributed to the neoliberal ideology and "get rich quick" mentality that has taken over the desiring selves of ordinary Tanzanian citizens—with new types of social relationships and the concomitant increase in insecurity and anxiety (Comaroff and Comaroff 1999; Moore and Sanders 2001; Sanders 2001, 2008; Smith 2008).

15. Elsewhere I have elaborated on how the elderly in Mbande in particular engaged in nostalgic discourses regarding the past and condemned the breakdown of cultural norms in the present and increasing economic disparities (Kamat 2008).

16. Pfeiffer (2003, 2005) has documented similar scenarios in the Mozambique context, relating the implementation of structural adjustment programs to the changing local moral worlds and the rise of the Pentecostal churches and their role in the lives of poor women.

Chapter 7

1. Medical anthropologists who are critical of the biomedical approaches to the understanding of efficacy have argued that efficacy is embedded in culturally specific expectations of the healing process, and that it has biological and behavioral dimensions, both of which are equally important (Etkin 1988; Nichter 1992; Waldram 2000; Whyte, van der Geest, and Harton 2002). As van der Geest et al. note: "Medicines

can also have social efficacy—that is, effects of the relations between those enacting illness and treatment. These different forms of efficacy reinforce one another. Moreover, in real life efficacies are assessed not by pharmacologists but by social actors, who have their own criteria and expectations" (2002:23). Similarly, medical anthropologists who have focused their research on side effects, particularly those related to Western pharmaceuticals, have demonstrated that the identification and evaluation of pharmacotherapeutic side effects is unconsciously mediated by social and cultural constructs (Bledsoe and Goubaud 1988; Etkin 1992, 1994). Etkin (1994) also notes that in many contexts, a side effect is taken either as a sign to discontinue treatment, or at least to interrupt the therapy, or as therapy signs of disease egress—an indication that "the drug is working and the illness is on its way out." In this chapter, I focus on the subjective, perceived efficacy and side effects of SP and ACT as mothers of young febrile children articulated them through illness narratives.

2. After the policy change from CQ to SP as the first-line antimalarial in 2001, SP remained classified as prescription-only. The Tanzania Food and Drugs Authority did not reclassify SP as an over-the-counter drug. In parts of Tanzania, "while the change in malaria policy resulted in higher treatment efficacy, it also led to an almost 50 percent decrease in the availability of antimalarials" (Obrist et al. 2007:e308; see also Hetzel et al. 2006).

3. According to Tanzania's national malaria treatment guidelines, ACT is contraindicated for pregnant women especially during the first trimester

4. The objective of a malaria-drug policy is to minimize treatment failure, which is the result of a complex interaction of efficacy, treatment-seeking behavior, compliance, real and perceived side-effects, and cost (Bloland and Ettling 1999:11).

5. The situation was not very different in neighboring Kenya and Uganda. In Kenya, the process of changing drug policy was protracted due to confusion over how much evidence was required to change existing national recommendations (Shretta et al. 2000). In Uganda, CQ and SP were selected for first-line treatment of uncomplicated malaria despite limited information about this combination (Kamya et al. 2002).

6. Drug supply companies had invested in small vans to deliver chloroquine to a variety of vendors, with "CHLOROQUINE" painted on the side. Clearly, the drug supply system had a vested interest in maintaining the status quo and resisted the recommendation that chloroquine should be replaced as the first-choice treatment (Mbuyazi 2003:21).

7. The problems of incorrect prescription and dispensing practices and the inappropriate consumption of drugs, including the nonadherence of patients to the full therapeutic doses, are key factors that contribute to the acceleration and persistence of parasite resistance and ultimately to the larger numbers of malaria-specific mortalities (Yeung et al. 2004).

8. For discussions among malaria researchers and policy makers surrounding home management of malaria and "dispensing" antimalarials to mothers at the level of the household, see Kofoed et al. (2003); Nsungwa-Sahiiti et al. (2004); Pagnoni et al. (2005).

9. By 2009, hardly anyone invoked CQ in their conversations with me or during FGDs and interviews.

10. A small number of mothers who participated in FGDs and interviews were unable to comment on their experiences with SP in relation to ACT because they

were young mothers who had borne children after SP was discontinued as a first-line antimalarial and replaced with ACT.

11. In Kiswahili: *Mabadiliko ni mazuri kwa sababu malaria ni nyingi sana . . . afadhali kuugua ukimwi kuliko malaria kwa sababu malaria inauua watu wengi, hasa ni watoto, watoto wengi wana poteza maisha kwa sababu ya malaria*.

12. I learned through my key informants that both Mama Rehema and her husband were HIV positive, and they were both on ARVs. Mama Rehema did not reveal her HIV status, or that of her husband, in any of the conversations with me or Mariam, my research assistant. Sakina, who was Mama Rehema's immediate neighbor, mentioned to me that Mama Rehema's husband had made sexual advances toward her on a number of occasions, and she had threatened him with a police complaint if he did not back off. In November 2011, I learned that Mama Rehema's husband had forced Mama Rehema to go and live with her relatives in Rufiji, along with her children. In March 2012, however, her husband died (apparently he had discontinued taking ARVs), and Mama Rehema returned to Mbande with her children. When I met her in June 2012 and asked her how she was doing, she gave me a broad smile and said, "I'm doing well, I'll tell you all about it later." I did not get a chance to follow-up on her story, however.

Chapter 8

1. ACTs are classified as prescription-only medication. At the time of my research, they were available only through health facilities and Part I pharmacies.

2. In 2004 the Institute of Medicine recommended a global subsidy of ACTs as the best means to achieve high coverage and prolong the efficacy of these drugs (Arrow, Panosian, and Gelband 2004). It argued that reducing the exfactory price of ACTs to that of common alternatives (roughly $0.50) would ensure their widespread distribution through private channels and crowd out other drugs. This concept was further developed by the Roll Back Malaria Partnership and launched by the Board of the Global Fund in November 2008 as the Affordable Medicines Facility-malaria (AMFm) (Sabot et al. 2009a:e6857; see also Goodman et al. 2009; Cohen, Dupas, and Schaner 2010). Through a co-payment to certain accredited ACT manufacturers (e.g., Novartis), the program aims to reduce the price of ACTs by roughly 95 percent to first-line buyers, such as governments, NGOs, and wholesalers (Cohen, Dupas, and Schaner 2011:7). The AMFm's capacity to meet its goals has been extensively debated, including how the structure of the distribution chain and nature of competition at all levels will affect final prices. Skeptics are concerned that the subsidy will be captured by middle-men within the private commercial supply chain and informal unqualified profit-maximizing retailers (Kamal-Yanni 2010; Patouillard, Hanson, and Goodman 2010:12). The primary function of the AMFm is to provide a "copayment" directly to preselected manufacturers of ACTs in order to reduce the price to first-line buyers to approximately US$0.05. As a result of this copayment, it is expected that the price of ACTs will be comparable to that of other antimalarials, such as sulfadoxine-pyrimethamine, in the private sector, and free or low cost in the public sector (Roll Back Malaria 2009:8). See also http://www.rbm.who.int/.

3. Unsubsidized ACTs are commonly sold at retail prices that are 20 to 40 times those of other alternatives such as amodiaquine and sulfadoxine-pyrimethamine making them prohibitively expensive for 40–60 percent febrile individuals who seek treatment from retail pharmacies and drug shops (Cohen, Dupas, and Schaner 2010).

4. See Tren et al. (2011) for a trenchant critique of the AMFm program, particularly with regard to the unhealthy consequences of the distorted procurement and distribution of ACTs. Significantly, in November 2012, the Global Fund Board decided to integrate the AMFm into core Global Fund grant management and financial processes, following an orderly transition period in 2013.

5. The Tanzania Food, Drugs and Cosmetics Act established the Tanzania Food and Drugs Authority (TFDA) as an executive agency in 2003. Since then, the TFDA has been responsible for all regulatory aspects of drugs and other medicinal products in the country. The TFDA accredited the first ADDO in August 2003. By August 2005, more than 150 shops were accredited across the Ruvuma region and an evaluation of the pilot program showed significant improvements in accessing quality medicines and pharmacy services. In all twenty-one regions of Tanzania, there were only 1,400 pharmacists in both the public and private sectors. By January 2008, in just four regions, 895 ADDOs had been accredited and 1,800 ADDO dispensers had been trained and accredited, which illustrates the enormous potential of ADDOs to improve access to pharmaceutical care in the community (Rutta et al. 2009).

6. These new generations of RDTs for *Plasmodium falciparum* are potential tools for parasite-based diagnosis and treatment of malaria; these tests are believed to be accurate in detecting malaria infections and are easy to use. They require no electricity or specialized laboratory training (D'Acremont et al. 2009). RDTs are therefore seen as an important vehicle for achieving targeted malaria treatment (Albertini et al. 2012; Chandler et al. 2011). A small sample of blood is collected through a finger prick and placed on a testing cassette. The blood sample is exposed to a buffer solution, and the presence of malaria antibodies can be determined within approximately fifteen minutes. Nonclinical staff can easily learn to perform the test and interpret the results (Cohen, Dupas, and Schaner 2011:81 see also Masanja et al. 2010, 2011; McMorrow et al. 2008, 2010, 2011; WHO 2011).

7. Elsewhere I have argued that programs aimed at training retail pharmacists and shop attendants to sell drugs in line with national malaria treatment guidelines, and to serve the best interests of the larger community, however well-intentioned, cannot ignore the fact that retail pharmacies operate at the lower end of a complex global pharmaceutical nexus. Thus, an ethnographic analysis of programs such as ADDOs and the scaling-up of highly subsidized ACTs and RDTs through retail pharmacies calls for a critical examination of the relationship between the strategic business interests of the global pharmaceutical companies; the shifting national drug policies; the production, distribution, and marketing of pharmaceuticals at national and regional levels; and the patterns of medicine transaction, consumption, and interpretations at the local level—in short, the social lives of medicines (Kamat and Nyato 2010).

8. These field trials were carried out as part of the Interdisciplinary Monitoring Project for Antimalarial Combination Therapy in Tanzania (IMPACT-Tz), a multiyear implementation research evaluation project. IMPACT-Tz was a large-scale study intended to evaluate the implementation of ACT in Rufiji district where malaria transmission is intense. It involved a comparison of ACT implementation in Rufiji district

using SP plus artesunate with continued use of the national first-line drug, SP, in two adjacent districts. IMPACT-Tz was one of the first large-scale ACT evaluations in sub-Saharan Africa under real life conditions in which ACT was delivered through existing public health infrastructures with minimal alterations. It aimed to produce robust results, applicable in similar health-resource-constrained settings in rural sub-Saharan Africa (Njau et al. 2008:2). The project leaders concluded that they were unsure if artemisinin-containing combination therapy would actually reduce transmission or stall resistance in African settings. They did, however, posit that although it would be an expensive and ambitious undertaking to extend the ACT strategy where resources and infrastructure are badly constrained, it may still represent "the best hope for confronting the crisis facing malaria treatment in the region" (Kachur et al. 2004:721). Significantly, Kachur et al. (2006:446) noted that even under conditions where the new treatments involving ACTs were accessible and available free of charge as part of the intervention project, a substantial proportion of community members sought to seek care from drug stores where the ACTs were unavailable and artemisinin monotherapies largely unaffordable. This finding suggests that just because people had access to ACTs, free of charge, did not mean that they would readily opt for them; for a number of reasons they chose to buy conventional monotherapies such as SP from drug stores. The IMPACT-Tz project also revealed that the total cost of three years of ACT implementation in Rufiji district was about a million US$ and the nationwide costs of the first three years of ACT implementation were estimated to be about US$48 million (Njau et al. 2008:11).

9. In 2005 the Global Fund approved a grant of US$54.2 million to help Tanzania roll out ACTs over a two-year period to cover drug costs and supporting activities (Njau et al. 2008:11). Tanzania was one of the first three countries to be included in the U.S. President's Initiative on Malaria (see PIM—USAID 2011, available at http://www.pmi.gov/countries/mops/fy11/tanzania_mop-fy11.pdf).

10. From an epidemiological standpoint, there are a number of factors that influence the timing of drug policy change. These include studies showing molecular markers of resistance, in vitro parasite sensitivity, parasitological and clinical failure rates, and community morbidity and mortality rates (Hastings, Korenromp, and Bloland 2007:739). In practice, however, networks of global and national planners, scientists, industry representatives, activists, NGOs, and public and private donors influence policy making and implementation. And globalization processes that undermine the implementation of equity-oriented public health policies affect the policies. These processes include the increased privatization of health-care services and the implementation of liberalized trade policies that define medicines as commercial goods protected by intellectual property rights (Whyte, van der Geest, and Harton 2002:148).

11. In 2006, there were at least thirty-one artemisinin-containing compounds registered with the TFDA. Kachur et al. (2006) found that in Dar es Salaam, licensed pharmacies and drug stores were selling as many as nineteen different artemisinin-containing oral pharmaceutical products, including one coformulated product, one copackaged product, and seventeen monotherapies. Notably, all but one of the products were legally registered. The researchers were able to purchase samples of each product without a prescription.

12. For an excellent representation of the structure of the distribution chain, see Patouillard, Hanson, and Goodman (2010).

13. A number of researchers have expressed concern that lowering the price of ACTs with the goal of crowding out monotherapies is also likely to increase inappropriate treatment, wasting subsidy dollars and potentially contributing to drug resistance. It has been suggested that the problem of overuse of ACTs may be mitigated by providing access to a subsidized RDT for malaria in tandem with subsidized ACTs. However, in one pilot study, the researchers found that while access to ACT increased by 59 percent in the presence of an ACT subsidy of 80 percent or more, only 56 percent of those buying a subsidized ACT at the drug shop tested positive for malaria (Cohen, Dupas, and Schaner 2011:1, 3).

14. I conducted research among the pharmaceutical wholesalers in the Kariakoo area of Dar es Salaam, where more than twenty wholesale drug shops are nestled along the Kipata-Nyamwezi and Congo road. Alongside, detailed interviews were conducted with sixteen owners or managers of wholesale pharmaceutical shops and I questioned them on a range of issues, including their career trajectory. I also conducted interviews with the owners and managers of another sixteen Part I pharmacies, again focusing on questions about the pharmaceutical business in general and their opinions on the government's decision to introduce highly subsidized ACTs and RDTs through retail pharmacies.

15. There are eight pharmaceutical manufacturers in Tanzania. The largest pharmaceutical producer in Tanzania is Shelys Pharmaceuticals, which accounts for half the production.

16. Pharmaceutical products from India dominate the share of drugs in the local market registered by the TFDA. In 2008, most (53.4 percent) of the registered essential medicines were from India, followed by Kenya (10.3 percent). Only 10 percent of those registered were locally produced drugs (Mhamba and Mbirigenda 2010). See Chaudhuri (2008) for an excellent analysis of the trade in pharmaceuticals between India and Tanzania. There are fifty-three companies supplying drugs to Tanzania, each with twenty or more drugs registered. Of these, forty-one are generic companies and twelve are MNCs. The largest company in terms of products registered is the Indian generic company, Cipla, with 165 products registered.

