

## Contestations Over “Tradition” and “Culture” in a Time of AIDS

Pauline E. Peters, Daimon Kambewa, and Peter A. Walker

In Malawi, the distress and unease caused by rising numbers of deaths and chronic illness due to HIV infection have led people to search for explanations. Here, we describe two particular “turns to culture.” Zomba villagers over two decades have come to link AIDS with *kanyera*, an indigenous illness syndrome. In contrast, the public media, government, and donors blame “promiscuity” and “cultural practices” for HIV infection. The resulting stigmatization causes people to avoid naming AIDS, and both turns to culture tend to link blame and stigma to women.

*Key Words:* AIDS; culture; gender; indigenous illness; Malawi; stigma

Had he died of “diarrhoea”  
the master of burial ceremony  
would have pronounced it easily  
without beating about the TB bush.  
Had the death cause been cancer,  
pneumonia, anaemia or malaria  
that bereaved uncle would have said so.

PAULINE E. PETERS is Senior Research Fellow, Center for International Development, Harvard University. A social anthropologist, she has researched and taught at Harvard University since 1982. She has conducted research on agrarian transformation in countries of Southern Africa.

DAIMON KAMBEWA is Lecturer in Rural Sociology, Bunda College of Agriculture, University of Malawi. His research focuses on land use and tenure, ecology, and society.

PETER A. WALKER is Associate Professor of Geography and Environmental Studies at the University of Oregon. His research on politics, culture, and environment has been conducted in Malawi and the United States.

Correspondence may be directed to Pauline E. Peters, Harvard University Center for International Development, 79 JFK St., Cambridge, MA 02138, USA. E-mail: pauline\_peters@harvard.edu

Had heart attack been the cause  
 those lengthy biographies  
 and mysterious witchcraft stories  
 wouldn't have covered the coffin.  
 But because it was AIDS  
 the fatal-stone was better left unturned.  
 Is it a taboo then  
 to mention HIV/AIDS at a funeral?

Gracious Changaya (Lwanda 2003:123)

Like other countries of Southern Africa, Malawi has seen a rapid rise in HIV infection since the first cases in the 1980s. The national prevalence of HIV dropped from 15 percent in the late 1990s to 12 percent in 2008 according to UNAIDS. Data drawn from 20 years of research in Zomba district villages in southern Malawi indicated that illnesses attributable to AIDS have become more recognized, but their cause remains a matter of debate. We explore why people avoid naming AIDS (*edzi*) in reference to people they love, know, or live among, suggesting the reason lies in the emphasis by public media and official sources on promiscuity and backward "culture," which has stigmatized AIDS in a way not found for most sexually transmitted diseases. We describe the ways in which people name or avoid naming AIDS, and consider how public stigmatization of AIDS by agencies and media has produced stigma that villagers seek to avoid. The two "turns to culture" are then laid out—villagers link the indigenous illness *kanyera* to AIDS while the public media focus on "cultural practices" as the cause of high rates of HIV infection.

The research on which we draw here is based on a 20-year longitudinal study in villages located in an area of approximately 300 square miles in southern Zomba district in the highlands of southern Malawi. Peters carried out 12-month studies of sample villages in 1986, 1990, 1997, and 2006, with shorter visits in most intervening years. Walker worked with her in the 1990, 1997, and 2006 rounds; Kambewa joined in 2006. The study used both quantitative (survey-based) and ethnographic methods, covering such topics as expenditure, multiple sources of income, landholding (measured) and land transfer, crops grown and sold, food stores and use, births, deaths and marriages, health, family and lineage formation, and so forth. Full-time research assistants lived in the sample villages throughout the studies, as did Peters most of the time.

#### NAMING AIDS

During 1986/1987, the first year of research, HIV and AIDS were barely heard of, although later we learned that the virus was present in the country.

By 1990/1991, however, people in the Zomba villages were hearing about “the new disease,” but many did not understand what it was. By the mid-1990s, its effects in terms of deaths and chronic illness were noticeable to villagers and researchers alike; these had worsened by 2006.

By then, most people accepted that the disease was passed on mainly through sexual contact and spoke of people needing to be “careful” or to avoid promiscuity. But HIV infection is not accepted as the only route through which diseases associated with AIDS are contracted, and only a few deaths were described to us as due to the new disease—AIDS. Most deaths over the past decade, due to illnesses medically associated with AIDS, were described in the same way as deaths before the epidemic: that is, in terms of symptoms (diarrhea, high fever, getting thin, stomach pains) or a named illness (such as pneumonia, tuberculosis, or cancer). Some deaths were said to be due to the witchcraft of jealous or malicious people, excluding the possibility that the illnesses were AIDS. Elsewhere in Southern Africa, researchers have found some people associating AIDS with witchcraft but, at least in 2006, people in Zomba villages did not do so. Other interpretations resembled those identified elsewhere in Malawi and neighboring countries: AIDS is sometimes transmitted through injections or infected blood or instruments; AIDS is purposively inflicted by God (or some say ancestors, *makolo*) to punish immoral behavior, by whites who hate Africans, or by government through infected condoms and other contraceptives in order to reduce the population (Kaler 2004; Allen and Heald 2004; Pfeiffer 2004; Mufune 2005; Rödlach 2006; Fassin 2007). In this paper, we focus on the interpretation common in the villages that AIDS is a more virulent form of the indigenous illness, *kanyera*.

