A World of Work

Imagined Manuals for Real Jobs

Edited by Ilana Gershon
Afterword by Jean Lave

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Introduction

Ilana Gershon

Wondering what kind of job you want? Wondering what you would need to know to be a magician in Paris? Or a salmon farmer in Norway? Or a professional wrestler in Mexico? Think about the work you have done. You generally need a complicated mix of skills to do any of it well. You often have to learn some tacit knowledge and have some direct training, you need to show social competence and master some physical skills—all specific to that particular occupation. To be a magician in Paris, you need to know how to perform tricks without much room to maneuver because you might have to do it in a restaurant. But you also need to know how to negotiate with a French government bureaucrat so that you can get a government stipend for being a creative artist. Some of what you need to know can be taught through books, some you can learn only after observing and practicing on the job itself, and some you learn from your mentors and co-workers. This book compiles imagined job manuals for real jobs. These manuals provide a sense of the different kinds of knowledge one would need to do a wide range of jobs from all over the world—from

being a cell phone repair person in Washington, D.C., to a ballerina in London.

This book offers fourteen imagined job manuals written by scholars in response to a "what if" thought exercise: What if a crime scene technician in Sweden or a journalist in Siberia decided to explain what it means to do their work well? There are chapters about occupations in Africa, Asia, Europe, Latin America, the Pacific Islands, and the United States, although the majority of chapters describe work in Europe and the United States. All are contemporary occupations—these are jobs you could have right now if you want. But these aren't lines of work that you can do without training. Some of the manuals detail work that requires a lot of physical dexterity, others describe jobs that demand social finesse or years of schooling. Many of the authors are anthropologists who have spent years observing and talking to people with these occupations, and a number of them have decided to coauthor with practitioners from their field sites.

I was inspired to create a collection of imagined job advice by a book I love to teach: *A World of Babies: Imagined Childcare Guides for Seven Societies,* edited by Judy DeLoache and Alma Gottlieb. Their book is also a "what if" collection—if every culture had a version of a Dr. Spock manual for how to raise a baby, what would these manuals look like? I was walking home one day after teaching the manual on how an Australian aboriginal grandmother would advise her granddaughter to raise her great-grandchild, and I started to wonder: What happens to all these babies when they grow up? What kinds of jobs will they get? And what social challenges do they face in these jobs, whether the job is repairing cell phones or designing costumes in Bollywood?

As the editors of *A World of Babies* point out, manuals are not a universal genre. Some manuals will lay out how to do a job in a way that might be familiar to anyone who has read a book like *Rookie Teaching for Dummies.* Some can't conform at all to this genre because of the nature of the work, or the cultural context. A village magistrate in Papua New Guinea might never have come across a job manual—or ever dreamed of writing one. But there are invariably moments in a job where someone with experience is explaining to someone new how to do the work well. The authors chose a voice, a perspective, from which to impart sage advice about the ins and outs of a particular occupation. There might be no job manuals in Papua New Guinea for being a judge, but village magistrates will often explain

in eulogies what their work is like and especially how difficult it is to do their work well. A Mexican trainer might only think to describe the life of a professional wrestler when talking a young woman, one who wants to become a *luchadora,* as she visits different gyms trying to figure out where she should train. The imagined job manuals collected here evoke many different genres—advice letters, gossipy emails, sermons, words of wisdom spoken in a bar—alongside more traditional entries. The authors use this wide range of genres to showcase the cultural diversity at the heart of this collection.

When people think of job manuals, they often think of technical how-to guides or professional self-help books. Not so in this book. These chapters are possible because of the paths cleared by earlier lyrical nonfiction narrators of American work lives, writers such as Studs Terkel and Barbara Ehrenreich. Because the authors are mostly scholars writing about lines of work they have studied, these pieces are ethnographic fictions. Even when one of the authors is a professional practitioner, most of the pieces are written in the voice of a fictional character offering a perspective based on research and using a composite of many people's experiences. But fictions are not always entirely fictional. These manuals are also ethnographic—which means that they are based on the authors' years spent observing and analyzing particular livelihoods. At the same time, the authors have taken some creative license in how they frame the chapters and the words used to describe work practices. The manuals are both ethnographic and fictional because they represent the workplace practices of the people they have studied as accurately *and* as engagingly as possible (see Narayan, p. 142).

The authors all focus on how culturally specific every job is. They pay careful attention to the fact that people pass along knowledge and skills in contextually specific ways—how a musician in Bolivia might teach a boy to play the charango will be different than how a Japanese musician will teach a geisha to play the shamisen. And people have their own culturally specific ways of talking about work, talking about having a career, talking about skills that can be passed on to others, talking about the unique challenges that arise in each workplace. A professional organizer in the United States might worry about becoming friends with her clients, of mixing the personal and the professional too much, while a journalist in Buryatia might think that helping those you are friends with or related to is the way to express what is most human about you, to enter into the web

of obligations is the main way that people get anything done in Buryatia. For an organizer in the United States, becoming professional means drawing boundaries with one's friends and potential friends so that your obligations are clearly demarcated. For a journalist in Buryatia, becoming a professional means treating friends and relatives as well as possible so that they will be in your debt when you need a favor or information. In this comparison, people have different understandings about how to treat relationships that are simultaneously personal and professional, and how being too personal or too professional can affect people's ability to get the work done.