17. Other researchers have noted that in Tanzania, when supplying regional wholesalers, importers added between 27 and 43 percent, while when directly supplying retailers they added between 50 and 67 percent (Patouillard, Hanson, and Goodman 2010).

18. In south-central Tanzania, Alba et al. (2010:9) found that the sales of SP remained very high in 2008 despite the change of treatment policy to ALu. In 2005, 64 percent of all antimalarial sales consisted of SP and in 2008 it still accounted for 51 percent of all antimalarial sales. ALu only accounted for 19 percent of total sales in 2008.

19. Duo-Cotexcin, which is made in China by Holley Pharma, was sold for 6,500 Tsh., Artefan, which is made in India by Ajanta Pharmaceuticals, was priced at 5,500 Tsh., and Artequik manufactured by Artepharm, Ltd. China, was sold for 5,000 Tsh. As such, the retail prices have actually come down over the last three or four years, but they are beyond the reach of most of the poor people in Tanzania (see also Ringsted et al. 2011).

20. To date, SP has been shown to remain effective among pregnant women in parts of sub-Saharan Africa, due to their substantial systemic immunity resulting from

repeated exposure in the past. Consequently, even in settings where resistance has been observed, SP continues to provide substantial benefit to pregnant women.

21. During my fieldwork in 2010 and 2011, I was unable to determine how common it was for pharmacists to recommend their own 'combination' therapy to their customers.

22. Following complaints from customers and independent investigations into fake Metakelfin, effective April 2008, the TFDA imposed a ban on this particular brand of antimalarial. The existence of poor quality, substandard, or fake antimalarials and drugs on the Tanzanian market has already been well documented (Whitty et al. 2008).

23. Until recently, ACT was contra-indicated during pregnancy by the national malaria treatment guidelines, and pregnant women depend on SP for IPTp (Ringsted et al. 2011).

24. In August 2011, I visited a number of retail pharmacies in the Dar es Salaam region to verify the availability of highly subsidized ACTs. I found that all pharmacies and drug shops that sold highly subsidized ACTs, manufactured by three Indian pharmaceutical companies, and carried the Global Fund logo, for Tsh. 1,000–2,000 per adult dose, also sold nonsubsidized ACTs such as Duo-Cotexcin for between Tsh. 10,000 and Tsh. 12,000. Some pharmacies also sold Halofantrine (chlorhydrate, brand name Halfan, SmithKline Beecham, France) for Tsh. 22,000.

25. Several medical anthropologists have provided ethnographic accounts of the tendency among people across the globe to seek out medicines and pharmaceuticals (among other commodities of desire) that originate or are believed to originate in places that are not just exotic,that is, geographically distant, but also culturally distant (see, for example, Nichter and Vuckovic 1994; Rekdal 1999; Luedke and West 2005; van der Geest and Whyte 1988; Whyte 1997).

26. The notification in Kiswahili read as follows:

> *Mpango wa ADDO ulilenga kuboresha upatikanaji wa dawa na huduma zitolewazo na maduka ya dawa baridi katika maeneo ya vijinini na miji midogo. Faida za mpango huu ni pamoja na kuboreshwa kwa utoaji wa huduma za dawa pamoja na ubora wa dawa zinazotolewa katika maduka hayo.*

27. In one of the best documented pilot studies undertaken to assess the impact of highly subsidized ACTs in rural Tanzania, the researchers found that fourteen months after the pilot study was implemented, the final survey revealed that some shops never stocked ACTs during the subsidy, and some customers did not buy ACTs when given the option. As many as 60 percent of the drug shops' antimalarials customers were still purchasing alternatives to the heavily subsidized, highly effective ACTs (see Cohen, Dupas, and Schaner 2010:2).

28. Similarly, it has been argued that RDTs are not yet a very effective means for reducing overtreatment. Cohen, Dupas, and Schaner (2011) report that regardless of their RDT test result, the majority of individuals in their sample went on to purchase an ACT dose.

29. As Cohen et al. (2011:27) have observed, although an RDT test provides a very useful signal as to whether or not to take an antimalarial, households faced with a negative test result may then face a great deal of uncertainty as to what illness they face and what medication choice is appropriate.

30. These efforts have afforded unprecedented access to lifesaving drugs. Yet some critics have argued that the focus of many new large-scale treatment initiatives has been narrowly conceptualized and is overly technology and commodity centered; that is, it is missing an understanding of local cultures and health systems and does not sufficiently promote prevention and much needed improvements in people's basic living conditions (Petryna 2009:193).

31. Joao Biehl has provided a trenchant critique of the extent to which Brazil's HIV/AIDS control program has become increasingly pharmaceuticalized and commodified. While making a comparison between the situation in Brazil and some of the African countries, Biehl notes that there have been some successes in controlling the spread of HIV/AIDS in Africa, through expensive technological innovations and interventions, made possible through public-private partnership. However, he notes that while public-private partnerships have proven somewhat effective in combating HIV/AIDS in select African countries, the sustainability of these partnerships is not guaranteed, particularly in the absence of more serious involvement by national governments and greater authority for international institutions to hold donors and partners accountable in the long term (Biehl 2007:86). Biehl's observations with regard to the pharmaceuticalization of the HIV/AIDS control programs are easily applicable to the Tanzanian context with regard to the extent to which the malaria control program has been pharmaceuticalized and medicalized.

32. As Packard has recently commented, "by focusing on malaria as a primary cause of Africa's underdevelopment, we are at risk of losing sight of factors such as the extremely high debt levels under which African countries attempt to maintain services and promote economic growth" (2009:80).

References

Adams, Vincanne, T. Novotny, and H. Leslie. 2008. "Global Health Diplomacy," editorial, *Medical Anthropology* 12(4):315–323.

Adams, A. M., S. Madhavan, and D. Simon. 2002. "Women's Social Network and Child Survival in Mali." *Social Science and Medicine* 54:165–178.

Adelson, Naomi. 2001. "Reimagining Aboriginality: An Indigenous People's Response to Social Suffering." In *Remaking a World: Violence, Social Suffering, and Recovery*, edited by Veena Das, Arthur Kleinman, Margaret Lock, Mamphela Ramphele, and Pamela Reynolds, 76–101. Berkeley: University of California Press.

Agyepong, Irene Akua. 2002. "Strategies to Improve Adherence to Recommended Chloroquine Treatment Regimes: A Quasi-experiment in the Context of Integrated Primary Health Care Delivery in Ghana." *Social Science and Medicine* 55:2215–2226.

Alba, Sandra, M. W. Hetzel, Catherine A. Goodman, A. Dillip, J. Liana, and Mshinda Hassan. 2010. "Improvements in Access to Malaria Treatment in Tanzania after Switch to Artemisinin Combination Therapy and the Introduction of Accredited Drug Dispensing Outlets—A Provider Perspective." *Malaria Journal* 9:164.

Albertini, A., D. Djalle, B. Faye, D. Gamboa, J. Luchavez, M. L. Mationg, G. Mwangoka, W. Oyibo, J. Bennett, S. Incardona, and E. Lee. 2012. "Preliminary Enquiry into the Availability, Price and Quality of Malaria Rapid Diagnostic Tests in the Private Health Sector of Six Malaria-Endemic Countries." *Tropical Medicine and International Health* February 17(2):147–152.

Allen, Denise Roth. 2002. *Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania*. Ann Arbor: Michigan University Press.

Amin, Abdinasir A., Dyfrig A. Hughes, Vicki Marsh, Timothy O. Abuya, Gilbert O. Kokwaro, Peter A. Winstanley, Sam A. Ochola, and Robert W. Snow. 2004. "The Difference Between Effectiveness and Efficacy of Antimalarial Drugs in Kenya." *Tropical Medicine and International Health* 9:967–974.

Appadurai, Arjun, ed. 1988. *The Social Life of Things: Commodities in Cultural Perspective*. Cambridge: Cambridge University Press.

Appiah-Kubi, Kojo. 2001. "Privatization in Ghana." *The Journal of Modern African Studies* 39(2):197–229.

Armelagos, George J., Peter J. Brown, and Bethany Turner. 2005. Evolutionary, Historical and Political Economic Perspectives on Health and Disease. *Social Science and Medicine* 61(4):755–765.

Armstrong Schellenberg, J., J. Bryce, D. de Savigny, T. Lambrecht, C. Mbuya, L. Mgalula, K. Wilczynska, and Tanzania IMCI Multi-Country Evaluation Health Facility Survey Study Group. 2004. "The Effect of Integrated Management of Childhood Illness on Observed Quality of Care of Under-fives in Rural Tanzania." *Health Policy and Planning* 19:1–10.

Arrow K., C. Panosian, and H. Gelband, eds. 2004. *Saving Lives, Buying Time: Economics of Malaria Drugs in an Age of Resistance*. Washington, DC: Institute of Medicine: National Academies Press.

Askew, Kelly M. 2002. *Performing the Nation: Swahili Music and Cultural Politics in Tanzania*. Chicago: University of Chicago Press.

———. 2006. "Sung and Unsung: Musical Reflections on Tanzanian Postsocialisms." *Africa* 76(1):15–43.

Atkinson, Sarah. 2002. Political Cultures, Health Systems and Health Policy. *Social Science and Medicine* 55:113–124.

Attaran, Amir, Karen I. Barnes, Christopher Curtis, Umberto d'Alessandro, Caterina I. Fanello, Mary R. Galinski, Gilbert Kokwaro, Sornchai Looareesuwan, Michae Makanga, Theonest K. Mutabingwa, Ambrose Talisuna, Jean Franncois Trape, and William M. Watkins. 2004. "WHO, the Global Fund, and Medical Practice in Malaria Treatment. *Lancet* 363:237–240.

Baer, Hans. 1996. "Toward a Political Ecology of Health in Medical Anthropology." *Medical Anthropology Quarterly* 10(4):451–454.

Baer, Hans, Merrill Singer, and John H. Johnsen. 1986. "Introduction Toward a Critical Medical Anthropology." *Social Science and Medicine* 23(2):95–98.

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

Bagachwa, M. S. D., and A. V. Y. Mbelle. 1993a. *Economic Policy Under a Multiparty System in Tanzania*. Dar es Salaam: Dar es Salaam University Press.

———. 1993b. "Introduction: The Global Context of Economic and Political Liberalization in Tanzania—An Overview." In *Economic Policy Under a Multiparty System in Tanzania*, edited by M. S. D. Bagachwa and A. V. Y. Mbelle, 7–16. Dar es Salaam: Dar es Salaam University Press.

Barat, L. M., N. Palmer, S. Basu, E. Worrall, K. Hanson, and A. Mills. 2004. "Do Malaria Control Interventions Reach the Poor? A View through the Equity Lens." *American Journal of Tropical Medicine and Hygiene* 71(August, suppl. 2):174–178.

Baregu, Mwesiga. 1987. "The Paradox of the Arusha Declaration." *African Review* 14(1–2):1–12.

———. 1993. The Economic Origins of Political Liberalization and Future Prospects. In *Economic Policy under a Multiparty System in Tanzania*, edited by M. S. D. Bagachwa and A. V. Y. Mbelle, 105–123. Dar es Salaam: Dar es Salaam University Press.

———. 1994. "The Rise and Fall of the One-Party State in Tanzania." In *Economic Change and Political Liberalization in Sub-Saharan Africa*, edited by J. A. Widner, 158–181. Baltimore, MD: The Johns Hopkins University Press.

Barkan, Joel D., ed. 1994. *Beyond Capitalism versus Socialism in Kenya and Tanzania*. Boulder, CO: Lynne Rienner.

Barke, M., and G. O'Hare. 1984. *The Third World: Diversity, Change and Interdependence*. Edinburgh: Oliver and Boyd.

Barker, Jonathan. 1979. "The Debate on Rural Socialism in Tanzania." In *Towards Socialism in Tanzania*, edited by Bismarck U. Mwanasasu and Cranford Pratt, 95–124. Toronto: University of Toronto Press.

Barnes, Karen I., and Nicholas J. White. 2005. "Population Biology and Antimalarial Resistance: The Transmission of Antimalarial Drug Resistance in *Plasmodium Falciparum*." *Acta Tropica* 94:230–240.

Bassett, Mary T., Leon A. Bijlmakers, and David M. Sanders. 2000. Experiencing Structural Adjustment in Urban and Rural Households of Zimbabwe. In *African Women's Health*, edited by Meredeth Turshen, 167–191. Trenton, NJ: Africa World Press.

Baume, Carol, Deborah Helitzer, and Patrick S. Kachur. 2000. "Patterns of Care for Childhood Malaria in Zambia." *Social Science and Medicine* 51:1491–1503.

Beattie, Allison, Jane Doherty, Lucy Gilson, Eyitayo Lambo, and Paul Shaw. 1996. *Sustainable Health Care Financing in Southern Africa: Papers from an EDI Health Policy Seminar Held in Johannesburg, South Africa, June 1996*. EDI learning resources series, World Bank Institute (WBI). Washington, DC: The World Bank and Washington, DC: Economic Development Institute of the World Bank.

Becker, Gaylene. 1997. *Disrupted Lives: How People Create Meaning in a Chaotic World*. Berkeley: University of California Press.

Beckerleg, Susan. 1994. "Medical Pluralism and Islam in Swahili Communities in Kenya." *Medical Anthropology Quarterly* 8(3):299–314.

Beckerleg, Susan, and Gillian Lewando Hundt. 2004. "Structural Violence in a Tourist Paradise." *Development* 47:109–114.

Beidelman, Thomas O. 1986. *Moral Imagination of Kaguru Modes of Thought*. Bloomington: Indiana University Press. Republished Smithsonian Institution Press, Washington, DC.

Bell, David, and Peter Winstanley. 2004. "Current Issues in the Treatment of Uncomplicated Malaria in Africa." *British Medical Bulletin* 71:29–43.

Bennell, Paul. 1997. "Privatization in Sub-Saharan Africa: Progress and Prospects During the 1990s." *World Development* 25(11):1785–1803.

Bennett, Sara, Barbara McPhake, and Anne Mills. 1997. "Introduction." In *Private Health Providers in Developing Countries: Serving the Public Interest?*, edited by Bennett Sara, Barbara McPhake, and Anne Mills, 1–18. London: Zed.

Berman, Peter, ed. 1995. *Health Sector Reform in Developing Countries: Making Health Development Sustainable*. Cambridge, MA: Harvard University Press.

Biehl, Joao. 2005. *VITA: Life in a Zone of Social Abandonment*. Berkeley: University of California Press.

———. 2006. "Pharmaceutical Governance." In *Global Pharmaceuticals: Ethics, Markets, Practices*, edited by Adriana Petryna, Andrew Lakoff, and Arthur Kleinman, 208–239. Durham, NC: Duke University Press.

———. 2007. *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton: Princeton University Press.

Biermann, Werner, and Jumanne Wagao. 1986. "The Quest for Adjustment: Tanzania and the IMF, 1980–1986." *African Studies Review* 29(4):89–103.

Bigsten, Arne, and Anders Danielson. 2001. *Tanzania: Is the Ugly Duckling Finally Growing Up?* Uppsala: Nordic Africa Institute.