The reference to the new disease (*nthenda yatsopano*) reflects widespread unwillingness to acknowledge publicly that a relative or friend has died of AIDS, as illustrated in the poignant poem with which we began this article. While some people now use the transliterated Chinyanja term *edzi* when talking in general about the contemporary situation, extremely few do so when referring to the death of a relative, close friend, or neighbor. Most use indirect terms to indicate AIDS—new disease, government disease (*nthenda ya boma*), current disease (*nthenda ya masiku ano*), this disease (*nthenda yomwewa*)—and all speakers of Chinyanja fully understand the reference. In English, the equivalent of these terms might be “that current illness . . . you know . . .”

The avoidance of naming AIDS appears related to the emphasis by many AIDS programs and public commentators on “promiscuity” or improper sex and the association of HIV and AIDS with certain death. The moralization of AIDS discourse has increased in recent years (Iliffe 2006), inhibiting acceptance of AIDS as “just” another disease. People with AIDS are

commonly described as *oyenda-yenda* or “movious” in Malawian English (“sleeping around”). While extramarital affairs (*chibwenzi*, friendship or love relationship) are fairly common, indigenous illnesses said to derive from specific types of improper sexual contacts (discussed later) are not stigmatized in the same way as AIDS. Men or women who have infringed certain important rules of sexual conduct have been able to consult elders or specialists to obtain the necessary help through certain rituals and medicine (*mankhwala*). Regret, shame, or carelessness may affect the proper diagnosis and treatment of the indigenous illnesses in any particular case, and the behavior contravening these cultural rules is recognized as improper and dangerous to the perpetrator and his or her close relatives. However, such behavior appears to fall within the expected range of “normal” errant human behavior, as the available remedies suggest (cf. Ashforth 2002:135 on South Africa). AIDS, in contrast, has become treated as a unique disease, stigmatized, even demonized, in public pronouncements.

Government and donor messages have linked HIV infection and AIDS with “promiscuity.” Most Christian churches and Islamic groups have taken a defensive stance, seeming obliged to emphasize the various ideals of their faiths rather than making a more realistic assessment of prevailing ideas and practices among their followers. Much of the moralizing and preaching have ignored the pre-existing ways in which sexuality is commented on, ways which, as Lwanda (2003) suggested, remain partially “hidden” in coded forms of speech or song.

But not only the “faith groups” have engaged in moralizing. In the research villages, for example, older people tend to accuse the young of increasing lack of discipline in all ways. Some elders blame Western ways (*za chizungu*), some invoke new media such as video. Many see AIDS as due to a general loosening of proper morality, whether in terms of Christian, Islamic, or ancestral codes; people warn of the dangers of forgetting “tradition” or “custom” (Schoffeleers 1999). The tension between older and younger generations is not new, but it appears to be more insistent as elders, especially grandmothers, deal with rising illness and death.

Women tend to be more stereotyped in blame assigned for the AIDS epidemic. Multiple sexual partnering in love affairs has long been known for both men and women, even though in opinion and probably practice it is more common among men. The tendency to dismiss men’s infidelity to men’s nature, while women are likely to be subject to sanction, has intensified in the face of the moralizing of AIDS. This is not inconsistent: husbands have authority over wives, able to beat them if they are “rude” (Ribohn 2006:172), and women have lower education, income, and access to formal employment. In the matrilineal-matrilocal area of our research, where almost all women live in their natal villages surrounded by their own kin,

they command considerable authority within the family, lineage, and village. Nevertheless, beyond these domains, even these women face discrimination and disadvantage. Moreover, political liberalization after the demise of Banda's authoritarian controls in 1994 has been associated with perceptions that culture has "loosened," and women in particular are implicated in the decline of morality (Ribohn 2006:169).

Two common stereotypes scapegoat women (with little evidence): that bargirls, young(ish) women who either work in or frequent the bars and rest-houses in rural trading centers and towns are the main transmitters of AIDS; and that, in the context of increasing stress on livelihoods over the past few decades, many women are forced to "sell sex" to support themselves and their families. In the 1990s public discourse on AIDS in Malawi saw female prostitution as a major "transmitter," which, combined with "low female social status compounded the cultural stigmatisation of women" (Lwanda 2006:156).