Communities of Practice

Each job manual is a written invitation to a would-be practitioner to join a group of workers who have different degrees of experience. Everyone in the workplace is connected by a series of loosely defined tasks and dilemmas they must face with some degree of coordination. In short, people enter what Jean Lave and Etienne Wenger call a "community of practice" (p. 56). These job manuals often adopt the perspective of a very experienced person, the voice is of an old-timer explaining to the newcomer some aspects that can be openly stated about what it might mean to be part of this community of practice.

Lave and Wenger might caution readers not to cling too tightly to the dichotomy between those with experience and those without it. Many people participate in workplaces with varying degrees of experience and different perspectives. The vet who visits the salmon and the salmon farmers on a Norwegian domestic salmon farm has a lot of experience tending to the fishes' health, but the farmers have their own experiences and insights. Together the vet and farmers collaborate. At the same time, they are collaborating in such a way that someone who just joined the farm a week ago can also participate. Indeed, newcomers to the salmon farm can often notice things about the daily practices that will, over time, change how things are done there. All these authors, in some way or another, show that jobs change in doing them, and the communities of practice change as people move from being newcomers to old-timers as new ideas get put into dialogue with earlier notions and practices.

All jobs are social and bring social tensions with them. Newcomers are always joining a cohort of fellow workers, not all of whom have the same duties. Many of these manuals will point out that doing your work well sometimes puts you in conflict with other people in your community of practice who are equally intent on doing their own work well. In his book *Postmortem,* which helped inspire some of the pieces in this collection, Stefan Timmermans writes about how forensic pathologists have an occupation that almost always puts them in conflict with the emergency medical workers or the funeral home morticians with whom they come into contact while investigating the cause of a death. The pathologists are invariably frustrated by the emergency medical workers, who may well have destroyed valuable evidence while trying and failing to save the dying person. But pathologists themselves often make morticians' tasks more complicated, since pathologists sometimes disfigure the corpse in an effort to ascertain cause of death while morticians want to make the corpse as presentable as possible for the funeral. These kinds of tensions will be present when one joins a workplace in which people with different jobs have responsibilities and functions that contradict each other in practice.

In short, the pressures and demands of one line of work will often put people in conflict with the pressures and demands of other peoples' lines of work. The chapter on costume designers in Bollywood shows how designers want to make sure that characters are dressed the same way in every shot of a scene or dressed appropriately for the time period. They have difficulty achieving this because the directors will make last-minute decisions for creative reasons or insist on a schedule that leaves little time for the costume designer to find the proper fabric or to sew the costume so that it looks as though the character has worn the outfit for years. The director wants to be able to shoot a scene on a particular day, and actors cannot afford to spend too much time on a single film. The end result of all this time pressure and creative wrangling is that the costume designer has to rely on the goodwill of local merchants to produce outfits that look good enough, and to do so in ways that sacrifice perfection for completion. In this case, the costume designer is working toward the same common goal as the director or the actors—they all want to make a film. But they might have different ideas about what makes a successful film, and each of their contributions will be evaluated differently by audiences when they see the

final result. This too can create social tensions as people try to do their jobs alongside others. All of the manuals in this volume trace the social dilemmas that are part of a job, addressing the social sophistication and adeptness that are required when dealing with other people and dealing with other people's job conditions.

What you need to know to join a community of practice, all the tacit knowledge you acquire, can't always be described in a job manual. If you think about workplaces as communities of practice—there are always things that a manual has to leave out, bodily and other implicit knowledge that you gain over time. Some of these chapters provide glimpses of the bodily knowledge you have to acquire to succeed at a particular occupation. Working in a needle factory in Massachusetts means that you have to learn a particular rhythm for picking a needle up, putting the needle in a machine, and pressing the drill down to create a hole. You stop the drill when it bottoms out, but you know that it has bottomed out because you know what the machine feels like when this has happened. You know because you have done this a hundred or five hundred or several thousand times before. Many tasks can't be explained with words alone. You learn all sorts of specific ways to hold your body, to sense exactly when to start a motion and when to stop it thanks to touch, smell, hearing, and sight. Unlike other job manuals, these not only explain what can be written down about doing a job but also discuss some of the skills you can gain only by doing the work, when being told what to do in the abstract is not enough.

Jobs All around the World

Does the country you live in affect the way you work? Do you need different skills to be a doctor in Malawi or the United States? Many of the authors discuss how important government regulations and local infrastructure can be. For instance, doctors in Malawi face significantly different challenges than doctors in the United States or in Germany. In the chapter on being an African physician, a doctor points out to her younger brother, who just finished his residency, that surgical threads for sutures might not be easily available, so her brother may have to make do with fishing thread. Electric generators break down often and, as a result, a doctor

has to do regular favors for a talented local electrician so that he will reliably fix the generators in a pinch. Medical textbooks written in Europe or the United States often assume an infrastructure—medical and pharmaceutical supplies and equipment, especially—that don't exist reliably or in predictable quantities in Malawi. Doctors there have to come up with creative alternatives that compensate for the lack of infrastructure. In doing so, people will often form communities of practice to address the problems the larger infrastructures present to them—doctors join with local electricians, international aid agencies, and patients' relatives to come up with imaginative alternatives for the supplies that are not easily available in Malawi. The chapters that follow show how people deal with the demands of a job in other countries. This draws attention to the resources and institutional structures readers might be taking for granted that, in fact, are not in place everywhere.