Bishop, Matthew, and Michael Green. 2008. *Philanthro-capitalism: How Giving Can Save the World*. London: A&C Black.

Bissell, Willliam Cunningham. 2005. "Engaging Colonial Nostalgia." *Cultural Anthropology* 20(2):215–248.

Bledsoe, Caroline H., and Barney Cohen. 1993. *Social Dynamics of Adolescent Fertility in Sub-Saharan Africa*. Washington, DC: National Academy Press.

Bledsoe, Caroline H., and Monica F. Goubaud. 1988. "The Reinterpretation and Distribution of Western Pharmaceuticals: An Example from the Mende of Sierra Leone." In *The Context of Medicines in Developing Countries*, edited by Sjaak van der Geest and Susan R. Whyte, 253–276. Dordrecht: Kluwer Academic Publishers.

Bloland, Peter B. 2003. "A Contrarian View of Malaria Therapy Policy in Africa." *American Journal of Tropical Medicine and Hygiene* 68(2):125–126.

Bloland, Peter B., and Mary Ettling. 1999. "Making Malaria-treatment Policy in the Face of Drug Resistance." *Annals of Tropical Medicine and Parasitology* 93(1):5–23.

Bloland, Peter B., Mary Ettling, and Sylvia Meek. 2000. "Combination Therapy for Malaria in Africa: Hype of Hope?" *Bulletin of the World Health Organization* 78(12):1378–1388.

Boesen, Jannik. 1979. "Tanzania: From Ujamaa to Villagization." In *Towards Socialism in Tanzania*, edited by Bismarck U. Mwanasasu and Cranford Pratt, 125–144. Toronto: University of Toronto Press.

Boesen, Jannik., K. J. Havnevik, J. Koponen, and R. Odgaard. 1986. *Tanzania: Crisis and Struggle for Survival*. Uppsala: Scandinavian Institute of African Studies.

Bosman, A., and K. N. Mendis. 2007. "A Major Transition in Malaria Treatment: The Adoption and Deployment of Artemisinin-Based Combination Therapies." *American Journal of Tropical Medicine and Hygiene* 977(suppl. 6):193–197.

Bourdieu, Pierre. 1990. *The Logic of Practice*. Stanford: Stanford University Press.

———. 1999. *The Weight of the World: Social Suffering in Contemporary Society*. Cambridge: Polity.

Bourgois, Philippe. 2001. "The Power of Violence in War and Peace. Post–Cold War Lessons from El Salvadore." *Ethnography* 2(1):5–37.

Breman, Joel G., Martin S. Alilio, and Anne Mills. 2004. "Conquering the Intolerable Burden of Malaria: What's New, What's Needed: A Summary." *American Journal of Tropical Medicine and Hygiene* 71(2):1–15.

Briggs, L. Charles, with Clara Mantini-Briggs. 2003. *Stories in the Time of Cholera: Racial Profiling During a Medical Nightmare*. Berkeley: University of California Press.

Briggs, L. Charles, and Mark Nichter. 2009. "Biocommunicability and the Biopolitics of Pandemic Threats." *Medical Anthropology* 3 (July 28):189–198.

Brodwin, Paul E. 1997. "Politics, Practical Logic, and Primary Health Care in Rural Haiti. *Medical Anthropology Quarterly* 11:69–88.

Brown, Peter J. 1997. "Culture and the Global Resurgence of Malaria." In *The Anthropology of Infectious Disease*, edited by Marcia Inhorn and Peter J. Brown, 119–141. Amsterdam: Gordon and Breach Science.

Bryceson, Deborah F. 1993. *Liberalizing Tanzania's Food Trade*. London: UNRISD.

Burawoy, Michael. 2000. *Global Ethnography: Forces, Connections, and Imaginations in a Postmodern World*. Berkeley: University of California Press.

Burawoy, Michael, and Katherine Verdery, eds. 1999. *Ethnographies of Change in the Postsocialist World*. Lanham, MD: Rowman and Littlefield.

Calves, Anne-Emmanuele. 1999. "Marginalization of African Single Mothers in the Marriage Market: Evidence from Cameroon." *Population Studies* 53:291–301.

———. 2002. "Abortion Risk and Decision Making Among Young People in Urban Cameroon." *Studies in Family Planning* 33:249–60

Caldas de Castro, Marcia, Yoichi Yamagata, Deo Mtasiwa, Marcel Tanner, Jurg Utzinger, Jennifer Keiser, and Burton H. Singer. 2004. "Integrated Urban Malaria Control: A Case Study in Dar es Salaam, Tanzania." *American Journal of Tropical Medicine and Hygiene* 71(suppl. 2):103–117.

Campbell, J., Joachim Mwami, and Mary Ntukula. 1995. "Urban Social Organization: An Exploration of Kinship, Social Networks, Gender Relations and Household and Community in Dar es Salaam." In *Gender, Family and Household in Tanzania*, edited by Colin Creighton and C. K. Omary, 221–252. Aldershot: Avebury.

Castle, Sarah. E. 1994. "The (Re)negotiation of Illness Diagnosis and Responsibility for Child Death in Rural Mali." *Medical Anthropology Quarterly* 8(3):314–335.

Castro, Arachu, and Merill Singer. 2004. *Unhealthy Health Policy: A Critical Anthropological Examination*. New York: Altamira Press.

Caulfield, Laura E., Stephanie A. Richard, and Robert E. Black. 2004. "Undernutrition as an Underlying Cause of Malaria Morbidity and Mortality in Children Less Than Five Years Old." *American Journal of Tropical Medicine and Hygiene* 71(2):55–63.

Chandler, Clare I. R., R. Hall-Clifford, T. Asaph, M. Pascal, S. Clarke, and A. K. Mbonye. 2011. "Introducing Malaria Rapid Diagnostic Tests at Registered Drug Shops in Uganda: Limitations of Diagnostic Testing in the Reality of Diagnosis." *Social Science and Medicine* 72(6):937–944.

Chandler, Clare I. R., C. Jones, G. Boniface, K. Juma, H. Reyburn, and C. J. Whitty. 2008. "Guidelines and Mindlines: Why do Clinical Staff Over-Diagnose Malaria in Tanzania? A Qualitative Study." *Malaria Journal* 7:53.

Chandler, Clare I. R., R. Mwangi, H. Mbakilwa, R. Olomi, C. J. Whitty, and H. Reyburn. 2008. "Malaria Overdiagnosis: Is Patient Pressure the Problem?" *Health Policy and Planning* 23(3):170–178.

Chandler, Clare I. R., Christopher J. M. Whitty, and Evelyn K. Ansah. 2010. "How Can Malaria Rapid Diagnostic Tests Achieve Their Potential? A Qualitative Study of a Trial at Health Facilities in Ghana." *Malaria Journal* 9:95

Chandramohan, Daniel, Shabbar Jaffar, and Brian Greenwood. 2002. "Use of Clinical Algorithms for Diagnosing Malaria." *Tropical Medicine and International Health* 7(1):45–52.

Chant, Silvia. 2007. "Dangerous Equations? How Female-headed Households Became the Poorest of the Poor: Causes, Consequences and Cautions." In *Feminisms in Development: Contradictions, Contestations and Challenges*, edited by A. Cornwall, E. Harrison, and A. Whitehead, 35–47. London: Zed.

Chapman, Rachel. 2011. *Family Secrets: Risking Reproduction in Central Mozambique*. Nashville, TN: Vanderbilt University Press.

Charlwood, Derek J. 2004. "Roll Back Malaria: A Failing Global Health Challenge: Developing a Market for Bed Nets and Insecticides Is Problematic." *British Medical Journal* 328(7452):1378

Chaudhuri, Sujit. 2008. Indian Generic Companies, Affordability of Drugs and Local Production in Africa with Special Reference to Tanzania. IKD Working paper no. 37. Open University Research Centre on Innovation Knowledge and Development.

Chima, Reginald Ikechukwu, Catherine A. Goodman, and Anne Mills. 2003. "The Economic Impact of Malaria in Africa: A Critical Review of the Evidence." *Health Policy* 63(1):17–36.

Clark, Shelley, Caroline Karibu, and Rohini Mathur. 2010. "Relationship Transitions Among Youth in Urban Kenya." *Journal of Marriage and Family* 72 (February):73–88.

Cleaver, F. 2002. "Men and Masculinities: New Directions in Gender and Development." In *Masculinities Matter! Men, Gender and Development*, edited by F. Cleaver, 1–27. London: Zed.

Clifford, James. 1997. "Spatial Practices: Fieldwork, Travel, and the Disciplining of Anthropology." In *Anthropological Locations: Boundaries and Grounds of a Field Science*, edited by Akhil Gupta and James Ferguson, 185–222. Berkeley: University of California Press.

Clinton Foundation and Government of Tanzania. 2008. *Tanzania Pilot ACT Subsidy. Report on Findings*. New York: Clinton Foundation.

Cohen, Jessica L., and William T. Dickens. 2012. "Adoption of Over-the-Counter Malaria Diagnostics in Africa: The Role of Subsidies, Beliefs, Externalities, and Competition." In *The Value of Information: Methodological Frontiers and New Applications in Environment and Health*, edited by Ramanan Laxminarayan and Molly K. Macauley. 173–191. Dordrecht, Springer.

Cohen, Jessica, and P. Dupas. 2010. "Free Distribution or Cost-Sharing? Evidence from a Randomized Malaria Prevention Experiment." *The Quarterly Journal of Economic* 125:1–45.

Cohen, Jessica, P. Dupas, and S. Schaner. 2010. "Prices, Diagnostic Tests and the Demand for Malaria Treatment: Evidence from a Randomized Trial." Working paper, Harvard University, Cambridge, MA.

———. 2011. Information, Peers, and Treatment-Seeking Behavior: Experimental Evidence from Rural Kenya. Mimeo.

Collier, Stephen J., and Andrew Lakoff. 2005. "Regimes of Living. In *Global Assemblages: Technology, Politics, and Ethics as an Anthropological Problem*, edited by A. Ong and S. J. Collier, 2–39. Malden, MA: Blackwell.

Comaroff, Jean L., and John L. Comaroff. 1999. "Occult Economies and the Violence of Abstraction: Notes from the South African Postcolony." *American Ethnologist* 26(2):279–303.

———. 2001. *Millennial Capitalism and the Culture of Neoliberalism*. Durham, NC: Duke University Press.

Comoro, C., S. E. D. Nsimba, M. Warsame, and G. Tomson. 2003. "Local Understanding, Perceptions and Reported Practices of Mothers/Guardians and Health Workers on Childhood Malaria in a Tanzanian District—Implications for Malaria Control." *Acta Tropica* 87:305–313.

Conteh, L., W. Stevens, and V. Wiseman. 2007. "The Role of Communication Between Clients and Health Care Providers: Implications for Adherence to Malaria Treatment in Rural Gambia." *Tropical Medicine and International Health* 12(3):382–391.

Coulson, Andrew. 1982. *Tanzania: A Political Economy*. Oxford: Clarendon Press.

Crawley, Jane. 2004. "Reducing the Burden of Anemia in Infants and Young Children in Malaria-Endemic Countries of Africa: From Evidence to Action." *American Journal of Tropical Medicine and Hygiene* 71(August, suppl. 2):25–34.

Creese, Andrew. 1997. "User Fees: They Don't Reduce Costs, and They Increase Inequity." *British Medical Journal* 315:202–203.

D'Acremont, V., C. Lengeler, H. Mshinda, D. Mtasiwa, M. Tanner, et al. 2009. "Time to Move from Presumptive Malaria Treatment to Laboratory-Confirmed Diagnosis and Treatment in African Children with Fever." *PLoS Medicine* 6(1): e252.

Das, Pam, and Richard Horton. 2010. "Malaria Elimination: Worthy, Challenging, and Just Possible." *Lancet* 376(9752):1515–1517, November 6. doi:10.1016/S0140–6736(10)61551–6.

Das, Veena. 2001. *Remaking a World: Violence, Social Suffering, and Recovery*. Berkeley: University of California Press.

de Savigny, Don, Charles Mayombana, Eleuther Mwangeni, Honorati Masanja, Abdulatif Minhaj, Yahya Mkilindi, Conrad Mbuya, Harun Kasale, and Graham Reid. 2004. "Care-seeking Patterns for Fatal Malaria in Tanzania." *Malaria Journal* 3(27):1–15.

De Souza, Terra A. C., K. E. Peterson, F. M. O. Andrade, J. Gardner, and A. Ascherio. 2000. "Circumstances of Post-Neonatal Deaths in Ceara, Northeast Brazil: Mothers' Health Care-Seeking Behaviors during Their Infants' Fatal Illness." *Social Science and Medicine* 51:1675–1693.

Deen, Jacqueline L., Lorenz von Seidlein, and Arjen Dondorp. 2008. "Therapy of Uncomplicated Malaria in Children: A Review of Treatment Principles, Essential Drugs and Current Recommendations." *Tropical Medicine and International Health* 13(9):1111–1130.

Desowitz, Robert S. 1991. *The Malaria Capers: Tales of Parasites and People*. New York: W. W. Norton.

Dettwyler, Katherine. 1992. *Dancing Skeletons: Life and Death in West Africa*. Long Grove, IL: Waveland Press.

Dilger, Hansjorg. 2003. "Sexuality, AIDS, and the Lures of Modernity: Reflexivity and Morality among Young People in Rural Tanzania." *Medical Anthropology* 22:23–52.

Dillip, Angel, Manuel W. Hetzel, Dominic Gosoniu, Flora Kessy, Christian Lengeler, Iddy Mayumana, Christopher Mshana, Hassan Mshinda, Alexander Schulze, Ahmed Makemba, Constanze Pfeiffer, Mitchell G Weiss and Brigit Obrist. 2009. "Socio-Cultural Factors Explaining Timely and Appropriate Use of Health Facilities for *Degedege* in South-Eastern Tanzania." *Malaria Journal* 8:144. doi:10.1186/1475–2875–8–1442009.

Dobson, Mary J., Maureen Malowany, and Robert W. Snow. 2000. "Malaria Control in East Africa: The Kampala Conference and the Pare-Taveta Scheme: A Meeting of Common and High Ground." *Parassitologia* 42(1–2):149–166.

Dondorp, Arjen M., S. Y., Lisa White, Chea Nguon, Nicholas P. J. Day, Duong Socheat, and Lorenz von Seidlein. 2010. "Artemisinin Resistance: Current Status and Scenarios for Containment." *Nature Reviews in Microbiology* 8:272–280.

Dondorp, A. M., F. Nosten, P. Yi, D. Das, A. P. Phyo, J. Tarning, K. M. Lwin, F. Ariey, W. Hanpithakpong, S. J. Lee, P. Ringwald, K. Silamut, M. Imwong, K. Chotivanich, P. Lim, T. Herdman, S. S. An, S. Yeung, P. Singhasivanon, N. P. Day,

N. Lindegardh, D. Socheat, and N. J. White. 2009. "Artemisinin Resistance in *Plasmodium falciparum* Malaria." *New England Journal of Medicine* 36:455–467.

Due, Jean M. 1993. "Liberalization and Privatization in Tanzania and Zambia." *World Development* 21(12):1981–1988.