Avoiding naming AIDS also seems due to the insistent message of its incurability, especially in the early years of public discussion of the epidemic (cf. Niehaus 2007). As others have pointed out (Morris 1985), the indigenous modes of healing in Malawi assume that all illnesses have remedies, even if a particular person may die from an illness. In the cases of serious illness, in the research villages over the past 20 years, those caring for a sick person struggle literally to the last breath to find medicines and other assistance for the patient. To do otherwise—to publicly accept that the person is dying and do nothing to try to find a cure—would be to implicate oneself in the cause of the illness and death through neglect, or worse, through witchcraft. To be told that a disease has no cure is a knell of doom without precedent. While we have never heard anyone liken a person suffering from HIV-related illnesses to "a living corpse" (Niehaus 2007 on South Africa), the often long-drawn out, terrible toll on the body that frequently results in a skeletal, helpless, and suffering person, unrecognizable from his or her normal self, causes huge distress and anxiety among care-giving relatives. The terror of the trajectory of the disease—at first silent and then deforming and destructive—and the knowledge or fear that there is no cure, nothing one can do to save the patient, conduce to a much greater sense of helpless unease in face of "this new disease" (cf. Chimwaza and Watkins 2004). In this disturbing context people seek to interpret the scourge visited on them.

#### STIGMA

In noticing that *edzi* is generally avoided by people when referring to the illness or death of someone they know, some commentators have described

the response as denial and as manifesting "stigma," with claims that "denial and stigma" reflect fatalism, defeatism, and a lack of "positive agency" (Bryceson, Fonseca, and Kazandira 2004:68). Others, however, express skepticism about the pervasiveness of stigma and find little evidence of it (Chimwaza and Watkins 2004:805; Chirwa and Chizimbi 2007:76; Kaler 2004; Smith 2003; Whiteside, Mattes, Willan, and Manning 2002:11). In our research in Zomba villages, we found little evidence of stigma in people's multiple reactions to HIV/AIDS, and feel that often its use to gloss a wide range of responses (shame, fear, suspicion, confusion, reluctance, blame, avoidance, anxiety, grief, and so on) does injustice to the complex ways in which many Malawians are seeking to come to terms with the accelerating rates of illness and death.

Prior to the advent of HIV and the consequent flood of funds, donors, and NGOs, the notion of stigma had not appeared in writing about Malawi. Malawians are certainly not free of prejudice understood as "an unfavorable attitude to a group or its individual members" (Parker and Aggleton 2003:16), and persons with severe physical deformities may be avoided or mocked and find it near impossible to find a suitable marital partner. For example, one young girl found in the initial 1986 study had a huge growth on her face—a monstrous look on one side while pretty on the unaffected side. She went to the local school and was not isolated, although she did lack friends. By 2006 she had two lovely children but no husband, and she remained living with her mother and older sister. She had never been asked to marry, but by dint of having children and being perfectly competent physically and mentally, she lived a fairly normal life with people among whom she had grown up. Among those considered "mad," stigma applies only to the most serious cases. The signs of severe mental illness or "madness" (*misala*) are uncut and unkempt hair, odd types of clothing or nakedness, persistent "wandering," especially in market centers, and sometimes talking to oneself or making incoherent sounds. But only the minority who are violent toward others or who have the propensity to set fire to buildings are feared and avoided. Moreover, prejudice toward individuals who suffer from physical abnormality or mental imbalance is not extended to other family members.

In sum, obvious examples of a culturally stigmatized status in the villages are rare. Thus, the use of stigma to discuss certain reactions to HIV/AIDS in Malawi is open to question. We found almost no evidence of stigma attached to people suffering from AIDS in the research villages. We concluded that the avoidance of naming *edzi* in the deaths of family, friends, or near neighbors related to the way in which HIV/AIDS was treated as unique and stigmatized in public media. As discussed elsewhere (Peters, Walker, and Kambewa 2008), villagers' avoidance of naming AIDS does

not deny the severity of the epidemic, but refuses the definition of increased illness and death as denoting a generalized doom. People seek ways to normalize the abnormal, to bring it back under their control. The avoidance of naming AIDS in any serious illness and death may be seen as a way for relatives and friends to *protect* the sufferer from the public stigmatization of the disease. The public stigmatization of AIDS in media and statements by various agencies is producing stigma and blaming people for harboring stigma.

A classic definition of a stigmatized person is someone who is "tainted, discounted," and "disqualified from full social acceptance" (Goffman 1963:3). During 2006, members of an NGO-organized club of "people living with HIV and AIDS" gave us examples of unkind remarks. One said that if sometimes one needs help to get food or firewood a relative or friend might say, "You didn't get that disease from me, you know!", and others quoted a common joking taunt, "Your units have run out, go and get some more!", likening a person on antiretroviral drugs (ARVs) to a cell phone that needs new inputs. These are examples of practices that put people suffering from AIDS in a marked category, but this is not universal, especially among closely connected people, and pales in comparison with accounts from other countries where people known or suspected of being HIV positive are shunned or even attacked. The behavior in Malawi that most resembled Goffman's definition of stigma came from health personnel. Members of the group of people living with AIDS gave several examples of callous behavior and comments: one hospital staff member removed a drip from one of them saying *mwatha kale inu* ("you were finished long ago" or "you're already dead"); another was refused medicine, told that it was for people without AIDS. Stories of unkind behavior by medical staff, especially toward patients with ragged clothes or poorly washed bodies, are not new, but the reported fears of medical staff of HIV, especially in the often poor conditions of clinics and hospitals, seem to have intensified this older practice of discrimination.