The global range of this collection also shows how much a country's legal or economic policies can affect people's daily work lives. Depending on your occupation, it can matter how your country's constitution defines the relationship between church and state. In the United States, chaplains who work in prisons and hospitals try to define their practices in broad spiritual terms instead of specific religious terms because government chaplains don't want to be seen as proselytizing. The chaplains are concerned that if they are denominationally religious in these contexts, this could be a violation of their clients' First Amendment rights. Government chaplains in the United Kingdom don't struggle with the same dilemma. There is no comparable legal restriction in Great Britain, where the Church of England has long been established as the state's religious partner. In this chapter, the authors compare government chaplains in the United States and the United Kingdom and show in detail how much the legal system can influence people's daily lives, down to the kind of spiritual care available to them in a hospital bed.

Similarly, when taking paying jobs, magicians in Paris have to make different economic calculations than magicians in other countries do. The French government offers creative artists what is called an "Intermittence du Spectacle," a yearly government stipend based on the amount they earned in the previous year by performing. To get this stipend, magicians have to perform a certain number of times in a calendar year. And

magicians aren't always sure if they will be hired to perform enough times that year. But they also want to have as many high-paying jobs as possible so that they have a good stipend the following year. Magicians thus have to make certain complicated calculations when they are offered a low-paying gig. If they take too many low-paying gigs, their stipend for the next year will be low too. But if they don't have enough gigs in a given year, they won't get any government support at all the next year. Bureaucratic regulations force French magicians to evaluate what it means to perform differently than magicians in other countries who are facing a different kind of bureaucracy. A country's government policies can affect people's daily work lives to such an extent that they influence whether or not a magician performs at a child's birthday party.

All this is an important reminder of how much national and cultural context matters at a moment when market analysts all too often describe the world of work as flat and homogenous. In today's global economy, labor market observers optimistically claim that labor is supposed to move freely and jobs are supposed to be so standardized that a computer programmer in Iran could just as easily be working in Bangalore or Silicon Valley. Yet people's on-the-ground experiences show that this is not true. Even ballerinas discover that this isn't true, although ballerinas everywhere are supposed to learn the same repertoire of ballet steps so that a ballerina in London should be able to fill in at a moment's notice for a dancer in Stockholm or New York. Yet dancers in London have contracts with the Royal Ballet company that have to be renewed every year. They feel far more vulnerable than the dancers in a Swedish company, where the government insists that dancers have contracts that last until retirement. As a result, ballerinas in London are much more worried than their counterparts in Stockholm about injury and are much less likely to start a family until they are at the end of their careers in their early forties. Ballet steps may be the same the world over, but the conditions under which the ballerina dances and when she or he starts raising a family depend on the country in which the dancer lives. The following chapters provide many more examples that this belief in the ever-increasing similarity of workplaces is misplaced. Yes, the legal and economic conditions of a nation shape the contours of work. But just as importantly, every single chapter describes how culturally specific a job can be. When a line of work is culturally specific, it means

that all the social interactions are context-dependent, and so are the range of solutions that might fix a situationally specific occupational dilemma.

Postscript

I have so many students who don't know what they want to do when they graduate, who don't even know what kinds of jobs are possible. They think mostly of the jobs that their parents and their parents' friends have, or the jobs that they see on television. They often wonder how to even begin to dream of other ways of living, of other kinds of work that they would enjoy. This collection is a graduation gift to my students, a bouquet of possibilities so that they can start thinking in concrete detail about what they need to know to do many different kinds of unusual jobs. Here it is: a world of work for all those who have wondered, "What careers could I dream of having? What would it be like day to day to be in a different line of work? And what are the range of things that go into doing *that* job?"

Suggested Readings

For an inspiring collection of imagined advice from an anthropological perspective:
Judy S. DeLoache and Alma Gottlieb, eds., *A World of Babies: Imagined Childcare Guides for Seven Societies*. Cambridge: Cambridge University Press, 2000.

For a theoretical lens on apprenticeship, learning, and communities of practice:
Jean Lave and Etienne Wenger, *Situated Learning: Legitimate Peripheral Participation*. Cambridge: Cambridge University Press, 1991.

For a sophisticated discussion of ethnographic fiction:
Kirin Narayan, "Ethnography and Fiction: Where is the Border?" *Anthropology and Humanism* 24, no. 2 (1999): 134–47.

For another rich ethnographic investigation of many of the analytical themes in these chapters:
Stefan Timmermans, *Postmortem: How Medical Examiners Explain Suspicious Deaths*. Chicago: University of Chicago Press, 2007.

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Letter to a Young Malawian Doctor

Claire Wendland and Chiwoza Bandawe

The citizens of Malawi share a proud tradition of peaceful coexistence among ethnically mixed people. Their southeast African nation is well known for its beautiful lakes and mountains, and for its friendly citizens. It is also known for its poverty. In recent years, some things have changed for the better. Electrification and cell phone coverage have reached more and more parts of the country, for instance, and both primary and secondary education have expanded. Still, most people remain quite poor: Over 90 percent of Malawians get by on under two dollars a day.