Due, Jean M., and Christina H. Gladwin. 1991. "Impacts of Structural Adjustment Programs on African Women Farmers and Female-headed households." *American Journal of Agricultural Economics* 73:1431–1439

Dumit, Joseph. 2012. *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Durham, NC: Duke University Press.

Duranti, Alessandro, and Charles Goodwin. 1992. *Rethinking Context: Language as an Interactive Phenomenon*. Cambridge: Cambridge University Press.

Durrheim, David N., Holly Ann Williams, Karen Barnes, Richard Speare, and Brian L. Sharp. 2003. "Beyond evidence: a retrospective study of factors influencing a malaria treatment policy change in two South African Provinces." *Critical Public Health* 13(4):309–330.

Durrheim, D. N., and H. A. Williams. 2006. "Assuring Effective Malaria Treatment in Africa: Drug Efficacy Is Necessary but Not Sufficient." *Journal of Epidemiology and Community Health* 59(3):178–179.

Dzimbiri, L., S. Ngware, and R. M. Ocharo, eds. 2000. *Multipartism and People's Participation*. Dar es Salaam: Tema.

Ellis, Frank, and Mdoe Ntengua. 2003. "Livelihoods and Rural Poverty Reduction in Tanzania." *World Development* 31(8):1367–1384.

English, M., H. Reyburn, C. Goodman, and R. W. Snow. 2009. "Abandoning Presumptive Antimalarial Treatment for Febrile Children Aged Less Than Five Years—A Case of Running Before We Can Walk?" *PLoS Medicine* 6(1): e1000015. doi:10.1371/journal.pmed.

Eriksen, J., S. E. D. Nsimba, O. M. S. Minzi, A. J. Sanga, M. Petzold, L. L. Gustafsson, M. Y. Warsame, and G. Thomson. 2005. "Adoption of the New Antimalarial Drug Policy in Tanzania—A Cross-sectional Study in the Community." *Tropical Medicine and International Health* 10(10):1038–1046.

Etkin, Nina L. 1988. "Cultural Constructions of Efficacy." In *The Context of Medicines in Developing Countries*, edited by Sjaak van der Geest and Susan Reynolds Whyte, 299–326. Holland: Kluwer.

———. 1992. "Side Effects: Cultural Constructions and Reinterpretations of Western Pharmaceuticals." *Medical Anthropology Quarterly* 6(2):99–113.

———. 1994. "The Negotiation of "Side" Effects in Hausa (Northern Nigeria) Therapeutics." In *Medicines: Meanings and Context*, edited by Nina L. Etkin and Michael L. Tan, 17–32. Amsterdam: University of Amsterdam Press.

Farmer, Paul. 1992. *AIDS and Accusations. Haiti and the Geography of Blame*. Berkeley: University of California Press.

Farmer, Paul. 1997. "On Suffering and Structural Violence: A View from Below." In *Social Suffering*, edited by Arthur Kleinman, Veena Das, and Margaret M. Lock, 261–283. Berkeley: University of California Press.

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

———. 2003. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press.

———. 2004. "The Anthropology of Structural Violence." *Current Anthropology* 45(3):305–325.

Fatoumata, Nafo-Traore. 2004. "Response to Accusations of Medical Malpractice by WHO and the Global Fund." *Lancet* 363:397.

Favre, E. M., and G. Barnish. 1999. "Malaria-Treatment Policies: When and How Should They be Changed?" *Annals of Tropical Medicine and Parasitology* 93:549–60.

Feachem, Richard, Allison A. Phillips, Geoffrey A. Targett, and Robert W. Snow. 2010. "Call to Action: Priorities for Malaria Elimination." *Lancet* 376(9758):1517–1521.

Feachem, Richard, and the Malaria Elimination Group. 2009. *Shrinking the Malaria Map: A Guide on Malaria Elimination for Policy Makers*. San Francisco, The Global Health Group, Global Health Sciences, University of California, San Francisco.

Feachem, Richard, and Oliver Sabot. 2008. "A New Global Malaria Eradication Strategy." *Lancet* 371(9624):1633–1635.

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

Feierman, Steven, and John M. Janzen. 1992. *The Social Basis of Health and Healing in Africa*. Berkeley: University of California Press.

Ferguson, James. 2006. *Global Shadows: Africa in the Neoliberal World Order*. Durham, NC: Duke University Press.

Finerman, Ruthbeth. 1994. "'Parental Incompetence' and 'Selective Neglect': Blaming the Victim in Child Survival." *Social Science and Medicine* 40(1):5–13.

Fogg, Carole, Francis Bajunirwe, Patrice Piola, Samuel Biraro, Francesco Checchi, James Kiguli, Proscovia Namiiro, Joy Musabe, Agnes Kyomugisha, and Jean-Paul Guthmann. 2004. "Adherence to a Six-dose Regimen of Artemether-lumefantrine for Treatment of Uncomplicated *Plasmodium falciparum* Malaria in Uganda." *American Journal of Tropical Medicine and Hygiene* 71(5):525–530.

Foley, Ellen E. 2010. *Your Pocket Is What Cures You: The Politics of Health in Senegal*. Brunswick, NJ: Rutgers University Press.

Font, F. M., Alonso Gonzalez, R. Nathan, et al. 2001. "Diagnostic Accuracy and Case Management of Clinical Malaria in the Primary Health Services of a Rural Area in South-Eastern Tanzania." *Tropical Medicine and International Health* 6(6):423–428.

Freyhold, Michaela Von. 1979. *Ujamaa Villages in Tanzania*. New York: *Monthly Review Press*.

Frost, Liz, and Paul Hoggett. 2008. "Human Agency and Social Suffering." *Critical Social Policy*, 28:438–460.

Gage-Brandon, A., and D. Meekers. 1993. "Sex, Contraception and Childbearing before Marriage in Sub-Saharan Africa." *International Family Planning Perspectives* 19:14–8.

Galtung, Johan. 1969. "Violence, Peace, Peace Research." *Journal of Peace Research* 6:167–191.

Garro, Linda C. 2000. "Remembering What One Knows and the Construction of the Past: A Comparison of Cultural Consensus Theory and Cultural Schema Theory." *Ethos* 28(3):275–319.

Garro, Linda C., and Cheryl Mattingly. 2000. "Narrative as Construct and as Construction." In *Narrative and the Cultural Construction of Illness and Healing*, edited by Cheryl Mattingly and Linda C. Garro, 1–49. Berkeley: University of California Press.

Gilson, Lucy. 1995. "Management and Health Care Reform in Sub-Saharan Africa." *Social Science and Medicine* 40:707.

———. 1997. "The lessons of User Fees Experience in Africa." *Health Policy and Planning* 12(4):273–285.

———. 1998. "Discussion: In Defense and Pursuit of Equity." *Social Science and Medicine* 47(12):1891–1896.

Gilson, Lucy, and Anne Mills. 1995. "Health Sector Reforms in Sub-Saharan Africa: Lessons of the Last Ten Years." *Health Policy and Planning* 32:215–243.

Gilson, L., S. Russell, and K. Buse. 1995. "The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy." *Journal of International Development* 7(3): 369–402.

Good, Byron J. 1994. *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.

Goodman, Catherine S. Patrick Kachur, Salim Abdulla, Eleuther Mwageni, Joyce Nyoni, Joanna A. Schellenberg, A. Mills, and P. Bloland. 2004. "Retail Supply of Malaria-Related Drugs in Rural Tanzania: Risks and Opportunities." *Tropical Medicine and International Health*. 9(6): 655–663.

Goodman, Catherine, P. Kachur, S. Abdulla, P. Bloland, and A. Mills. 2007. "Drug Shop Regulation and Malaria Treatment in Tanzania—Why Do Shops Break the Rules, and Does It Matter?" *Health Policy and Planning* 22(6):393–403.

———. 2009. "Concentration and Drug Prices in the Retail Market for Malaria Treatment in Rural Tanzania." *Health Economics* 18:727–742.

Government of Tanzania. President's Malaria Initiative. 2009. Malaria Operational Plan for Tanzania. Available at http://pmi.gov/countries/mops/fy10/tanzania_mop-fy10.pdf

Green, Linda. 1998. "Lived Lives and Social Suffering: Problems and Concerns in Medical Anthropology." *Medical Anthropology Quarterly* 12(1):3–7

Green, Maia. 2006. "Presenting Poverty, Attacking Representations: Anthropological Perspectives on Poverty in Development." *Journal of Development Studies* 42(7):1108–1129.

Greenwood, B. M., A. K. Bradley, A. M. Greenwood, O. Byass, K. Hammeh, K. Marsh, S. Tulloch, F. S. Oldfield, and R. Hayes. 1987. "Mortality and Morbidity from Malaria among Children in a Rural Area of the Gambia, West Africa." *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 81(3):478–486

Groes-Green, Christian. 2009. "Hegemonic and Subordinated Masculinities: Class, Violence and Sexual Performance Among Young Mozambican Men." *Nordic Journal of African Studies* 18:286–304.

Gupta, Akhil, and James Ferguson. 1997. "Discipline and Practice: 'The Field' as Site, Method and Location in Anthropology." In *Anthropological Locations: Boundaries and Grounds of a Field Science*, edited by Akhil Gupta and James Ferguson, 1–46. Berkeley: University of California Press.

Gysels, Marjolein, Robert Pool, and Betty Nnalusiba. 2002. "Women Who Sell Sex in a Ugandan Trading Town: Life Histories, Survival Strategies and Risk." *Social Science and Medicine* 54(2):179–192.

Haram, Liv. 2005. "'Eyes Have No Curtains': The Moral Economy of Secrecy in Managing Love Affairs among Adolescents in Northern Tanzania in the Time of AIDS." *Africa Today* 51:57–73.

Harrington, John A. 1999. "Between the State and Civil Society: Medical Discipline in Tanzania." *Journal of Modern African Studies* 37(2):207–239.

Harvey, David. 2005. *A Brief History of Neoliberalism.* New York: Oxford University Press.

Hastings, Ian, Eline Korenromp, and Peter Bloland. 2007. "The Anatomy of a Malaria Disaster. Drug Policy Choice and Mortality in African Children." *The Lancet Infectious Diseases* 7:739–748.

Hausmann-Muela, Susanne, Joan Muela Ribera, Adiel K. Mushi, and Marcel Tanner. 2002. "Medical Syncretism With Reference to Malaria in a Tanzanian Community." *Social Science and Medicine* 55:403–413.

Hausmann-Muela, Susanne, Joan Muela Ribera. 2003. "Recipe Knowledge: a Tool for Understanding Some Apparently Irrational Behaviour." *Anthropology and Medicine* 10(1):87–105.

Hausmann-Muela, Susanne, Joan Muela Ribera, and Marcel Tanner. 1998. "Fake Malaria and Hidden Parasites—The Ambiguity of Malaria." *Anthropology and Medicine* 5(1):43–61.

Helitzer-Allen, D. L., Carl Kendall, and J. J. Wirima. 1993. "The Role of Ethnographic Research in Malaria Control: An Example from Malawi." *Research in the Sociology of Health Care* 10:269–286.

Hetzel, M. W., A. Dilip, C. Langeler, B. Obrist, J. Msechu, A. Makemba, C. Mshana, A. Schulze, and H. Mshinda. 2008. "Malaria Treatment in the Retail Sector: Knowledge and Practices of Drug Sellers in Rural Tanzania." *BMC Public Health* 8:157.

Hetzel, M. W., N. Iteba, A. Makemba, et al. 2007. "Understanding and Improving Access to Prompt and Effective Malaria Treatment and Care in Rural Tanzania: The ACCESS Programme." *Malaria Journal* 6:83.

Hetzel, M. W, J. Msechu, C. Goodman, L. Langeler, B. Obrist, S. P. Kachur, A. Makemba, R. Nathan, A. Schulze, and H. Mshinda. 2006. "Decreased Availability of Antimalarials in the Private Sector Following the Policy Change from Chloroquine to Sulphadoxine-Pyrimethamine in the Kilombero Valley, Tanzania." *Malaria Journal* 5:109.

Ho, Kathleen. 2007. "Structural Violence as a Human Rights Violation." *Essex Human Rights Review* 4:1–17.

Hood, Michael. 1988. *Tanzania after Nyerere*. London: Pinter.

Hsu, Elisabeth. 2002. "'The Medicine from China Has Rapid Effects': Chinese Medicine Patients in Tanzania, Countervailing Creativity: Patient Agency in the Globalisation of Asian Medicines." *Anthropology and Medicine*, Special Issue 9(3):291–314.

Hunt, Linda M. 2000. "Strategic Suffering: Illness Narratives as Social Empowerment among Mexican Cancer Patients." In *Narrative and the Cultural Construction of Illness and Healing*, edited by Cheryl Mattingly and Linda C. Garro, 88–107. Berkeley: University of California Press.

Hydén, Goran. 1980. *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*. Berkeley: University of California Press.

———. 1999. "Top-Down Democratization in Tanzania." *Journal of Democracy* 4:142–155.

Hydén, Goran, and Bo Karlstrom. 1993. "Structural Adjustment as a Policy Process: The Case of Tanzania." *World Development* 21(9):1395–1404.

Iliffe, John. 1979. *A Modern History of Tanganyika*. Cambridge: Cambridge University Press.

———. 1998. *East African Doctors: A History of the Modern Profession*. Cambridge: Cambridge University Press.

Janes, Craig R. 2004. "Going Global in Century XXI: Medical Anthropology and the New Primary Health Care." *Human Organization* 63(4):457–471.

Janes, Craig R., and Kity K. Corbet. 2009. "Anthropology and Global Health." *Annual Review of Anthropology* 38(October):167–183.

Janzen, John M. 1978. *The Quest for Therapy in Lower Zaire*. Berkeley: University of California Press.

Jenkins, Garry. 2011. "Who's Afraid of Philanthrocapitalism?" *Case Western Reserve Law Review* 61(3):753–821.

Jennings, Michael. 2002. "'Almost an OXFAM in Itself': OXFAM, *Ujamaa* and Development in Tanzania." *African Affairs* 101:501–530.

Kachur, P. S., C. Black, S. Abdulla, and C. Goodman. 2006. "Putting the Genie Back in the Bottle? Availability and Presentation of Oral Artemisinin Compounds at Retail Pharmacies in Urban Dar-es-Salaam." *Malaria Journal* 5:25.

Kachur, P. S., J. Schulden, C. Goodman, et al. 2004. "Prevalence of Malaria Parasitemia among Clients Seeking Treatment for Fever or Malaria at Drug Stores in Rural Tanzania." *Tropical Medicine and International Health* 11:441–451.

Kager, P. A. 2002. "Malaria Control: Constraints and Opportunities." *Tropical Medicine and International Health* 7:1042–6.

Kaiser, Paul. 1996. "Structural Adjustment and the Fragile Nation: The Demise of Social Unity in Tanzania." *Journal of Modern African Studies* 34(2):227–230.

Kallander, Karin, Jesca Nsungwa-Sabiiti, and Stefan Peterson. 2004. "Symptom Overlap for Malaria and Pneumonia—Policy Implications for Home Management Strategies." *Acta Tropica* 90:211–214.