The public stigmatization of HIV infection and AIDS as due to "promiscuity," along with fear of recognizing a condition described as fatal, also led to widespread reluctance to be tested for infection. Many people waited until they were chronically and seriously ill before seeking more than symptomatic treatment. In the Zomba villages, however, only two people who we knew (or surmised) to be suffering from AIDS-related illness were seen to be treated differently from other sick people. One young very sick woman had returned home from town to her mother's compound; she was divorced as her sickness increased. When she first arrived, we were surprised to see the mother ignore her daughter, who spent most of her time lying on a mat in the compound, trying to find ways of feeding herself. The mother was overheard blaming her daughter for the illness. This fitted with what

a couple of neighbors thought to be the problem: the mother feared that people were blaming her for not having brought up her daughter properly, implying promiscuous behavior by the daughter. However, as the daughter became increasingly incapacitated, the mother took on the task of looking after her, feeding and cleaning her, and did so carefully until her death. In the other case, a daughter returned home to her mother's compound; she was one of the few known to be taken (on the back of her husband's bicycle) to the local town hospital for ARV treatment. But she got steadily worse. Although she was frequently visited by her sisters, cousins, and friends, her mother and father, living in the same compound, were rarely seen sitting with her. This—particularly the behavior of the mother—was considered by all who commented on it as extremely unusual. In the other cases we observed, the patients, most of whom were not described as suffering from AIDS, were treated with the same care as other sick people.

There is no preexisting social stigma attached to sexual relations. Thus, to suppose that avoidance of naming AIDS is because the disease is connected fundamentally with sexual activity and that the latter cannot be talked about publicly is mistaken. In fact, sexual activity is discussed among peers (gender and age), in rituals of initiation, in cases of conflict in marriage, and in common gossip. Moreover, erotic dances and jokes about sex are common in the villages (cf. Morris 2000:72). Nevertheless, in everyday life, sexual activity between named individuals is appropriately discussed only in specific circumstances and by specific categories of persons (such as peers, grandparents to grandchildren, or "guardians" to quarrelling spouses). Sexual activity is beset with multiple cultural controls, infringement of which brings illness to the perpetrator and/or the innocent members of his or her family, as discussed below.

Several anthropologists have sought to push the understanding of stigma beyond the stigmatized individual's social identity and the interpersonal relation of stigmatizer and stigmatized to see stigma as a threat to the "moral experience of individuals and groups" (Yang et al. 2007:1529); that is, "it threatens what matters most for those in a local world" (Yang and Kleinman 2008:399). From this vantage, one might gain some understanding of why Zomba villagers avoid the term *edzi* while, in most cases, not treating the sufferers of AIDS as outcasts.

Everyday responses among villagers like those in Zomba district are a struggle against the burdens, including public stigmatization of *edzi* as disease and constitute efforts to treat the victims of "the new disease" who are relatives or friends in ways that fit their sense of propriety, namely as full members of their moral universe. At the same time, caught up in a wave of moralizing, they turn to "custom" for answers, and their attempts to assess blame contribute to interpretations and actions that may hinder

rather than help stem the misery. Below, we describe two ways in which different categories of Malawians seek sense in what otherwise seems inexplicable carnage. The two “turns to culture” show that Malawians’ responses to the HIV epidemic must be understood within the context of their cultural and social relations, practices and knowledge.

#### AIDS AND THE INDIGENOUS ILLNESS OF KANYERA

Fairly early in the spread of HIV infection, as people became aware of the escalating rates of illnesses and deaths among adults, the similarity between the illnesses associated by medical authorities with AIDS and the well-known syndrome of kanyera (also written *kanyela*) was noted by people in our sample and elsewhere (Forster 2001:254, Lwanda 2005:115, Morris 2000:109). The similarity was seen in symptoms and in their connection with sexual relations, although, as we shall see, in very different ways. By 2006 in our sample, the relationship between AIDS and kanyera had emerged more strongly among some villagers and *asing’anga* (traditional healers).

To explore the new emphasis on kanyera as the same as or very like AIDS, we need first to situate it within the cultural conceptions of illness. Brian Morris (1985:17) identified four Malawian “disease complexes”: illnesses considered “natural” (expected, normal), usually phrased as “from God”; illnesses due to witchcraft (*ufiti*) or sorcery (*matsenga*); those due to ancestral or foreign spirits; and those due to “moral or ritual infringement,” one type of which is kanyera. Information from respondents in Zomba district is very like that provided by Morris (1985) and De Gabriele (1997). The sickness syndromes of *tsempho*, also called *mdulo*, and the sub-categories of kanyera and *chitayo*, are attributed to infringement of moral rules—“someone who has not behaved well” (*sanayende bwino*)—with reference to marital and sexual relations in specific situations. These sicknesses share certain symptoms—diarrhea, getting thin or swollen, overall pains, coughs, weakness, pain or blood in urine—that occur in combinations. The interpretation of the signs takes account of the known or suspected actions of the sufferer or those around him or her.