Western-style medicine has been present here for over a hundred and fifty years, since the earliest Scottish missionary doctors reached what is now northern Malawi. The country's first postcolonial president was a Malawian physician, Dr. Hastings Kamuzu Banda, who had trained in the United States and practiced for years in Britain and West Africa. (Dr. Banda, referred to near the end of the letter below as "Kamuzu," maintained a very tight grip

on power for three decades before the country's mid-1990s transition to multi-party democracy.) Doctors are still relatively few and far between outside of the country's few large referral hospitals, however. Malawi's medical school is relatively new—it only graduated its first fully domestically trained doctors at the turn of the millennium—so the rural district hospitals still may have only one or two doctors on staff. Nurses, midwives, medical assistants, and "clinical officers" (whose training is a bit like that of physician assistants in the United States) provide the great majority of Malawi's primary health care. The nation's poverty, and government budget restrictions imposed through international economic policies, mean that salaries are low, medications often run out, staffing is limited, and supplies are inconsistent in the threadbare public hospitals where most patients seek care. The hypothetical "six million" hospital budget mentioned in the letter may sound fine, for instance, until one recalculates from Malawi kwacha to dollars: it would be a little over fifteen thousand dollars for a year. Given these limitations, relatives provide much of the basic nursing care, and for this and many other reasons, maintaining good relationships with one's relatives is crucial. Doctors have to be flexible and creative to do their work well. Many also supplement that work with research jobs or part-time employment in private clinics.

When Wendland studied among medical students and interns at the University of Malawi College of Medicine years ago, she often asked them, "If you had a little brother or sister who wanted to become a doctor in Malawi, what would your advice be?" Some students, especially very junior ones, were enthusiastic. Most were cautious, advocating a long conversation about the pros and cons of medicine so that their siblings might make well-informed decisions. Some, including most of the interns, advised against the whole idea. These discussions were often illuminating and surprising. And so we have imagined here an older sister, long finished with her medical training and with several years of experience as the sole doctor in a district hospital in Malawi, writing a long letter full of advice to her younger brother, who is about to begin work as a District Health Officer (DHO).

Dear little brother,

You have asked for my advice as you finish your internship and begin work at Wathanzi District Hospital. I am not sure why you want it now: You never listened to my advice when I told you to find some other kind of work! I said, the white coat and stethoscope, you may admire them, but they are not for everyone. We have one doctor in the family now that I am working in Chakumpoto. One is enough. Think about all the other kinds of work you could pursue, maybe the law, maybe teaching. But you were not deterred. You had to continue on this path!

I am teasing, little brother. Of course if you have a heart for this kind of work, it is what you should do, despite the trauma and the cost. You know already, from your five years at the medical college and your year and a half of internship, how it will challenge you. But I am happy to give what advice I can. In my eight years at Chakumpoto District Hospital, I have learned a few things.

I have never seen Wathanzi, but my colleague Thokozani used to work there before she got her position with that Johns Hopkins project. I asked about it when I came to the city for a training session last month. The place is quite nice for a district hospital, she says, rebuilt in the 1970s and well maintained. It sounds a bit like my hospital—a women's ward, a men's ward, pediatrics, the maternity wing, around eighty beds in total, although sometimes you will have many more patients than beds, and some will need to stay on the floor. There is a surgical theater and the outpatient block, X-ray and a small pharmacy. All of these are laid out in a compound surrounded by a metal fence. The district health officer's house—your house, soon—is just outside the compound, close enough that anyone from the hospital can walk there in an emergency and knock on your door. It has a nice garden where you can cultivate some tomatoes and greens and keep a few chickens. On the hospital compound there are several well-grown mango trees. That's good, as your patients will need some shade—and perhaps a nice snack of mango—while they are sitting on the grounds waiting for the clinic or the pharmacy to open. Oh, and of course there is a guardians' shelter at the back of the compound, with a tap and a concrete basin, where relatives cook meals and wash clothes for those in hospital.

Figure 1.1 The patient entrance at a district hospital in Malawi. Photograph by Mary O'Regan.

The district health officer position has been vacant since Thokozani left last year. A clinical officer, Mr. Mpeni, runs the hospital, along with the matron Mrs. Mapilisi. They are both very sound, said Thokozani, but they will be slow to trust a new doctor—they have seen so many come and go over the years. (Thokozani sounded regretful about that, but she said her salary at the project is much better, and that she had to think of the school fees for her two boys and the seven children her sisters left behind.) Only about half of the nursing posts are vacant, so you will have more staff than most of the districts—but of course not as many as your patients actually need. The pharmacist is skilled and honest. Thokozani never had to worry about medications finding their way to the market in Wathanzi, as I have struggled with here in Chakumpoto. Of course there are many, many times when the pharmacy runs out of supplies. You'll have gotten used to these stock-outs in your internship, I know, and will have a sense of what other drugs you might use when the best ones run out, or which you can ask your patients'

relatives to go buy at a private pharmacy. Oh, and Thokozani also said Wathanzi's X-ray technician died last year, but he had been training an assistant already when he got sick and that one is taking pretty good films.

Being in Charge

It will be strange for you, I know, starting as the DHO in charge of all of these people when you have just finished your internship. Do not worry. You are the doctor, and they will respect your training and your knowledge—after all, we are known as the brains of the Malawian educational system! It took some time for me, a woman and a Chewa coming up to the North. I had to learn ChiTumbuka quickly. And I had to be very authoritative at first. This stern manner will not be necessary for you. You are a man, and you will be working in the Central Region, where we are from.