Kamal-Yanni, M. 2010. "Affordable Medicines Facility for Malaria: Reasonable or Rash?" *Lancet* 375:121.

Kamat, Vinay R. 2004. "Negotiating Illness and Misfortune in Post-Socialist Tanzania: An Ethnographic Study in Temeke District, Dar es Salaam." PhD diss., Department of Anthropology, Emory University.

Kamat, Vinay R. 2008. "This Is Not Our Culture! Discourse of Nostalgia and Narratives of Health Concerns in Post-Socialist Tanzania." *Africa* 73(3):359–383.

Kamat, Vinay R., and Daniel Nyato. 2010. "Soft Targets or Partners in Health? Retail Pharmacies and Their Role in Tanzania's Malaria Control Program." *Social Science and Medicine* 71(3):626–633.

Kamya, M. R., N. N. Bakyaita, A. O. Talisuna, W. M. Were, and S. G. Staedke. 2002. "Increasing Antimalarial Drug Resistance in Uganda and Revision of the National Drug Policy." *Tropical Medicine and International Health* 7:1031–1041.

Kangwana, Beth P., Sarah V. Kedenge, Abdisalan M. Noor, Victor A. Alegana, Andrew J. Nyandigisi, Jayesh Pandit, Greg W. Fegan, James E. Todd, Simon Brooker, Robert W. Snow, and Catherine A. Goodman. 2011. "The Impact of Retail-Sector Delivery of Artemether-Lumefantrine on Malaria Treatment of Children under Five in Kenya: A Cluster Randomized Controlled Trial." *PLoS Medicine* 8:e1000437. doi:10.1371/journal.pmed.

Kathewera, Banda Maggie, Flossie Gomile-Chidyaonga, Sarah Hendriks, Tinyade Kachika, Zunzo Mitole, and Seodi White. 2005. "Sexual Violence and Women's Vulnerability to HIV Transmission in Malawi: A Rights Issue." *International Social Science Journal* 57(186):649–660.

Kelly, Ann H., and Uli Beisel. 2011. Neglected Malarias: The Frontlines and Back Alleys of Global Health. *BioSocieties* 6(1):71–87.

Kikula, Idris. 1997. *Policy Implications on the Environment: The Case of Villagisation in Tanzania*. Uppsala, Sweden: The Nordic Africa Institute.

Kim, J. Y., J. V. Millen, J. Gershman, and A. Irwin, eds. 2000. *Dying for Growth: Global Inequalities and the Health of the Poor*. Monroe, ME: Common Courage Press.

Kiondo, Andrew S. Z. 1995. "When the State Withdraws. Local Development, Politics and Liberalisation in Tanzania." In *Liberalised Development in Tanzania*, edited by Peter Gibbon. Uppsala, Nordic Africa Institute.

Kitua, Andrew Y., T. A. Smith, P. L. Alonso, H. Urassa, H. Masanja, J. Kimario, and M. Tanner. 1997. "The Role of Low Level Plasmodium *Falciparum Parasitaemia* in Anaemia among Infants Living in an Area of Intense and Perennial Transmission." *Tropical Medicine and International Health* 2(4):325–333.

Kitua, Andrew Y., A. Mwita, Z. Premji, et al. 1999. "Implementation of a New Anti-Malarial Treatment Policy in Tanzania: The Rationale for the Change and the Guide to the Process of Policy Implementation." National Institute for Medical Research, Dar es Salaam, Tanzania.

Kleinman, Arthur. 1997. "The Violence of Everyday Life: The Multiple Forms and Dynamics of Social Violence." In *Violence and Subjectivity*, edited by Veena Das, Arthur Kleinman, Mamphela Ramphele, and Pamela Reynolds, 226–241. Berkeley: University of California Press.

———. 2009. *What Really Matters: Living a Moral Life amidst Uncertainty and Danger*. Oxford: Oxford University Press.

Kleinman, Arthur, Veena Das, and Margaret M. Lock, eds. 1997. *Social Suffering*. Berkeley: University of California Press.

Kleinman, Arthur, and Joan Kleinman. 1991. "Suffering and Its Professional Transformation." *Culture, Medicine and Psychiatry* 15 (3):275–301.

Koda, Bertha. 1995. "The Economic Organization of the Household in Contemporary Tanzania." In *Gender, Family and Household in Tanzania*, edited by C. K. Omary and C. Creighton, 139–155. Aldershot: Avebury.

———. 1998. "Changing Land Tenure Systems in the Contemporary Matrilineal Social System: The Gendered Dimension." In *The Making of a Periphery: Economic Development and Cultural Encounters in Southern Tanzania*, edited by Pekka Seppala and Bertha Koda, 195. Uppsala, Sweden: Nordiska Afrikainstitutet.

Koenig, Michael A., T. L. Koeniga, Feng Zhaoa, et al. 2004. "Coercive Sex in Rural Uganda: Prevalence and Associated Risk Factors." *Social Science and Medicine* 58:787–798.

Kofoed, Poul-Erik, Francisco Lopez, Peter Aaby, Kathryn Hedegaard, and Lars Rombo. 2003. "Can Mothers Be Trusted to Give Malaria Treatment to Their Children at Home?" *Acta Tropica* 86:67–70.

Koram, K. A., and M. E. Molyneux. 2007. "When Is 'Malaria' Malaria? The Different Burdens of Malaria Infection, Malaria Disease, and Malaria-Like Illnesses." *American Journal of Tropical Medicine and Hygiene* 77(suppl. 6):1–5.

Lagarde, Mylene, and Natasha Palmer. 2008. "The Impact of User Fees on Health Services Utilization in Low-and Middle-Income Countries: How Strong Is the Evidence?" *Bulletin of the World Health* 86:839–848.

Langwick, Stacey A. 2011. Bodies, *Politics, and the African Healing. The Matter of Maladies in Tanzania*. Bloomington: Indiana University Press.

Lal, Priya. 2010. "Militants, Mothers, and the National Family: Ujamaa, Gender and Rural Development in Postcolonial Tanzania." *The Journal of African History* 51(1):1–20.

Lal, Priya. 2012. "Self-Reliance and the State: The Multiple Meanings of Development in Early Post-Colonial Tanzania." *Africa* 82 (2):212–234.

Larme, Anne C. 1997. "Health Care Allocation and Selective Neglect in *Rural* Peru." *Social Science and Medicine* 44(11):1711–1723.

Laxminarayan, Ramanan. July 2003. Economics of Malaria Resistance and the Optimal Use of Artemisinin-Based Combination Treatments (ACTs). Working paper no. 5, Disease Control Priorities Project (39 pages). Bethesda, MD: Fogerty International Center, National Institutes of Health.

Lewinson, Anne. 2006. "Love in the City: Navigating Multiple Relationships in Dar es Salaam, Tanzania." *City and Society* 18(1):90–115.

Lockhart, Chris. 2002. "*Kunyenga*, 'Real Sex,' and Survival: Assessing the Risk of HIV Infection among Urban Street Boys in Tanzania." *Medical Anthropology Quarterly* 16(3):294–311.

———. 2005. "Previously Married Women and HIV/AIDS in Urban Tanzania: Sex, Exchange, and the Search for Social Legitimacy." *Women's Health and Urban Life* 4(2):6–26.

———. 2008. "The Life and Death of a Street Boy in East Africa: Everyday Violence in the Time of AIDS." *Medical Anthropology Quarterly* 22(1):94–115.

Lovell, Anne M. 2006. "Pharmaceuticals in Urban Ecologies." In *Global Pharmaceuticals: Ethics, Markets, Practices*, edited by Petryna Adriana, Andrew Lakoff, and Arthur Kleinman, 136–170. Durham, NC: Duke University Press.

Lubell, Y., H. Hopkins, C. J. Whitty, S. G. Staedke, and A. Mills. 2008. "An Interactive Model for the Assessment of the Economic Costs and Benefits of Different Rapid Diagnostic Tests for Malaria." *Malaria Journal* 7(1):21.

Lubell, Y., H. Reyburn, H. Mbakilwa, R. Mwangi, K. Chonya, C. J. Whitty, and A. Mills. 2007. "The Cost-Effectiveness of Parasitologic Diagnosis for Malaria-Suspected Patients in an Era of Combination Therapy." *American Journal of Tropical Medicine and Hygiene* 77(suppl. 6):128–132.

Lucas, R. M., and A. J. McMichael. 2005. "Association or Causation: Evaluating Links Between Environment and Disease." *Bulletin of the World Health Organization* 83(10):792–795.

Luedke, J. Tracy, and Harry J. West. 2005. *Borders and Healers: Brokering Therapeutic Resources in Southeast Africa*. Bloomington: Indiana University Press.

Lugalla, Joe L. 1995a. *Crisis, Urbanization, and Urban Poverty in Tanzania: A Study of Urban Poverty and Survival Politics*. New York: University Press of America.

———. 1995b. "The Impact of Structural Adjustment Policies on Women's and Children's Health in Tanzania." *Review of African Political Economy* 63:43–53.

———. 1997. "Economic Reforms and Health Conditions of the Urban Poor in Tanzania." *African Studies Quarterly* 1(2):19–37.

Maitland, Kathryn, and Kevin Marsh. 2004. "Pathophysiology of Severe Malaria in Children." *Acta Tropica* 90:131–140.

Makemba, A. M., P. J. Winch, V. M. Makame, G. L. Mehl, Z. Premji, J. N. Minjas, and C. J. Shiff. 1996. "Treatment Practices for *Degedege*: A Locally Recognized

Febrile Illness, and Implications for Strategies to Decrease Mortality from Severe Malaria in Bagamoyo District, Tanzania." *Tropical Medicine and International Health* 1(3):305–313.

Makundi, Emmanuel A., E. G. Leonard, Malebo Mboera, and Andrew Y. Kitua. 2007. "Priority Setting on Malaria Interventions in Tanzania: Strategies and Challenges to Mitigate Against the Intolerable Burden." *American Journal of Tropical Medicine and Hygiene* 77(suppl. 6):106–111

Malowany, Maureen. 2000. "Unfinished Agendas: Writing the History of Medicine of Sub-Saharan Africa." *African Affairs* 99:325–349.

Management Sciences for Health. Annual Report. The Power of Partnership. 2006. Available at http://www.msh.org/resource-center/msh-2006-annual-report.cfm.

Manfredi, C. 1999. "Can the Resurgence of Malaria be Partially Attributed to Structural Adjustment Programmes?" *Parassitologia* 41(1–3):389–390.

Manjate, Rosa Marlene, Rachel Chapman, and Julie Cliff. 2000. "Lovers, Hookers, and Wives: Unbraiding the Social Contradictions of Urban Mozambican Women's Sexual and Economic Lives." In *African Women's Health*, edited by Meredeth Turshen, 49–68. Trenton, NJ: Africa World Press.

Marsh, Kevin. 2010. Research Priorities for Malaria. *Lancet* 376(9753):1626–1627.

Marsh, V. M., W. M. Mutemi, J. Muturi, A. Haaland, W. M. Watkins, G. Otieno, and K. Marsh. 1999. "Changing Home Treatment of Childhood Fevers by Training Shop Keepers In Rural Kenya." *Tropical Medicine and International Health* 4: 383–389.

Mascarenhas, Adolpho. 1979. "After Villagisation—What?" In *Towards Socialism in Tanzania*, edited by Bismarck U. Mwanasu and Cranford Pratt, 145–165. Toronto: University of Toronto Press.

Mboera, L. E., E. A. Makundi, and A. Y. Kitua. 2007. "Uncertainty in Malaria Control in Tanzania. Crossroads and Challenges for Future Interventions." *American Journal of Tropical Medicine and Hygiene* 77(suppl. 6):112–118.

Mbugua, J. K., G. H. Bloom, and M. M. Segall. 1995. "Impact of User Charges on Vulnerable Groups: The Case of Kibwezi in Rural Kenya." *Social Science and Medicine* 41(6):829–835.

Mbuyazi, Godfrey M. 2003. The Role of Research in Changing Antimalarial Drug Policy in Tanzania. The Alliance for Health Policy and Systems Research, National Institute for Medical Research, Dar es Salaam, Tanzania.

Mbuyazi, Godfrey, Paul Bloch, Mathias Kamugisha, Andrew Kitua, and Jasper Ijumba. 2005a. "Intermittent Preventive Treatment of Malaria During Pregnancy: A Qualitative Study of Knowledge, Attitudes and Practices of District Health Managers, Antenatal Care Staff and Pregnant Women in Korogwe District, North-Eastern Tanzania." *Malaria Journal* 4(31):31.

Mbuyazi, Godfrey, and Miguel Gonzalez-Block. 2005b. "Research Influence on Antimalarial Drug Policy Change in Tanzania: Case Study of Replacing Chloroquine with Sulfadoxine-Pyrimethamine as the First-Line Drug." *Malaria Journal* 4(1):51.

McGoey, Lindsey. 2012. "Philanthrocapitalism and Its Critics." *Poetics* 40(2):185–199.

McHenry, Dean. 1979. *Tanzania's Ujamaa Villages: The Implementation of a Rural Development Strategy*. Berkeley: Institute of International Studies, University of California.

———. 1994. *Limited Choices: The Political Struggle for Socialism in Tanzania*. Boulder, CO: Lynne Rienner.

McMorrow, Meredith, M. Aidoo, and Patrick Kachur. 2011. "Malaria Rapid Diagnostic Tests in Elimination Settings—Can They Find the Last Parasite?" *Clinical Microbioligical Infection* 17:1624–1631.

McMorrow, Meredith L., M. I. Masanja, S. M. Abdulla, E. Kahigwa, and S. P. Kachur. 2008. "Challenges in Routine Implementation and Quality Control of Rapid Diagnostic Tests for Malaria—Rufiji District, Tanzania." *American Journal of Tropical Medicine and Hygiene* 79:385–390.

McMorrow, Meredith L., M. I. Masanja, E. Kahigwa, S. M. Abdulla, and S. P. Kachur. 2010. "Quality Assurance of Rapid Diagnostic Tests for Malaria in Routine Patient Care in Rural Tanzania." *American Journal of Tropical Medicine and Hygiene* 82:151–155.

Meekers, D. 1994. "Sexual Initiation and Premarital Childbearing in Sub-Saharan Africa." *Population Studies* 48:47–64.

Meena, Ruth. 1991. "The Impact of Structural Adjustment Programs on Rural Women in Tanzania." In *Structural Adjustment and African Women Farmers*, edited by Christina H. Gladwin, 169–190. Gainsville: University of Florida Press.

Mengisteab, Kidane, and Cyril Daddieh, eds. 1999. *State Building and Democratization in Africa: Faith, Hope and Reality*. Westport, CT: Praeger.

Meessen, Bruno, David Hercot, Mathieu Noirhomme,Valéry Ridde, Abdelmajid Tibouti, Christine Kirunga Tashobya, and Lucy Gilson. 2011. "Removing User Fees in the Health Sector: AReview of Policy Processes in Six Sub-Saharan African Countries." *Health Policy and Planning* 26:ii16–ii29.