The underlying problem causing *tsempho*/*mdulo* is conceptualized as the improper mixing of hot and cold/cool states, which produces serious illness (cf. Marwick 1965). The normal, healthy adult is warm, pre-pubertal and elderly persons are cool, those engaged in sexual intercourse are hot, very sick people are cold. Pregnant women and young mothers and their babies are all cool, as are young girls and boys undergoing initiation. Sexual intercourse is hot, but is life-giving within the marital and lineage settings.

Heterosexual relations are seen as "a wholesome, enjoyable and necessary activity and essential for general wellbeing" (Morris 2000:70; cf. Watkins 2004:681). Most people become sexually active by the age of 15, with delay for some young women in secondary school (Poulin 2007, Clark, Poulin, and Kohler 2009); women as well as men in marriage expect regular and enjoyable sexual intercourse and often look outside marriage for fulfillment (Schatz 2005, Tawfik and Watkins 2006). The matrilineal societies, especially those (as in Zomba) with uxori-local residence for married men, have high rates of formation and dissolution of marital relations and somewhat greater lenience regarding non-marital affairs, although this does not erase the tendency to expect women to be more faithful than men, nor prevent jealousy and anger between spouses over love affairs. In addition, long-term studies, including our own, show that some people, young and older, are changing certain practices in a bid to reduce their risk of HIV infection (Smith and Watkins 2005).

Sexual intercourse has strong ritual power. In the past, the headman and his wife (or headwoman and her husband) had to have ritual sexual intercourse at the place where a new village was to be settled. Given its power, sexual intercourse is "hot" and thus dangerous to anyone in a ritually "cool" state. Sexual intercourse is prohibited during funerals and mourning, during the initiation of one's children, and before or during critical activities like hunting, metal-working, and brick-making. Anyone infringing this prohibition brings danger and illness on themselves and/or others around them. Tsempho is the result of marital sexual intercourse at times or places when it should be avoided. Extra-marital sexual activity can bring tsempho onto a child if the erring parent does not take the proper medicines before touching the child. Pregnancy is a particularly vulnerable period, since a husband returning home after having sexual intercourse with another woman can cause tsempho in his wife and the unborn child if he does not take appropriate steps to avert this. The result is miscarriage or, in the case of a wife with a small baby, swelling of the child (*kutupirana*), who becomes weak, looks malnourished, and may die. Terms used by respondents to describe what happens include *kulumpha mwana* (jumping the child) or *kusemphana* (mixing or crossing, referring to the mixing of incompatible fluids in sex). In the past it was said that men returning from a long journey would also have to seek medicines to avoid visiting tsempho on the child since he had been in touch (possibly sexual) with others.

Kanyera has long been defined as an illness complex marked by weakness, weight loss, cough, and diarrhea, which befalls a man if he has sexual intercourse with a woman who is menstruating or has just given birth. A man who has sexual intercourse with a woman who had just miscarried or aborted is said to suffer from *chitayo* (from *kutaya*, to throw away).

In 2006, our respondents appear to have merged chitayo with kanyera (see below). In both these cases, sexual contact involves an improper and dangerous mixing of incompatible fluids and states. The hot state of the woman's "blood" (including sexual fluids) during menstruation or after birth or miscarriage proves dangerous to the man. Morris noted that both kanyera and chitayo "are known by men as *matenda yankazi*, 'illnesses of women,' considered distinct from . . . venereal diseases" (1985:21). These latter have their own recognized signs and names: *chizonono* (gonorrhea), *chindoko* (syphilis), and *mabomu* (lymphogranuloma venereum).

Many of the signs or symptoms of the range of illnesses identified by Malawians overlap, and people interpret these in different ways at different times. As one example, consider a young woman who, in 1990, had several young children and a new baby. The last to youngest child, about one year old, was thin and sickly. The woman, Naphiri (pseudonym), was married to a young man who was the father of the youngest child but not of the others. They were prone to quarrelling. As the child grew weaker, Naphiri began to accuse her husband of causing tsempho in the child, thus accusing him of infidelity. Some around her (friends and neighbors) said that the real reason for the child's state was *utumbidwa*; that is, the new baby had been born "too soon" and the sick child had to be weaned very quickly. Others muttered that Naphiri was a careless and shiftless woman who was prone to move from man to man.

Is kanyera the same as AIDS? There is no single interpretation of AIDS or of the mounting tide of illness and deaths in the research villages. Nevertheless, during 2006, some people were linking kanyera and AIDS more so than in previous years. Most people recognized the common symptoms of kanyera and AIDS, but while some said the two illnesses were the same, others were uncertain, and yet others insisted that the two illness complexes were distinct.

Two cases can exemplify this last position. Abiti Flora, in her mid-40s, was one of the few people in the research villages open about her HIV positive status; her polygynous husband, who was also positive, never spoke about his status. He died in November 2006 during an episode of serious malaria; Abiti Flora died in 2007. In 2006, she spoke several times about the difficulties she faced due to repeated bouts of illness, but accepted, without apparent bitterness or extreme anxiety, that she had a fatal condition. One time, after speaking of her difficulties, she shrugged and said "my future is the same as before I knew I was positive—everyone has to die some time" (literally, you don't know when you die, *wakufa sadziwika*). She was adamant that edzi and kanyera were different. She regarded kanyera as an illness that had been around for a long time and was contracted by men who have had sexual intercourse with a woman who has miscarried or who has

her monthly period. AIDS, she said, was a new disease that afflicts both women and men in different ways. She did not know the origin of this new disease, but she knew it was transmitted through sex and through injections.