I have been thinking hard about how to advise you on being Wathanzi's only doctor. We can hope this situation will not last long: The College of Medicine is so large now that most of the districts shall have three or four doctors eventually, and Wathanzi is not so remote, or so hot, or so troubled, that it will be hard to staff. But for now, you will be alone. That has some advantages, and it poses some challenges.

You can make a positive impact quite quickly, if you show you are willing to work hard and to be stubborn on behalf of your patients. The leadership of a single committed doctor can be powerful.

But: There is no one to check your excesses. If you stop seeing your patients as humans and just work through the line without exchanging a kind word, no one will correct you. If you become angry and fatalistic, there is no one to restore your spirits. If you feel this happening, call me, little brother. I have been there, and I can help. If you stop keeping up to date and practice only the medicine that you learned in school, who will notice? (There is a balance to be struck. You want to learn enough to stay up to date, but not so much that you are always away from the hospital at a training session!) The burden is on you to keep learning, to keep thinking, to keep caring, to keep being the best doctor you can.

You must be available—always. When an overloaded *matola*[1] blows a tire and flips over and everyone riding in the back is badly injured, when an *azamba*[2] brings in a woman after two days of obstructed labor out in the village, when cholera breaks out during the rainy season, you will be the one on the spot. You must be careful about getting too tired. You must be restrained about drinking beer—yes, I heard stories about your time at the college. Mr. Mpeni the clinical officer can help, but you are in charge each and every moment, and you will need to stay sharp.

Chronic Illness

As you know, many of your patients will be infected with HIV. Dealing with HIV is not quite a simple thing for a doctor here! In the days when I was training—before Malawi finally got the money for antiretroviral medications—we used to say it was better not even to test. Yes, a negative status was a great relief. But to tell patients that they were positive was like giving a death sentence, telling them to give up hope. The government promoted voluntary counseling and testing, but my colleagues and I didn't test ourselves, and we rarely recommended testing for our patients. (And at any rate, the test reagents were often unavailable.)

Now things are different. I find that most pregnant women want to get tested. We can easily get them medicines to prevent transmission to the infant, and now, with the new policy, we shall even be able to treat the mothers afterward. Some will be afraid, and your nurses will have to speak with them gently. Sometimes if a woman tests positive, the whole family will blame her even when it is obvious that it is the man who has been "movious" as we say, moving from girlfriend to girlfriend. Here in the North wives can be put out of the house when

1. A *matola* is a pickup truck that takes on paying passengers, who are typically loaded in great numbers in the back; it serves as a form of informal public transit.

2. An *azamba* is a person, usually lacking formal medical training, who attends births in homes or village settings.

the blaming gets bad. In Wathanzi District, of course, you have matrilineal families: it's the wife's house and the wife's family's compound where the married couple stays. Still, she can fear for her livelihood, or for abuse.

I find the men harder to test. Many will not come until they are quite sick, because they think a positive test will sap them of their will to live, and to work, and to earn for their families. We have had better success in recent years once a few of the hospital staff let it be known quietly that they themselves were taking ARVs. Word got around fast. When everyone could see that our ambulance driver was getting fat and driving almost every day—he had been as thin as a maize stalk and had not come to work for months, although I did not let him go because then how could his family eat, so sometimes I drove the ambulance myself and more often one of the sisters who had a driving license did . . . where was I?—ah, then some of the men began to come in for testing too.

Testing is not the only difficulty. Sometimes dealing with so much HIV is dull: Skin rashes are HIV, chest infections are HIV, sore throat is candidiasis from HIV. You can get so bored that you don't pay attention, and you miss the time when a sore throat is actually diphtheria and what looks like a chest infection is actually asbestosis. (Down in Wathanzi you'll still have some old men who worked in the South African asbestos mines.)

Also, you cannot be afraid of the knife when you are a district doctor. I know they like to say that getting HIV at work is rare, but you and I know it is not. Not when we still sometimes run out of gloves and have to reboil them so often that they fall apart in surgery. Not when we re-use needle drivers until their teeth are dull and the needle dances and twists and stabs us. But you must put aside the fear and do your work in the surgical theater.

What of yourself? Take care, little brother. Do not think, "Of course I will get it, so there is no hope" and become careless with needles and scalpels: That is dangerous for yourself, for your patients, and your nurses. (Do not be careless in your own life either. It is not proper for me to speak of these things to you my *mlongo,* but we are doctors, so I will say this much: you have heard people say "You can't eat sweets with the wrapper on," no

doubt.[3] Nonsense. I say find yourself a good and faithful wife, as I have found myself a good and faithful husband, and until then if you must eat sweets, leave the wrapper on.)

Everyday Challenges

Do not become lost in administration. A never-ending flow of paperwork will find its way to your desk. We already had ledgers, and now there are new computer programs. But the ledgers have not gone away, as they are useful for when the computers fail or the electricity is out, so now you have two places to note everything. Two? I should say many. Every donor who contributes something to keep the hospital running expects some kind of form to be filled out on its use. So if GIZ gave the ophthalmoscope, and NORAD gave the X-ray machine, and USAID is supporting the antiretrovirals, but only for pregnant women, and . . . you get the idea.[4] And the Ministry of Health requires many of its own records. Add it all up, and it becomes quite a lot. You could spend all your time doing this kind of thing. Sometimes perhaps it is a bit tempting to do so. After all, you can't kill anyone with paperwork, at least not in the obvious ways that you can with a scalpel. When you are feeling unsure of yourself, you may wish to leave the wards and the theater to Mr. Mpeni. Don't let that happen, little brother. Unless your clinicians are very different than most humans, they will soon begin to take advantage of you. And the people in your district will see what is happening, and they will feel wronged.