Mhamba, Robert, and Shukarani Mbiringenda. 2010, July. The Pharmaceutical Industry and Access to Essential Medicines in Tanzania. EQUINET Discussion paper no. 83, Institute of Social and Economic Research, Rhodes University.

Miles, Ann. 2010. "Ecuadorian Women's Narratives of Lupus, Suffering, and Vulnerability." In *Chronic Conditions, Fluid States: Chronicity and the Anthropology of Illness*, edited by Lenore Manderson and Carolyn Smith-Morris, 113–130. New Brunswick, NJ: Rutgers University Press.

Mills, Anne, Yoel Lubell, and Kara Hanson. 2008. "Malaria Eradication: The Economic, Financial and Institutional Challenge." *Malaria Journal* 7(suppl. 1):S11.

Ministry of Health, The United Republic of Tanzania. 1997. "Policy Implications of Adult Morbidity and Mortality: End of Phase I Report." Ministry of Health, Dar es Salaam, Tanzania. Dar es Salaam: Ministry of Health.

Molyneux, C. S., G. Murira, J. Masha, and R. W. Snow. 2002. "Intra-household Relations and Treatment Decision Making for Child Illness: A Kenyan Case Study." *Journal of Biosocial Science* 34:109–131.

Moore, Henrietta L. 1999. *Anthropological Theory Today*. Cambridge: Polity.

Moore, Henrietta L. 2011. *Still Life: Hopes, Desires and Satisfactions*. Cambridge: Polity.

Moore, Henrietta L., and Todd Sanders. 2001. *Magical Interpretations, Material Realities: Modernity, Witchcraft, and the Occult in Postcolonial Africa*. London: Routledge.

Mosley, W. Henry, and Lincoln C. Chen. 1984. "An Analytical Framework for the Study of Child Survival in Developing Countries." *Population and Development Review* 10(suppl.): 25–45.

Msamanga, G. I., D. P. Urassa, and P. G. M. Mujinja. 1996. "Equity of Access to Public, Private Not-for-Profit and Private for Profit Health Facilities in Two Regions of Tanzania." Dar es Salaam: Muhimbili University College of Health Sciences, DSM, Tanzania.

Muela Ribera, Joan, and Suzanna Hausmann-Muela. 2011. "The Straw that Breaks the Camel's Back: Redirecting Health-Seeking Behavior Studies on Malaria and Vulnerability." *Medical Anthropology Quarterly* 25:103–121.

Mugittu, Kefas, M. Ndejembi, A. Malisa, M. Lemnge, Z. Premji, A. Mwita, W. Nkya, J. Kataraihya, S. Abdulla, H. P. Beck, and H. Mshinda. 2004, December. "Therapeutic Efficacy of Sulfadoxine-Pyrimethamine and Prevalence of Resistance Markers in Tanzania Prior to Revision of Malaria Treatment Policy: Plasmodium Falciparum Dihydrofolate Reductase and Dihydropteroate Synthase Mutations in Monitoring in Vivo Resistance." *American Journal of Tropical Medicine and Hygiene* 71(6):696–702.

Mugittu, Kefas, Salim Abdulla, Nicole Falk, Honorati Masanja, Ingrid Felger, Hassan Mshinda, Hans-Peter Beck, and Blaise Genton. 2005. "Efficacy of Sulfadoxine-pyrimethamine in Tanzania after Two Years as First-Line Drug for Uncomplicated Malaria: Assessment Protocol and Implication for Treatment Policy Strategies." *Malaria Journal* 4–55.

Mulligan, J. A., R. Mandike, N. Palmer, H. Williams, S. Abdulla, P. Bloland, and A. Mills. 2006. "The Cost of Changing National Policy: Lessons from Malaria Treatment Policy Guidelines in Tanzania." *Tropical Medicine and International Health* 11(4):452–461.

Munishi, Gasper. 1997. "Private Health Care in Tanzania: Private Health Sector Growth Following Liberalization in Tanzania." A Report on Work in Progress with Support from the International Health Policy Program. Dar es Salaam: University of Dar es Salaam and the International Health Policy Program.

Murrell, Peter. 1993. "What Is Shock Therapy?: What Did It Do in Poland and Russia?" *Post-Soviet Affairs* 9 (2):111–140.

Mushi, Deograsias. 2007. "Financing Public Health Care: Insurance, User Fees, or Taxes? Welfare Comparisons in Tanzania." Research on Poverty Alleviation. Dar es Salaam, Tanzania.

Mvungi, M. V. 1980. Lugha ya Kiswahili na jamii (Swahili language and society). In Urithi na Utamaduni Wetu (Our Cultural Heritage), edited by Cuthbert K. Omari and M. V. Mvung, 61–71. Dar es Salaam: Tanzania Publishing House.

Mwabu, Germano. 2001. "User Charges for Health Care: A Review of the Underlying Theory and Assumptions." In *Social Provision in Low-Income Countries*, edited by Germano Mwabu, Cecilia Ugaz, and Gordon White, 186–208. Oxford: Oxford University Press.

Mwabu, Germano, J. Mwanzia, and W. Liambia. 1995. "User Charges in Government Health Facilities in Kenya: Effect on Attendance and Revenue." *Health Policy and Planning* 10(2):164–170.

Mwanasasu, U. Bismarck, and Cranford Pratt, eds. 1979. *Towards Socialism in Tanzania*. Toronto: University of Toronto Press.

Mwangi, T. W., M. Mohamed, H. Dayo, R. W. Snow, and K. Marsh. 2005. "Clinical Algorithms for Malaria Diagnosis Lack Utility Among People of Different Age Groups." *Tropical Medicine and International Health* 10(6):530–536.

Mwenesi, Halima A., Trudy Harpman, Kevin Marsh, and Robert W. Snow. 1995. "Perceptions of Severe Malaria among Mijikenda and Luo Residents of Coastal Kenya." *Journal of Biosocial Science* 27:235–244.

Mwenesi, Halima A., Trudy Harpman, and Robert W. Snow. 1995. "Child Malaria Treatment Practices among Mothers in Kenya." *Social Science and Medicine* 40(9):1271–1277.

Mwesigye, Runumi Francis. 1995. "Effects of User Charges on Quality of Curative Services: A Perspective of Uganda's Rural Health Units." Entebee: Health Planning Unit, Ministry of Health.

Najera, José A., Matiana González-Silva, and Pedro L. Alonso. 2011. "Some Lessons for the Future from the Global Malaria Eradication Programme (1955–1969)." *PLOS Medicine*, available at info:doi/10.1371/journal.pmed.1000412.

Nanda, Priya. 2002. "Gender Dimensions of User Fees: Implications for Women's Utilization of Health Care." *Reproductive Health Matters* 10(20):127–134.

Nations, Marilyn, and Linda Anne Rebhun. 1988a. "Angels With Wet Wings Won't Fly: Maternal Sentiment in Brazil and the Image of Neglect." *Culture, Medicine and Psychiatry* 12(2):141–200.

———. 1988b. "Mystification of a Simple Solution: Oral Rehydration Therapy in Northeast Brazil." *Social Science and Medicine* 27(1):25–38.

Ndulu, Benno J., and Francis W. Mwega. 1994. "Economic Adjustment Policies." In *Beyond Capitalism versus Socialism in Kenya and Tanzania*, edited by Joel D. Barkan, 101–128. Boulder, CO: Lynne Rienner.

Nguyen, Vinh-Kim, M. 2005. "Antiretroviral Globalism, Biopolitics, and Therapeutic Citizenship. In *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, edited by A. Ong and S. Collier, 124–144. Malden, MA: Blackwell.

Nguyen, Vinh-Kim M., and K. Peschard. 2003. "Anthropology, Inequality, and Disease: a Review." *Annual Review of Anthropology* 32, 447–474.

Ngware, Suleiman. 2000. "Institutional Capacity Building: Local Self-Governance under Multiparty System in Tanzania." In *Multipartism and People's Participation*, edited by L. Dzimbiri, S. Ngware, and R. M. Ocharo, 52–102. Dar es Salaam: Tema.

Ngware, Suleiman, and J. M. Lusugga Kironde, eds. 1996. *Urbanising Tanzania: Issues, Initiatives and Priorities*. Dar es Salaam: University of Dar es Salaam.

Nichter, Mark. 1980. "The Layperson's Perception of Medicine as Perspective into the Utilization of Multiple Therapy Systems in the Indian Context." *Social Science and Medicine* 14B:255–263.

———. 1992. "Ethnomedicine. Diverse Trends, Common Linkages." In *Anthropological Approaches to the Study of Ethnomedicine*, edited by Mark Nichter, 223–259. Amsterdam: Gordon and Breach.

———. 2002. "The Social Relations of Therapy Management." In *New Horizons in Medical Anthropology*, edited by Mark Nichter and Margaret Lock, 81–110. London: Routledge.

———. 2008. *Global Health: Why Cultural Perceptions, Social Representations, and Biopolitics Matter*. Tucson: University of Arizona Press.

Nichter, Mark, and Carl Kendall. 1990. "Beyond Child Survival: Anthropology and International Health in the 1990s." *Medical Anthropology Quarterly* 5(3):195–203.

Nichter, Mark, and Mimi Nichter. 1996. *Anthropology and International Health: Asian Case Studies*. Amsterdam, The Netherlands: Gordon and Breach.

Nichter, Mark, and Nancy Vuckovic. 1994. "Agenda for an Anthropology of Pharmaceutical Practice." *Social Science and Medicine* 39(11):1509–1525.

Njau, J. D., C. A. Goodman, S. P. Kachur, J. Mulligan, J. S. Munkondya, N. McHomvu, S. Abdulla, P. Bloland, and A. Mills. January 7, 2008. "The Costs of Introducing Artemisinin-based Combination Therapy: Evidence from District-wide Implementation in Rural Tanzania." *Malaria Journal* 7:4.

Njau, J. D., C. Goodman, S. P. Kachur, N. Palmer, R. A. Khatib, S. Abdulla, A. Mills, and P. Bloland. 2006. "Fever Treatment and Household Wealth: The Challenge Posed for Rolling Out Combination Therapy for Malaria." *Tropical Medicine and International Health* 11(3):299–313.

Nordyke, Robert J., and John W. Peabody. 2002. "Market Reforms and Public Incentives: Finding a Balance in the Republic of Macedonia." *Social Science and Medicine* 54:939–953.

Nosten, Francois, and Philippe Brasseur. 2002. "Combination Therapy for Malaria: The Way Forward?" *Drugs* 62(9):1315–1329.

Nsimba, Stephen, E. D. 2006. "How Sulfadoxine-Pyrimethamine (SP) Was Perceived in Some Rural Communities after Phasing Out Chloroquine (CQ) as a First-Line Drug for Uncomplicated Malaria in Tanzania: Lessons to Learn Towards Moving From Monotherapy to Fixed Combination Therapy." *Journal of Ethnobiology and Ethnomedicine* 2(5):1–8.

Nsimba, Stephen, E. D. Amos, Y. Massele, Jaran Eriksen, Lars L. Gustafsson, Goran Tomson, and Mariam Warsame. 2002. "Case Management of Malaria in Under-Fives at Primary Health Care Facilities in a Tanzanian District." *Tropical Medicine and International Health* 7(3):201–209.

Nsungwa-Sahiiti, Jesca, Karin Kallander, Xavier Nsabagasani, Kellen Namusisi, George Pariyo, Annika Johansson, Goran Tomson, and Stefan Peterson. 2004. "Local Fever Illness Classifications: Implications for Home Management of Malaria Strategies." *Tropical Medicine and International Health* 9(11):1191–1199.

Nyang'oro, Julius E. 1995. "Civil Society, Democratization, and State Building in Kenya and Tanzania." In *State Building and Democratization in Africa: Faith, Hope and Reality*, edited by Kidane Mengisteab and Cyril Daddieh, 183–199. Westport, CT: Praeger.

Nyerere, Julius Kambarage 1966. *Freedom and Unity: Uhuru na Umoja*. Oxford: Oxford University Press.

———. 1977. *The Arusha Declaration. Ten Years After*. Dar es Salaam: Government Printers.

Obrist, Brigit. 2006. *Struggling for Health in the City: An Anthropological Inquiry in Health, Vulnerability and Resilence in Dar es Salaam, Tanzania*. London: Peter Lang.

Obrist, Brigit, Nelly Iteba, Christian Langeler, et al. 2007. "Access to Health Care in Contexts of Livelihood Insecurity: A Framework for Analysis and Action." *PLoS Medicine* 4(10):e308.

Ochs, Elinor, and Lisa Capps. 1996. "Narrating the Self." *Annual Review of Anthropology* 25:19–43.

Omari, C. K. 1995. "Decision-Making and the Household: Case Studies from Tanzania." In *Gender, Family and Household in Tanzania*, edited by Creighton Colin and C. K. Omari, 203–220. Aldershot: Avebury.

O'Meara, Wendy Prudhomme, Judith Nekesa Mangeni, Rick Steketee, and Brian Greenwood. 2010. "Changes in the Burden of Malaria in Sub-Saharan Africa." *Lancet* 10(8):545–555.

Ong, Aihwa. 2006. *Neoliberalism as Exception: Mutations in Citizenship and Sovereignty*. Durham, NC: Duke University Press.

Ong, Aihwa, and Stephen J. Collier, eds. 2005. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Malden, MA: Blackwell.

Ortner, Sherry B. 1984. "Theory in Anthropological since the Sixties." *Comparative Studies in Society and History* 26(1):126–166.

Packard, Randall. 1998, June. "'No Other Logical Choice': Global Malaria Eradication and the Politics of International Health in the Post-war Era." *Parassitologia* 40(12): 217–229.

Packard, Randall. 1989. *White Plague, Black Labor: The Political Economy of Health and Diseases in South Africa*. Berkeley: University of California Press.

———. 1997. "Malaria Dreams: Postwar Visions of Health and Development in the Third World." *Medical Anthropology* 17:279–296.

———. 2007. *The Making of a Tropical Disease: A Short History of Malaria*. Baltimore, MD: Johns Hopkins University Press.

———. 2009. "'Roll Back Malaria, Roll in Development'? Reassessing the Economic Burden of Malaria." *Population and Development Review* 35:53–87.

Packard, Randall, Ruth L. Berkelman, Howard Frumkin, and Peter J. Brown, eds. 2004. *Emerging Illnesses and Society: Negotiating the Public Health Agenda*. Baltimore, MD: Johns Hopkins University Press.

Packard, Randall M., and Peter J. Brown. 1997. "Rethinking Health, Development, and Malaria: Historicizing a Cultural Model in International Health." *Medical Anthropology* 17:181–194.

Pagnoni, Franco, et al. 2005. "Artemisinin-based Combination Treatment in Home-based Management of Malaria," letter to the editor. *Tropical Medicine and International Health* 10(6):621–622.

Patouillard, E., K. G. Hanson, C. A. Goodman. 2010. "Retail Sector Distribution Chains for Malaria Treatment in the Developing World: A Review of the Literature." *Malaria Journal* 9:50

Peabody, John W. 1996. "Economic Reform and Health Sector Policy: Lessons from Structural Adjustment Programs." *Social Science and Medicine* 43(5):823–835.