A married couple in their 50s, among the wealthy and influential families in local society, held the same opinion. Neither of them had been seriously ill over the years up to 2006 and, as far as we knew, they were free of HIV; they were also among the most prosperous people in the area. Asked what they saw as the most common illnesses in the area, they answered malaria and edzi. Asked how one recognizes the latter, the husband said, "It is easy to see the signs," and listed these as straight and weak hair, being very thin, and with persistent diarrhea. Asked about kanyera, both described it as a locally known disease, which appeared to have decreased in incidence. The wife explained that men got the disease after having sexual intercourse with a woman who had not finished her monthly period or who has miscarried. Asked how they differentiate kanyera and AIDS, they answered that only men get kanyera whereas both men and women get AIDS, and they noted some differences in the respective symptoms. Again, they saw some overlap in symptoms, but that the two illness complexes were quite distinct.

Other people held ambivalent or contradictory positions on possible links between kanyera and AIDS, some suggesting that AIDS was a more virulent form of kanyera. One detailed account, gathered in several conversations over months, comes from Che Sanderson. This man, in his 60s, was a well-respected village headman, a keen farmer and a builder, an elder in the CCAP (Congregational) church, and an enthusiastic commentator on social life. During fieldwork in 1997, he had said that at first he had not believed the stories about a new incurable disease but over time, he had realized that a serious new disease had come to the villages. He mentioned several indirect terms used for AIDS, including *kanyera waukulu* (big or serious kanyera) but did not emphasize this description over any other. In 2006, however, he was more definite in linking kanyera and AIDS, although with occasional ambiguity. Che Sanderson stressed that the increase in illness derived from people no longer observing certain cultural norms (*miyambo*). He said that most people attributed the rise in orphans to *matenda obwerawa* (sickness that has come, or AIDS) but in his view, many people were dying because of kanyera. He said that he wondered why people just talk about AIDS when they do not know whether a person has really been tested or not, and he argued that the signs people focus on are those for kanyera. He described the latter as a serious disease that needs to be recognized, saying, "AIDS is only one of the problems causing people to die." He said that the reason for many of those dying is because they are disobeying the customary rules about stillbirth or abortion (*chitayo*),

menstruation (kusamba), and the rules that prevent tsempho (see above). When people do not follow these traditional rules (miyambo), he stressed, the result is kanyera.

He blamed several aspects of modern life for the rise in both kanyera and AIDS although he moved between them in speech often in ways that did not clearly distinguish one from the other. He blamed modified initiation rites, insisted on by most Christian churches (including his own, CCAP), which did not teach young people about the customary rules of avoiding sex at times such as menstruation, stillbirth, and so on. Only the traditional or non-Christian rites did so. Che Sanderson complained about the bias of radio reports, which blamed initiation rites for the spread of HIV/AIDS. He pointed out that the real problem is indiscriminate sex (*chigololo cha chipwilikiti*). He admitted that this happens on the last day of initiation when new initiates are taken back ceremoniously to their homes and there is a great deal of festivity. It is normal, he said, for parents who have had to abstain from sex during the initiation of their children to look forward to resuming sexual relations with one another, but the problem is the indiscriminate sexual encounters that take place at the same time. Initiation is not the only time that careless sexual encounters take place, he insisted, since the same thing happens at dances in the nights before a wedding or other festivity, and at bars and bottle stores. "Should we then ban weddings?" he asked sarcastically, referring to the attacks on cultural practices by radio and other media.

He said that the government talks only of AIDS when it should also be talking about kanyera. The government tells people that AIDS is caused by *tizirombo* (small animals, the Chichewa translation of virus) but "we villagers see that the problem is kanyera," caused by the failure to follow traditional rules (*miyambo ya makolo*).

The equation of AIDS and kanyera was put forward most often by asing'anga, local or "traditional" doctors. Of three well-known practitioners in our research area who had many clients, two, after a little prevarication, said they saw the two diseases as the same and had medicines for them; the third was less clear. Che Alimu is a senior headman in one study village and is a prosperous and successful farmer and asing'anga. Unlike the other two who are Nyanja-Lomwe and Christian, he is Yao and Muslim, but the dominant cultural concepts and practices are identical across the men. Asked in 2006 to name the main illnesses he is asked to treat, he listed the common venereal diseases, *mutu* (literally head, referring to types of headache, some of which are attributed to witchcraft, some to troubling spirits, and some to "natural" causes such as malaria), chitayo, and kanyera. In these last two, he explained, the illness in men is caused by their "drinking" or "sucking" (*amayamwa*) through their penis in sexual

intercourse “the bad things” (*zoipa*) produced in menstruation, birth, and miscarriage in women. Che Alimu described the medicines he used both as a preventive and a treatment for kanyera and chitayo; they act as purges and emetics, opening the patient’s body to expel “the bad things,” so causing him to heal or to prevent him from developing the disease. Che Alimu added that if someone does not improve within a week, he sends him to the hospital or local clinic.