Do you remember our parents speaking of *uMunthu*? That is what you must keep in mind: how we Malawians realize that all people are human beings and that we are all connected to each other through our

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3. *Mlongo* is a sibling of the opposite sex. In this case, as a woman is writing, it indicates her brother.

4. The three acronyms represent bilateral aid organizations active in Malawi: GIZ is the Deutsche Gesellschaft fur Internationale Zusammenarbeit from Germany, NORAD is the Norwegian Agency for Development Cooperation, and USAID is the U. S. Agency for International Development.

humanity. I am because you are, dear brother, and you are because I am. The people you work with and those you serve expect you to be treating them as fellow human beings: with kindness, respect, hospitality, loyalty, sociability, sympathy, and endurance. In the work of a doctor, all the more so, my dear! I remember one of our senior lecturers explaining that *uMunthu* is the collective consciousness of the African people, shaping our behavior patterns, our expressions, helping us to know what being an ethical human is, and what we need to grow spiritually and find fulfillment. In the work that you do you have an opportunity to feel the most vital needs of others: to live all the characteristics of *uMunthu*.

You may have an opportunity to teach it, too. Wathanzi is not so terribly far from the city, so you may have *azungu* who want to volunteer in your hospital.[5] We get a few even as far north as Chakumpoto. Two I can think of in the last several years were really wonderful, a midwife from Scotland and an intern from America. Both of them stayed for several months, worked hard, learned enough ChiTumbuka to get by, and consulted with me regularly when they had questions. I would welcome either one back! (In fact, Dan the intern promised to return when his training is done.) Others were more trouble than they were worth. We had one German medical student who did not want to put in drips or even catheters because she was so frightened of HIV—she just wanted to watch us work, as if Chakumpoto were a zoo. And I remember two American students who thought they could do anything they wanted, even surgery, because this was Africa. Do not be too quick to say yes to volunteers, and when they arrive talk to them seriously about your expectations. You must help them to understand that not only do they have something to give to Africa but they also have something to receive. Apart from the work in the hospital, they can learn *uMunthu* in action, to learn the value of a lesser emphasis on individualism and a greater one on communal cohesion—and to realize that the Malawian *uMunthu* concept of togetherness is a powerful way of life that we

5. *Azungu* (singular: *mzungu*) are white foreigners.

Africans can teach the world. Do you remember when grandma died, the whole community came together and they mourned with us? It was the whole community that felt broken, it was not just left to our family.

And while I am on the topic of people who can be both a blessing and a challenge . . . ah, relatives! I know that you rejoiced when you got the news of your posting at Wathanzi, only two hours by minibus from our family home. Yes, in many ways that is a very good thing. Our parents will be proud to have their son the doctor nearby. I think our mother will be taking you to her standard-eight classes as an inspiration to her students every time you visit![6] And father will no doubt hang a picture of you in your white coat on his wall at work, near the president's picture, and that old family photo where we are all so young and serious-looking.

There is a difficult side to relatives too. Someone will come to the hospital who says, "Ah, I am the son of your daddy's brother's wife's sister, and we have not met, but I have this problem" . . . and then they will expect you to drop whatever you are doing and escort them through the hospital. And probably expect you to buy their medications or bandages when it's all done. This is a challenge. You must take good care of them, or people will say you have lost your culture and become like a *mzungu.* But you must not let them take from your work too often, either, or your patients will grumble that you are favoring your family and neglecting everyone else.

You may also find many relatives who ask you for support, school fees for their children, to take in orphans, or to help them with capital to start a small business or such. With all your schooling, you count as a senior person in the family, young as you are. And people do think that because we are doctors we are rich! If they only knew how little we actually earn. I mean, it is much more than the average Malawian, true. But it is not enough to pay for school fees for every Jack and Jim, so you may have to think carefully about how to manage your relatives—and your salary.

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6. Standard eight is the equivalent of eighth grade. It is the final year of free public education.

Resourcing

Where you must be most clever is in resourcing. We are a poor country, you know, we are just developing. Still, there *is* money to be had, there *are* drugs, there *are* supplies . . . but you must learn how to get them.

When you deal with district officials, do not give in too quickly. Say you ask for a budget of six million, and they give you two point eight. Do not just say "chabwino, I will do what I can."[7] Say "fine, I will have to close the hospital." They will be unhappy. They may say you are rude. But they will at least find a way to make a few more hundred thousand appear—better than you would have had if you had just said yes right away!

There are donors too. Many of them deal directly with the Ministry of Health, but if you can make your hospital's reputation strong, then more of that money may come your way. And some donors you can deal with directly. It will be good if you can ask Thokozani about them—she was very good about arranging for donations! She told me, send them pictures of starving children, yes, that is often what they need to see. But send them pictures too of white-coated doctors working among them. It should not look too hopeless, both for our pride and for their pocketbooks. They all want to make a big difference with a little money. So your hospital needs to look like a place where everything is all ready to get better if only some helpful donor would provide an ambulance, or some autoclaves, or whatever.