Pender, John. 2001. "From 'Structural Adjustment' to 'Comprehensive Development Framework': Conditionality Transformed?" *Third World Quarterly* 22(3):397–411.

Peterson, Alan, and Deborah Lupton. 1996. *The New Public Health: Health and Self in the Age of Risk*. New York: Sage.

Petryna, Adriana. 2009. *When Experiments Travel: Clinical Trials and the Global Search for Human Subjects*. Prince, NJ: Princeton University Press.

Petryna, Adriana, Andrew Lakoff, and Arthur Kleinman. 2006. *Global Pharmaceuticals: Ethics, Markets, Practices*. Durham, NC: Duke University Press.

Pfeiffer, James. 2002. "African Independent Churches in Mozambique: Healing the Afflictions of Inequality." *Medical Anthropology Quarterly* 16(2):176–199.

———. 2004. "Condom Social Marketing, Pentecostalism, and Structural Adjustment in Mozambique: A Clash of AIDS Prevention Messages." *Medical Anthropology Quarterly* 18(1):77–103.

———. 2005. "Commodity Fetichismo, the Holy Spirit, and the Turn to Pentacostal and African Independent Churches in Central Mozambique." *Culture, Medicine and Psychiatry* 29:255–283.

Pfeiffer, James, and Mark Nichter. 2008. "What Can Critical Medical Anthropology Contribute to Global Health?" *Medical Anthropology Quarterly* 22 (4):410–415.

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

Pitcher, M. Anne, and Kelly M. Askew. 2006. "African Socialisms and Post-Socialisms." *Africa* 76(1):1–14.

Plowe, Christopher V. 2003. "Monitoring Antimalarial Drug Resistance: Making the Most of the Tools at Hand." *Journal of Experimental Biology* 206:3745–3752.

Poulin, M. 2007. "Sex, Money and Premarital Partnerships in Southern Malawi." *Social Science and Medicine* 65:2383–2393.

Pratt, Cranford. 1979. "Tanzania's Transition to Socialism: Reflections of a Democratic Socialist." In *Towards Socialism in Tanzania*, edited by Bismarck U. Mwanasu and Cranford Pratt, 193–236. Toronto: University of Toronto Press.

Premji, Zul, Y. Hamisi, C. Shiff, J. Minjas, P. Lubega, and C. Makwaya. 1995. "Anaemia and *Plasmodium Falciparum* Infections among Young Children in a Holoendemic Area, Bagamoyo Tanzania." *Acta Tropica* 59:55–64.

Premji, Z., C. Makwaya, and J. N. Minjas. 1999. "Current Clinical Efficacy of Chloroquine for the Treatment of Plasmodium Falciparum Infections in Urban Dar es Salaam, United Republic of Tanzania." *Bulletin of the World Health Organization* 77(9):740–744.

Price, Laurie. 1987. "Ecuadorian Illness Stories: Cultural Knowledge in Natural Discourse." In *Cultural Models and Language and Thought*, edited by Dorothy Holland and Naomi Quinn, 313–342. New York: Cambridge University Press.

Quinn, Naomi. 2005. "Introduction to Finding Culture in Talk: A Collection of Methods." In *Finding Culture in Talk: A Collection of Methods*, edited by Naomi Quinn, 1–34. New York: Palgrave Macmillan.

Radcliffe-Brown, A. R. 1940. "On Joking Relationships." *Africa* 13(3):195–210.

Reeler, Anne V. 2000. "Anthropological Perspectives on Injections: A Review." *Bulletin of the World Health Organization* 78(1):135–143.

Rehwagen, C. 2006. "WHO Ultimatum on Artemisinin Monotherapy Is Showing Results." *British Medical Journal* 332: 1176.

Rekdal, Ole Bjorn. 1999. "Cross-Cultural Healing in East African Ethnography." *Medical Anthropology Quarterly* 13(4):458–482.

Reyburn, H., H. Mbakilwa, R. Mwangi, O. Mwerinde, R. Olomi, C. Drakeley, and C. J. Whitty. 2007. "Rapid Diagnostic Tests Compared with Malaria Microscopy for Guiding Outpatient Treatment of Febrile Illness in Tanzania: Randomised Trial." *British Medical Journal* 334(7590):403.

Reyburn, H., J. Ruanda, O. Mwerinde, and C. Drakeley. 2006. "The Contribution of Microscopy to Targeting Antimalarial Treatment in a Low Transmission Area of Tanzania." *Malaria Journal* 5:4.

Rifkin, Susan, and Gill Walt. 1986. "Why Health Improves: Defining the Issues Concerning 'Comprehensive Primary Health Care' and 'Selective Primary Health Care. *Social Science and Medicine* 23(6):559–566.

Ringsted, Frank, M. Isolide, S. Massawe, M. Martha, I. Lemnge, and C. Bygbjerg. 2011. "Saleability of Anti-Malarials in Private Drug Shops in Muheza, Tanzania: A Baseline Study in an Era of Assumed Artemisinin Combination Therapy (ACT)." *Malaria Journal* 10:238.

Roberts, L., and M. Enserink. 2007. "Did They Really Say . . . Eradication?" *Science* 318:1544–1545.

Roll Back Malaria. 2008. Geneva, World Health Organization.

Russell, Steve, and Lucy Gilson. 1997. "User Fee Policies to Promote Health Service Access for the Poor: A Wolf in Sheep's Clothing." *International Journal of Health Services* 27(2):359–379.

Rutta, E., K. Senauer, K. Johnson, G. Adeya, R. Mbwasi, J. Liana, S. Kimatta, M. Sigonda, and E. Alphonce. 2009. "Creating a New Class of Pharmaceutical Services Provider for Underserved Areas: The Tanzania Accredited Drug Dispensing Outlet Experience." *Progress in Community Health Partnership* 3(2):145–153.

Sabea, Hanan. 2001. Reviving the Dead: Entangled Histories in the Privatisation of the Tanzanian Sisal Industry. *Africa* 71(2):286–313.

Sabot, Oliver J., Alex Mitwa, Justin Cohen, et al. 2009a. "Piloting the Global Subsidy: The Impact of Subsidized Artemisinin-Based Combination Therapies Distributed Through Private Drug Shops in Rural Tanzania." *PLoS One* 4(9):e6857. doi:10.1371/journal.pone.0006857.

Sabot, Oliver J., S. Yeung, F. Pagnoni, M. Gordon, N. Petty, K. Schmit, and A. Talisuna. 2009b. Distribution of Artemisinin-Based Combination Therapies Through Private-Sector Channels: Lessons From Four Country Case Studies. Discussion paper. Affordable Medicines Facility-Malaria. Resources for the Future. Washington, DC.

Sachs, Jeffrey, and Pia Malaney. 2002. "The Economic and Social Burden of Malaria." *Nature* 415:680–685.

Sanders, Todd. 1999. "Modernity, Wealth and Witchcraft in Tanzania." *Research in Economic Anthropology* 20:117–131.

———. 2001. "Save Our Skins: Structural Adjustment, Morality and the Occult in Tanzania." In *Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa*, edited by Henrietta L. Moore and Todd Sanders, 160–183. London: Routledge.

———. 2003. "Invisible Hands and Visible Goods: Revealed and Concealed Economies in Millennial Tanzania." In *Transparency and Conspiracy: Ethnographies of Suspicion in the New World Order*, edited by Harry G. West and Todd Sanders, 148–174. Durham, NC: Duke University Press.

———. 2008. *Beyond Bodies: Rainmaking and Sense Making in Tanzania*. Toronto: University of Toronto Press.

Sarris, Alexander H., and Rogier van der Brink. 1993. *Economic Policy and Household Welfare during Crisis and Adjustment in Tanzania*. New York: New York University Press.

Scheper-Hughes, Nancy. 1989. Death Without Weeping. Has Poverty Ravaged Mother Love in the Shanty Towns of Brazil? *Natural History*. October 8–16.

———. 1992. *Death Without Weeping: The Violence of Everyday Life In Brazil.* Berkeley: University of California Press.

Scheper-Hughes, Nancy, and P. Bouregeois. 2004. "Introduction. Making Sense of Violence." In *Violence in War and Peace: An Anthology*, edited by N. Scheper-Hughes and P. Bouregeois, 1–27. Oxford: Blackwell.

Scheper-Hughes, Nancy, and Margaret Lock. 1987. "The Mindful Body: A Prolegomenon To Future Work In Medical Anthropology." *Medical Anthropology Quarterly* 1:6–41.

Schneider, Leander. 2004. "Freedom and Unfreedom in Rural Development: Julius Nyerere, Ujamaa Vijijini, and Villagization." *Canadian Journal of African Studies* 38(2):344–392.

Schoepf, Brooke G., Claude Schoepf, and Joyce V. Millen. 2000. "Theoretical Therapies, Remote Remedies: SAPs and the Political Ecology of Poverty and Health in Africa." In *Dying for Growth: Global Inequality and the Health of the Poor*, edited by J. V. M. Jim Yong Kim, Alec Irwin, and John Gershman, 91–125. Monroe, ME: Common Courage Press.

Scott, James. 1999. *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*. New Haven, CT: Yale University Press.

Sen, Amartaya. 1999. *Development as Freedom*. Oxford: Oxford University Press.

Seppala, Pekka.1998. *Diversification and Accumulation in Rural Tanzania*. Stockholm: Nordic Africa Institute.

Seppala, Pekka, and Bertha Koda. 1998. *The Making of a Periphery: Economic Development and Cultural Encounters in Southern Tanzania*. Uppsala: Nordic Africa Institute.

Setel, Philip W. 1999. A *Plague of Paradoxes: AIDS, Culture, and Demography in Northern Tanzania*. Chicago: University of Chicago Press.

Sharma, V. P. 1996. "Re-emergence of Malaria in India." *Indian Journal of Medical Research* 103:26–45.

Shaw, Paul R., and Charles C. Griffin. 1995. *Financing Health Care in Sub-Saharan Africa through User Fees and Insurance*. Washington, DC: World Bank.

Shiff, Clive, W. Checkley, P. Winch, Z. Premji, J. Minjas, and P. Lubega. 1996. "Changes in Weight Gain and Anaemia Attributable to Malaria in Tanzanian Children Living Under Holoendemic Conditions." *Transactions of the Royal Society of Tropical Medicine and Hygiene* 90:262–265.

Shretta, R., J. Omumbo, B. Rapuoda, and R. W. Snow. 2000. "Using Evidence to Change Antimalarial Drug Policy in Kenya." *Tropical Medicine and International Health* 5(11):755–764.

Silberschmidt, Margrethe. 2001. "Disempowerment of Men in Rural and Urban East Africa: Implications for Male Identity and Sexual Behaviour." *World Development* 29:657–671.

———. 2005. "Poverty, Male Disempowerment, and Male Sexuality: Rethinking Men and Masculinities in Rural and Urban East Africa." In *African Masculinities*, edited by Lahouzine Ouzgane and Robert Morrell, 189–203. New York: Palgrave Macmillan.

Silberschmidt, M., and V. Rasch. 2001. "Adolescent Girls, Illegal Abortions and 'Sugar-Daddies' in Dar es Salaam: Vulnerable Victims and Active Social Agents." *Social Science and Medicine* 52:1815–1826.

Singer, Merrill, and Hans Baer. 1995. *Critical Medical Anthropology*. Amityville, NY: Baywood.

Skarbinski, J., P. O. Ouma, L. M. Causer, et al. 2009. "Effect of Malaria Rapid Diagnostic Tests on the Management of Uncomplicated Malaria with Artemether-Lumefantrine in Kenya: A Cluster Randomized Trial." *American Journal of Tropical Medicine and Hygiene* 80(6):919–926.

Smith, Daniel Jordan. 2007. "Modern Marriage, Men's Extramarital Sex, and HIV Risks in Southeastern Nigeria." *American Journal of Public Health* 97:997–1005.

Smith, James Howard. 2008. *Bewitching Development: Witchcraft and the Reinvention of Development in Neoliberal Kenya*. Chicago: University of Chicago Press.

Snow, Robert W., J. R. M. Armstrong, D. Foster, M. T. Winstanley, V. M. Marsh, C. R. J. C. Newton, C. Waruiru, I. Mwangi, P. A. Winstanley, and K. Marsh. 1992. "Childhood Deaths in Africa: Uses and Implications of Verbal Autopsies." *Lancet* 340:351–355.

Snow, Robert W., E. L. Korenromp, and E. Gouws. 2004. "Pediatric Mortality in Africa: Plasmodium Falciparum Malaria as a Cause or Risk?" *American Journal of Tropical Medicine and Hygiene* 70 (suppl. 2):16–24.

Snow, Robert W., Carlos A. Guerra, Abdisalan M. Noor, Hla Y. Myint, and Simon I. Hay. 2005. "The Global Distribution of Clinical Episodes of Plasmodium *Falciparum* Malaria." *Nature* 434(7030):214–217.

Snow, Robert W., E. Mccabe, C. N. M Mbogo, C. S. Molyneux, E. S. Some, Vo. Mung'ala, and C. G. Nevill. 1999. "The Effect of Delivery Mechanisms on the Uptake of Bed Net Re-Impregnation in Kilifi District, Kenya." *Health Policy and Planning* 14(1):18–25.

Snow, Robert W., J. R. M. A. Schellenberg, D. Foster, V. O. Mungala, and K. Marsh. 1994. "Factors Influencing Admission to Hospital during Terminal Childhood Illness in Kenya." *International Journal of Epidemiology* 23:1013–1019.

Snow, Robert W., Jean-Francois Trape, and Kevin Marsh. 2001. "The Past, Present and Future of Childhood Malaria Mortality in Africa." *Trends in Parasitology* 17(12):593–597.

Snow, R. S., E. A. Okiro, P. W. Gething, et al. 2010. "Equity and Adequacy of International Donor Assistance for Global Malaria Control: An Analysis of Populations at Risk and External Funding Commitments." *Lancet* 376(6750):1409–1416.

Snyder, Katherine A. 2001. "Being of 'One Heart': Power and Politics among the Iraqi of Tanzania." *Africa* 71(1):128–148.

Somi, M. F., J. R. G. Butler, F. Vahid, J. Njau, S. P. Kachur, and S. Abdulla. 2007. "Is There Evidence for Dual Causation between Malaria and Socioeconomic Status? Findings from Rural Tanzania." *American Journal of Tropical Medicine and Hygiene* 77(6):1020–1027.

Spalding, Nancy Jackson. 1996. "State-Society Relations in Africa: An Exploration of the Tanzanian Experience." *Polity* 29(1):65–96.

Sparr, Pamel. 1994. "What Is Structural Adjustment?" In *Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment*, edited by Pamela Sparr, 1–12. London: Zed.

Stephen, Nancy L. 2011. *Eradication: Ridding the World of Diseases Forever*? Ithaca, NY: Cornell University Press.

Stoger-Eising, Viktoria. 2000. "*Ujamaa* Revisited: Indigenous and European Influences in Nyerere's Social and Political Thought." *Africa* 70(1):118–143.