Che Alimu described the signs of kanyera as identical to those locally considered to mark AIDS: weight loss, weakness, pallor, hair straightening and thinning, “long fingers” indicating extreme thinness, diarrhea, and coughing. Asked if he treated people with AIDS, he first replied that AIDS has no cure, so he cannot claim to have treated anyone. But soon afterward, he said that the signs of AIDS (*maonekedwe a munthu wa edzi*) are the same as those of kanyera, and that people have stopped calling the condition kanyera and call it AIDS. The problem, he asserted, is that people have been told there is no cure for AIDS and they forget that there is a cure for kanyera. As the two conditions are the same, those who know the medicines for kanyera also have the medicine for AIDS. But he explained that he cannot state this openly because the government does not want to hear this. Here, he was indirectly referring to several well-publicized cases of persons, including traditional doctors, claiming to have medicine that cured AIDS, in response to which government spokesmen had denied this possibility and made vague threats about preventing such claims.

Another healer who lived near but not in our sample villages, Che Mapira, repeated the local interpretation of kanyera but added a new element saying that the “bad things” coming from a woman in the states of menstruation or miscarriage contain *tizirombo* (little organisms, virus) that are whitish in color (*totuwa*). These enter a man’s body during sex and then drain the blood of the man. Moreover, unlike most of the other respondents, Che Mapira said that a woman is also infected with kanyera because during such sexual encounters the “bad blood” (*magazi oipa*) is pushed back inside her instead of coming out. He claimed to have the medicines that clean the body of these *tizirombo*. He said that since AIDS is the same as kanyera, he treats it but that he does not claim to do so because the government forbids it. He uses several techniques of divining (*kuombeza*) to assess what the patient is suffering from. After the diagnosis, he gives the patient medicine to drink to cure the kanyera, and tells him to come back for a check-up. He usually finds that the *tizirombo* have disappeared.

A third asing’anga, Che Baisoni, is a long-term sample member and describes himself as specializing in the treatment of illnesses caused by witchcraft, but in several interviews he spoke of the relationship of kanyera and AIDS. He described the same set of causes and symptoms of kanyera as

others and stated that kanyera is the same as AIDS. However, he suggested a different path of infection, stating that this new disease does not come from God (equivalent to natural or expected) but from contraceptives promoted by the government: the condoms and the drugs given to women for birth control have poison in them, which attacks the body and makes the user ill. When men come to him for treatment of sores around the penis and he finds out that they have been using condoms, he tells them that the sores are due to the poison in the condoms and to stop using them. Similarly, the *mankhwala* (birth control pills or injection) given to women for family planning prevent them from menstruation so that the "bad blood" stays inside them instead of flowing out. This buildup produces many illnesses like cough, diarrhea, vomiting, high blood pressure, and tuberculosis. He confirmed he had treated people with AIDS, and gave the example of a young woman who had come with what he considered signs of AIDS; he advised her not to use condoms. In a separate conversation, he mentioned, without further comment, that one of his daughters had died of AIDS.

In Che Baisoni's statements, one sees the slippage between diagnosis and assigned causes: he judges the illness in part by its signs so that he sees kanyera and AIDS as the same. Yet, in addition to his indicating infringement of rules governing sexual conduct as causing kanyera, he also posits a different cause of similar signs and even of what he considered AIDS in "poisoned" contraceptives. In a separate conversation he appeared to distinguish AIDS and kanyera. In short, inconsistencies and disagreements abound in the 2006 understanding among people in a rural area in Zomba district on the relationship between "the new disease" or AIDS and kanyera, a well-known and longstanding illness.

We now consider a different "cultural turn," one taken by public media.

#### PUBLIC MEDIA DISCUSSION OF "CULTURAL PRACTICES"

As with poverty and malnutrition, HIV infection was a non-subject under the Banda regime. After the elections that swept "multi-party democracy" into power in 1994, the succeeding governments under Muluzi and Mutharika put more effort into programs dedicated to combating HIV and AIDS, with the aid flows directed from many sources ballooning to more than US \$180 million by 2006. Unlike the silence about AIDS under Dr Banda, from the mid-1990s to 2006, AIDS became a major topic covered in daily and weekly newspapers, on radio and TV, along with coverage of cases of witchcraft, corruption, and stories about sex, love, and crime. Here, we concentrate on the coverage by the major English medium newspapers, which have some pages in Chichewa translation, and full newspapers in

Chichewa on the weekends. Although very few villagers buy newspapers, those obtained circulate widely and the stories are quickly known (cf. Englund 2006:176). Major radio programs and the national TV station often carried the same stories.

During 2006, newspapers carried frequent reports of meetings about HIV and AIDS, statements by representatives of government, NGOs, donors, religious and other groups, and expressions of concern about the rates of death and illness related to HIV and AIDS. Many articles condemned "cultural practices," a gloss for certain rituals involving sexual intercourse (such as at the end of initiation rites or after the death of a spouse), and customs involving apparently non-voluntary sexual intercourse (such as "widow inheritance"). Some examples follow.