You can be creative not just with funds but with people, and with things. Find out what people are good at. Maybe you have a medical assistant who is too slow in OPD, but he handles medicines well and can step in when the pharmacist must attend a funeral. Up here we had a wonderful senior nurse whose arthritis became so bad she could no longer get around the wards quickly. Now she handles much of the paperwork for me, and she is my staff disciplinarian. One stern lecture from her and a misbehaving worker mends his ways!

As for things, of course you know already how to sterilize fishing line for suture and to turn a used intravenous drip into a catheter. Not ideal, and

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7. *Chabwino* means okay.

we should not have to do these things. But it is better to do them, I think, than to have no catheters and no sutures at all. Find the district's most ingenious metal-worker and its best electrician. Learn from them. When you have something that needs repair, ask them to show you how to fix it. We've made our autoclave last years beyond what it should have up here in Chakumpoto, and the ambulance too.

Community Work

As DHO you will need to lead community outreach projects. I can share with you a few things about how the community operates—for there were some unforeseen lessons I learned the hard way.

Zeal of Key Players Is Critical

In my first year here we established health clubs in two local schools. Two teachers offered to be patrons. We provided them with basic health education training and a set program for weekly club activities. The first year went well. During the second year, though, one of the patrons, Woyamba Mphunzitsi, left the district for three months. Michael Thandizani stepped in, saying that he would run the club. I spent as much time as I could spare training him on health education basics. He tried hard, but he was a novice, and he was dutiful but unenthusiastic. The club floundered and struggled, and meetings grew intermittent. It was only after Woyamba returned that the health club picked up again. He came back with an energy and momentum that quickly re-established the club on a sound footing.

I learned a powerful lesson: Regardless of how meticulously an intervention is planned, its success depends upon the zeal and preparation of key players. When recruiting leaders, ensure that they have passion for the task or you will find difficulties.

Do Not Play Favorites

In my second year we held a health education display at one of the schools. The function went off very well; the students and community drama group performed admirably. When it was my turn to make

speeches, I took the opportunity to award the best male and female participants with a backpack for their efforts. I announced the recipients of the prizes, and to the crowd's applause they came forward. Soon after the ceremony was over, several health club members—including the chairperson—approached me, very upset. They complained bitterly that they had worked hard on the displays and had expected a prize. I explained that only one male and female could get the prize—and that the prizes were not intended to denigrate any of the other participants but rather to encourage the club members. They were not appeased. In fact, they threatened to quit the club altogether, and boycotted the after-party of soft drinks and biscuits. One of the schoolteachers, having observed what transpired, called me aside. She advised that in future, I should not single anyone out. The presenting of ballpoint pens or some small gift that included everyone would be more effective than giving out individual prizes.

This event highlights an important downside to community living. Do you remember the psychology professor's lecture on the "pull-down" motive? It's really true that individual achievement can have high social costs; I have seen it up in the north often and Thokozani tells me it is even more an issue in Wathanzi. If everything and everyone must be equitable for a community to hold together, the one that succeeds "leaves" the group. You know already that when someone in Malawi excels at work or in business, he or she is more likely to receive discouragement than praise. That is why we used to joke that "PhD" stood for "pull him down." You will get a lot of this, dear brother. In the community, remember that when you can maximize equity, you minimize trouble.

The Community Always Asserts Itself

I remember we once held a music and drama display at one of the schools. After selecting the date to ensure minimal disruption to the school program, the headmaster had told all the pupils and teachers that classes would be cancelled. The school was to gather by the big tree under the hill to watch the display. The pupils all came—but instead of the usual turnout of many teachers, there were only two. After only

a few songs and poems there was suddenly a mass exodus of pupils. Shocked and embarrassed, the headmaster put the program on hold and tried to find out what was happening. It turned out that some of the teachers had sent a message to the students that they would be writing mock exams, and that any pupil who did not come right then would fail the year. The students all heeded the call and rushed to their classrooms. With half the audience there—and an apologetic headmaster—we finished the program. When I followed the issue up later it emerged that some of the teachers were feeling resentful toward the health club: its patrons received a very small allowance, which was perceived as depriving other teachers. Money issues are very sensitive in a space where poverty reigns supreme.

It is sensitive, too, where nongovernmental organizations with loads of funding make the rules. Some give remuneration, which becomes expected of all programs. I remember as we were designing our vaccination outreach in Chakumpoto we brought together interested parties, including the chiefs, to share their concerns. When a health assistant visited the villages to follow up later, he was castigated by the chiefs. Having not been paid for their time in attending the meeting, they felt cheated and were furious to the point of threatening not to cooperate with the vaccination program. Yet the underlying rule of the program was never to pay: neither to pay the chiefs to attend a meeting, nor to pay the assistants who would go from village to village administering injections. The rationale was that if the community is involved in a project that it benefits from, then without a financial incentive, the program stands a better chance of being sustained.

Ah, how to instill voluntarism and community cooperation when money is so scarce? Brother, involve the community right from the start if you want a real "community-based" intervention. In the design of the vaccination program, funding was never discussed with the community. When the budget was drawn up, the external coordinators of the program determined who would be paid (mostly their consultants) and who would not (health workers and village leaders). There thus was a clear inequality that went against the ethos of *uMunthu,* which we had intended to be an important framework guiding this intervention.