Stratton, Leeanne O'Neill, Marie S. Kruk, Margaret E. Bell, et al. 2008. "The Persistent Problem of Malaria: Addressing the Fundamental Causes of a Global Killer." *Social Science and Medicine* 67(5):854–862.

Swantz, Marja-Lissa. 1995. *Blood, Milk and Death: Body Symbols and the Power of Regeneration among the Zaramo of Tanzania*. Westport, CT: Bergin and Garvey.

———. 1997. Community and Village-Based Provision of Key Social Services: A Case Study of Tanzania. Helsinki, Finland: United Nations University, Unu/ World Institute for Development Economics Research (Unu/Wider).

Tanner, Marcel, and Don de Savigny. 2007. "Malaria Eradication Back on the Table." *Bulletin of the World Health Organization* 86(2):82–83.

Tanner, Marcel, and Carol Vlassoff. 1998. "Treatment-Seeking Behavior for Malaria: A Typology Based on Endemicity and Gender." *Social Science and Medicine* 46(4–5):523–532.

Tarimo, D. S., G. K. Lwihula, J. N. Minjas, and I. C. Bygbjerg. 2000. "Mothers' Perceptions and Knowledge on Childhood Malaria in the Holoendemic Kibaha District, Tanzania: Implications for Malaria Control and the IMCI Strategy." *Tropical Medicine and International Health* 5(3):179–184.

Tarimo, D. S., J. N. Minjas, and I. C. Bygbjerg. 2001. "Perception of Chloroquine Efficacy and Alternative Treatments for Uncomplicated Malaria in Children in a Holoendemic Area of Tanzania: Implications for the Change of Treatment Policy." *Tropical Medicine and International Health* 6(12):992–997.

———. 2002. "Sulfadoxine-Pyrimethamine Monotherapy in Tanzanian Children Gives Rapid Parasitic Clearance but Slow Fever Clearance That Is Improved by Chloroquine in Combination Therapy." *Tropical Medicine and International Health* 7(7):592–598.

Tarimo, D. S., D. P. Urassa, and G. I. Msamanga. 1998. "Caretakers Perceptions of the Clinical Manifestations of Childhood Malaria in Holoendemic Rural Communities in Tanzania." *East African Medical Journal* 75:93–96.

Tibandebage, Paula, and Maureen Mackintosh. 2005. The Market Shaping of Charges, Trust and Abuse: Health Care Transactions in Tanzania." *Social Science and Medicine* 61(7):1385–1395.

Topan, Farouk. 2008. "Tanzania: The Development of Swahili as a National and Official Language." *Language and National Identity in Africa*, edited by Andrew Simpson, 252–266. Oxford: Oxford University Press.

Townsend, Meta K. 1998. *Political-Economy Issues in Tanzania*. Lewiston, NY: Edwin Mellen Press.

Trape, J. 2001. "The Public Health Impact of Chloroquine Resistance in Africa." *American Journal of Tropical Medicine and Hygiene* 64:12–17.

Trape Jean-François, Gilles Pison, Marie-Pierre Preziosi, Catherine Enel, Annabel Desgrées du Loû, Valérie Delaunay, Badara Samb, Emmanuel Lagarde, Jean-François Molez, and François Simondon. 1998. "Impact of Chloroquine Resistance on Malaria Mortality." *Comptes Rendus de l'Academie des Sciences, Series III* 321(8): 689–697.

Tren, Richard, Roger Bate, Kimberly Hess, Thompson Ayodele, and Franklin Cudjoe. September 2011. The Global Fund's Malaria Medicine Subsidy: A Nice Idea with Nasty Implications. Africa Fighting Malaria Policy Paper. Africa Fighting Malaria, Washington DC.

Tripp, Aili Mari. 1997. *Changing the Rules: The Politics of Liberalization and the Urban Informal Economy in Tanzania*. Berkeley: University of California Press.

Trostle, J., B. Bronfman, and A. Langer. 1999. "How Do Researchers Influence Decision-Makers? Case Studies of Mexican Policies." *Health Policy and Planning* 14:103–114.

Tsing, Anna Lowenhaupt. 2005. *Friction: An Ethnography of Global Connection*. Princeton: Princeton University Press.

Turnbull, David. 1989. "The Push for a Malaria Vaccine." *Social Studies of Science* 19(2):283–300.

Turshen, Meredeth. 1977. "The Impact of Colonialism on Health and Health Services in Tanzania." *International Journal of Health Services* 7(1):7–35.

———. 1984. *The Political Ecology of Disease in Tanzania*. New Brunswick, NJ: Rutgers University Press.

———. 1999. *Privatizing Health Services in Africa*. New Brunswick, NJ: Rutgers University Press.

UNICEF. 2007. Malaria and Children. Progress in Intervention Coverage.

van der Geest, Sjaak, and Susan Reynolds Whyte, eds. 1988. *The Context of Medicines in Developing Countries: Studies in Pharmaceutical Anthropology*. Amsterdam: Het Spinhuis.

van der Geest Sjaak, Anita Hardon, and Susan Reynolds Whyte. 1990. "Planning for Essential Drugs: Are We Missing the Cultural Dimension?" *Health Policy and Planning* 5(2):182–185.

———. 1996. "The Anthropology of Pharmaceuticals: A Biographical Approach." *Annual Review of Anthropology* 25:153–178.

Vavrus, Frances. 2005. "Adjusting Inequalities: Structural Adjustment Policies in Tanzania." *Harvard Educational Review* 75:174–201.

Verdery, Katherine. 1996. *What Was Socialism, and What Comes Next?* Princeton, NJ: Princeton University Press.

Vestergaard, L. S., and P. Ringwald. 2007. "Responding to the Challenge of Antimalarial Drug Resistance by Routine Monitoring to Update National Malaria Treatment Policies." *American Journal of Tropical Medicine and Hygiene* 77(suppl. 6):153–159.

Vlassoff, Carol, and Lenore Manderson. 1998. "Incorporating Gender in the Anthropology of Infectious Diseases." *Tropical Medicine and International Health* 3(12):1011–1019.

Waldram, James B. 2000. "The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues." *Medical Anthropology Quarterly* 14(4):603–625.

Walley, Christine J. 2004. *Rough Waters: Nature and Development in an East African Marine Park*. Princeton, NJ: Princeton University Press.

Wang, Shr-Jie, Christian Lengeler, Deodatus Mtasiwa, Thimas Mshana, Lusinge Manane, et al. 2006. "Rapid Urban Malaria Appraisal (RUMA) II: Epidemiology of urban malaria in Dar es Salaam (Tanzania)." *Malaria Journal* 5:28.

Wangwe, Samuel M., Haji H. Semboja, and Paula Tibandebage, eds. 1998. *Transitional Economic Policy and Policy Options in Tanzania*. Dar es Salaam: Mkuki Na Nyota.

Wardlow, Holly. 2006. *Wayward Women: Sexuality and Agency in a New Guinea Society*. Berkeley: University of California Press.

Weiss, Brad. 2002. "Thug Realism: Inhabiting Fantasy in Urban Tanzania." *Cultural Anthropology* 17(1):93–124.

Weller, S. C., and R. D. Baer. 2001. "Intra-and Intercultural Variation in the Definition of Five Illnesses: AIDS, Diabetes, The Common Cold, Empacho, and Mal De Ojo." *Cross-Cultural Research* 35(2):210–226.

White, Nicholas J. 2004. "Antimalarial Drug Resistance." *Journal of Clinical Investigation* 113(8):1084–1092.

Whitty, J. M. Christopher, Richard Allan, Virginia Wiseman, Sam Ochola, Maria Veronicah, Nakayanzi-Mugisha, Benjamin Vonhm, Mahemba Mwita, Constantine

Miaka, Aggrey Oloo, Zul Premji, Craig Burgess, and Theonest K. Mutabingwa. 2004. "Averting a Malaria Disaster in Africa—Where Does the Buck Stop?" *Bulletin of the World Health Organization* 82(5):381–384.

Whitty, Christopher, Chandler Clare, Ansah Evelyn, Leslie Toby, and Staedke Sarah. 2008. "Deployment of ACT Antimalarials for Treatment of Malaria: Challenges and Opportunities." *Malaria Journal* 7(suppl. 1):S7.

Whyte, Susan Reynolds. 1997. *Questioning Misfortune*. Cambridge: Cambridge University Press.

Whyte, Susan Reynolds, and Sjaak van der Geest. 1994. "Injections: Issues and Methods for Anthropological Research." In *Medicines, Meaning and Context*, edited by Nina Etkin and Michael Tan, 137–161. Quezon City, Philippines: Hains Press.

Whyte, Susan Reynolds, Sjaak van der Geest, and Anita Harton. 2002. *The Social Lives of Medicines*. Cambridge: Cambridge University Press.

Wilkinson, Ian. 2004. "'The Problem of 'Social Suffering:' The Challenge to Social Science." *Health Sociology Review* 13(2):113–121.

Willen, Sarah. 2007. "Illegality,' Mass Deportation, and the Threat of Violent Arrest: Structural Violence and Social Suffering in the Lives of Undocumented Migrant Workers in Israel." In *Trauma and Memory: Reading, Healing, and Making Law*, edited by Austin Sarat, Nadav Davidovitch, and Michal Alberstein, 168–203. Stanford: Stanford University Press.

Williams, Holly Ann, and Caroline O. H. Jones. 2004. "A Critical Review of Behavioral Issues Related to Malaria Control in Sub-Saharan Africa: What Contributions Have Social Scientists Made?" *Social Science and Medicine* 59:501–523.

Williams, Holly Ann, S. Patrick Kachur, N. Charity Nalwamba, Allen Hightower, Christopher Simoonga, and Peter C. Mphande. 1999. "A Community Perspective on the Efficacy of Malaria Treatment Options for Children in Lundazi District, Zambia." *Tropical Medicine and International Health* 4(10):641–652.

Winch, Peter J. 1999. "The Role of Anthropological Methods in a Community-Based Mosquito Net Intervention in Bagamoyo District, Tanzania." In *Anthropology in Public Health: Bridging Differences in Culture and Society*, edited by Robert A. Hahn, 44–62. New York: Oxford University Press.

Winch, Peter J., Ahmed M. Makemba, S. R. Kamazima, M. Lurie, G. K. Lwihula, Zul Premji, Japhet N. Minjas, and Clive J. Shiff. 1996. "Local Terminology for Febrile Illnesses in Bagamoyo District, Tanzania and Its Impact on the Design of a Community-Based Malaria Control Programme." *Social Science and Medicine* 42(7):1057–1067.

Winch, Peter J., Ahmed M. Makemba, Viola R. Makame, Mfauma S. Mfaume, Matthew C. Lynch, Zul Premji, Japhet N. Minjas, and Clive J. Shiff. 1997. "Social and Cultural Factors Affecting Rates of Regular Retreatment of Mosquito Nets with Insecticide in Bagamoyo District, Tanzania." *Tropical Medicine and International Health* 2(8):760–770.

Wiseman, John A. 1995. "Introduction: The Movement towards Democracy." In *Democracy and Political Change in Sub-Saharan Africa*, edited by John A. Wiseman, 1–10. London: Routledge.

Wiseman, V., M. Kim, T. K. Mutabingwa, and C. J. M. Whitty. 2006. "Cost-Effectiveness Study of Three Antimalarial Drug Combinations in Tanzania." *PLoS Medicine* 3(10): e373. doi: 10.1371/ journal.pmed.0030373.

World Bank. 1987. Financing Health Services in Developing Countries: An Agenda for Reform. Washington, DC.

———. 1993. Investing in Health: The World Development Report. Washington, DC: World Bank.

———. 1994. Adjustment in Africa—Reforms, Results and the Road Ahead. New York: Oxford University Press.

World Bank/IMF. 2009. RegardingTanzania's Debt. Available at http://www.imf.org/external/pubs/ft/dsa/pdf/dsacr10173.pdf.

World Health Organization. 1993. *Implementation of the Global Malaria Control Strategy: Report of a WHO Study Group on the Implementation of the Global Plan for Action for Malaria Control, 1993–2000*. Geneva: WH0.

———. 1999. A Standard Verbal Autopsy Method for Investigating Causes of Death in Infants and Children. WHO/CDS/CSR/ISR/99.4. Available at http://www.who.int-csr-resources-publications surveillance-whocdscsrisr994.pdf.

———. 2000. *The Abuja Declaration on Roll Back Malaria in Africa by the African Head of States and Governments*. Abuja, Nigeria: World Health Organization, Geneva.

———. 2005. Geneva: World Health Organization.

———. 2007. *World Malaria Report 2007*. Geneva: World Health Organization.

———. 2008. *World Malaria Report 2008*. Geneva: World Health Organization.

———. 2010a. *Guidelines for the Treatment of Malaria*. Technical Report. Geneva: World Health Organization.

———. 2010b. *Malaria Rapid Diagnostic Test Performance. Results of WHO Product Testing of Malaria RDTs: Round 2*. Technical Report. Geneva: World Health Organization.

———. 2010c. *Global Report on Antimalarial Drug Efficacy and Drug Resistance, 2000–2010*. Geneva: World Health Organization.

———. 2010d. *World Malaria Report 2010*. Geneva, World Health Organization.

———. 2011. *World Malaria Report 2011*.Geneva: World Health Organization.

World Health Organization/UNICEF. 2003. The Africa Malaria Report. Geneva: World Health Organization.

Worrall, Eve, Suprotik Basu, and Kara Hanson. 2005. "Is Malaria a Disease of Poverty? A Review of the Literature." *Tropical Medicine and International Health* 10(10):1047–1059.

Yeung, Shunmay, Wirichada Pongta Vornpinyo, Ian M. Hastings, Anne J. Mills, and Nicholas J. White. 2004. "Antimalarial Drug Resistance, Artemisinin-based Combination Therapy, and the Contribution of Modeling to Elucidating Policy Choices." *American Journal of Tropical Medicine and Hygiene* 71(suppl. 2):179–186.

Yeung, Shunmay, and Nicolas J. White. 2005. "How Do Patients Use Antimalarial Drugs? A Review of the Evidence." *Tropical Medicine and International Health* 10(2):121–138.

Zikusooka, Charlotte M., Diane McIntyre, and Karen I. Barnes. 2008. "Should Countries Implementing an Artemisinin-Based Combination Malaria Treatment Policy Also Introduce Rapid Diagnostic Tests?" *Malaria Journal* 7:176. doi:10.1186/1475–2875–7–176.

Index

About the Author

Vinay Kamat received his PhD in social work from the Tata Institute of Social Sciences in Bombay, India, in 1992 and his PhD in anthropology from Emory University in 2004. He had been an assistant professor of anthropology at the University of British Columbia since 2003 and in 2010 was promoted to associate professor. Since 1998, Kamat has performed extensive fieldwork in Tanzania on topics such as malaria control and social suffering. In recent years he served as principle investigator on projects in both India and Tanzania. He received a Wenner-Gren Richard Carley Hunt fellowship in 2011 to work on his malaria research and his research for this book. Kamat has published in such journals as *Social Science and Medicine*, *Medical Anthropology Quarterly*, *Anthropology and Medicine*, *Africa*, and *Medical Anthropology*.