The community made it clear that these differences were important. What I learned is that the "pay me!" stance the villagers insisted upon in this intervention was an attempt to rectify an imbalance, to reassert human dignity and social identity. It was a recognition of the distortions of development and donor practices. You know what, dear brother, at one level aid or assistance is perceived by recipients to be an undermining experience in which something is taken away by aid providers (time, self-respect, pride, dignity, and collective autonomy). Hence, in line with the norm of reciprocity—an integral component of *uMunthu*—the loss must be repaid somehow.

The desire for restitution will sometimes put you in uncomfortable dilemmas. You may be administering health projects run by NGOs that provide no payment, yet expect much extra work from health personnel. Your staff may expect that as a fellow Malawian you will be more sympathetic to their situation and more generous with allowances. In the case of the vaccine program, I was able to approach the Ministry of Health for additional funds. My staff were very pleased to receive this recognition of their efforts and participated enthusiastically.

Why to Stay

There will be times when you think, "I cannot stay working here any longer. I am a doctor. I am trained in medical sciences, I can explain the molecular pathways of oncogenesis and the full life cycles of twenty parasites. Yet here I am, wards overflowing with sick patients, working with four antibiotics (on a good day), no pregnancy tests, a microscope with a broken 100x lens, and chiefs demanding payment. What is the point? Should I not look into finding work in London, or Dubai, or at least Durban?"

I can tell you, my dear, that I have been in this same place many a time. If someone had come at the right moment and offered me a position in (say) Cape Town, I would have said yes. Indeed, some of my friends from the College of Medicine emigrated. You know that Margaret went to Adelaide to train in radiology and never came home, and Dalitso is in Manchester. We keep in touch. I know they have cars and nice houses

and that they enjoy their work. (Did I tell you that Dalitso married an Englishwoman?) But it is clear to me too that in some ways my life is more satisfying. I know every day that I make a difference. They mostly work with old people who have many chronic diseases. I work mostly with children, often acutely ill, and if I can treat a cerebral malaria case effectively, then I have changed the course of someone's life—and that of his family too.

A doctor's status is not so high there as it is here, and sometimes foreign doctors are treated with suspicion. Dalitso and Margaret both say that the everyday racism they encounter in the *mzungu* world is wearying. Here everyone's eyes dilate with admiration when I come into the room, and my word is accepted as truth. Even in church! Truly that can be tedious with old friends, but it is useful around town—I can easily get credit with the local businesses, and sometimes they offer small gifts. At the *chigayo* the mill owner will sometimes give an extra sack of *ufa* to the doctor.[8] That's nice, given my salary and how often it is "delayed" for one reason or another.

Our status is also useful politically. A doctor in Malawi can have real power. When we speak about what it will take to heal the nation, people listen. We may not have the money and advanced technologies that our brothers in rich countries have, but we have authority and status, and if those things appeal to you, then a district practice in Malawi can be richly rewarding indeed.

And that brings me to my last point in this very long letter. I know that our parents urged us to stay clear of politics. I understand their fear. Grandfather was never the same after his years in prison under Kamuzu. I am not, myself, blind to the dangers. But we are doctors now. Sometimes when people have it made, they are making a good income, their family life is happy, they can become blind to the suffering of others. Insulated. You and I? That can never happen. A doctor here in Malawi would have to sit behind her desk all day without seeing patients to think that all is well in our nation. A doctor would have to be very stupid not to see how poverty and political malfeasance and lack of high-quality education are

8 A *chigayo,* or maize mill, grinds up dried corn into flour—*ufa*—that is used to make the staple stiff cornmeal porridge most Malawians eat daily.

at the bottom of so many of the problems we see. And I know you are not stupid. Drugs are vital! Surgery is important! Health knowledge is critical. But you cannot help but see that medicines and operations and health education alone are not going to be enough. A healthy country needs good roads and traffic enforcement so that these terrible *matola* accidents end; environmental safety measures so that children don't die of pesticide poisoning; decent agricultural policies so everyone has nourishing food to eat and seeds to plant; an end to corruption so that the drugs intended for our hospitals stop going to the markets instead; strong leaders who push back against pharmaceutical prices so high that cancer treatment cannot happen in the districts—and can rarely happen in the capital city. So you may choose to use your status as a doctor to exert political pressure. This could be in small ways, as when you talk with the district about your budget. It might be in more risky ways. Perhaps you will even pursue elected office someday. (If you become president, can I be your Minister of Health? I think I would be a very good Minister of Health.) You may have a heart for the people, and perhaps working with them in the hospital as a healer will be enough. But if you want to heal our nation, you may need to work beyond the hospital as well.

Good luck and good health, my brother. I have faith in you.

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Suggested Readings

On medical and nursing work in a southern African hospital, see:

Julie Livingston, *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durham, NC: Duke University Press, 2012.

On medical training in Malawi, see:

Claire Wendland, *A Heart for the Work: Journeys through an African Medical School*. Chicago: University of Chicago Press, 2010.

On community participation challenges, see these articles:

Lisa C. Jordan, G. Anne Bogat, and Gloria Smith, "Collaborating for Social Change: The Black Psychologist and the Black Community." *American Journal of Community Psychology* 29, no. 4 (2001): 599–620.

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On *uMunthu,* see:

Chiwoza Bandawe, "Psychology Brewed in an African Pot: Indigenous Philosophies and the Quest for Relevance." *Higher Education Policy* 18 (2005): 289–300.

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