The editorial column in *The Daily Times* of January 20, 2006 denounced the "perpetrators of bad cultural practices," referring to a case where a 15-year-old girl told an NGO that during initiation she had been forced to have sexual intercourse with an older man (referred to as *fisi*) in a rite called *kuchotsa fumbi* (literally, remove the dust). The editor accused people who, "claiming to be patriotic custodians of tradition and culture," insist on continuing the practices of *kuchotsa fumbi*, *kulowa chokolo* (wife inheritance among patrilineal groups), and *kupimbila* (giving a daughter in marriage to settle a debt) despite the known dangers of HIV. A spokesperson for the Centre for Human Rights and Rehabilitation was reported as saying that HIV continues to spread because people "fail to refrain from immoral sexual practices such as *chokolo* (wife inheritance) and *gwamula* (sneaking at night into a woman's hut) . . . . We have found that polygamy, wife inheritance and *gwamula* are some of the contributing factors to the increase of HIV/AIDS cases" (*The Daily Times* March 20, 2006). The Blantyre District social welfare officer was reported as bemoaning the fact that, despite the many "sensitisation campaigns . . . behaviour change remains a big challenge," adding that "traditional practices like *kulowa kufa* and *kuchotsa fumbi* are still being practised in many areas" (*The Nation* November 30, 2006). Some articles included other causes such as rape, polygamy, and inadequate support by men to their families, resulting in their daughters becoming prostitutes, which were listed in a report of a prayer rally organized by the Catholic Commission for Justice and Peace and the district authorities in Nsanje (*The Nation*, August 21, 2006). Some blamed selected cultural practices: the District Commissioner for Nsanje maintained that *kulowa kufa* "poses the greatest danger . . . if we continue with this sexual-cleansing practice, we should not dream about development. We are actually risking the extinction of this generation." He said that the rite "encourages people to engage in sex" and hence to be exposed to HIV (*The Nation* October 12, 2006).

This selection reveals several things of note. First, there is virtually no discussion of ordinary sexual relations. The obsession is with "exotic" rituals and customs, distracting public attention from the overwhelmingly more significant mode of transmission, namely, the broad range of heterosexual relations in and outside of marriage, *not* limited to "prostitution." The approach tends to inject gender discrimination into the discussion. Second, no evidence is produced to support claims for selected cultural practices as causes of the spread of HIV. In response, Kalipeni and Ghosh warned against exaggerating the significance of "cultural practices such as initiation, widow inheritance, and death cleansing" as high-risk activities when "we do not know the actual extent to which these cultural practices are adhered to in the face of the AIDS epidemic" (2007:1118; cf. Lwanda 2006:165). Third, there is a tendency toward moralizing language, such as references to specific rituals as "immoral" or "bad," without clarifying the cultural rationales for the rituals. Associated with this is the accusation that people are unwilling to "change," and are portrayed as conservative and backward.

Yet much research suggests that people are making changes in their practices, both everyday and "cultural." Already in the mid-1990s, some of Peters' women friends told her that they had decided to divorce their husbands because they had been told or suspected that the husbands had girlfriends elsewhere; one friend stated explicitly that she feared he was exposing her to AIDS. Some of our young research assistants spoke of their awareness of the dangers of AIDS and were "holding their hearts"; that is, being sexually abstinent till they had found a marriage partner. By 2006, people of various ages had made adjustments in their lives: one chief had insisted on having his new wife and himself tested before marriage, another man was tested after he suspected (wrongly) that his wife had taken a lover, some men and women admitted that they limited their sexual activities outside marriage and were more careful in selecting mates. These changes did not include all people, nor had they yet had any palpable effect on the rates of illness and death. But both the widespread understanding and the various attempts to adjust behavior suggest neither fatalism (of which we found little evidence) nor widespread denial of sexual contact as the main route of transmission.

The newspaper reports also presented distorted versions of Malawian custom. Most seriously, the notion of "sexual cleansing" introduces an inappropriate metaphor and meaning to this and other rites. As explained, the basic concepts in Malawian thought about well-being and illness turn on a contrast between hot and cold. Morris warned against the tendency "to conflate this hot/cold symbolism with the Judeo-Christian ritual dualisms between unclean and pure" (2000:84). It is particularly problematic

because the language of pollution seems to be gaining ground in the proliferating commentary about sexual relations. Hence, in a fairly early article on AIDS in Malawi, two writers referred to ritual sexual intercourse by a selected man with an initiated girl and with a recently widowed woman as "cleansing" them (Tembo and Phiri 1993:46-47). The language of pollution has also moved into technical and consultancy reports. De Gabriele (1997), who, like Morris (2000) and Kaspin (1996), objects to the misleading language of pollution, cited a 1996 consultancy report on women's anemia as stating that *mdulo* or *tsempho* are "diseases... based on an underlying belief that women are unclean during menstruation and after delivery or abortion. During these times a woman would pollute food by adding salt." (1997:12). This language fundamentally distorts the key ideas at play.

The cultural rationale for sexual intercourse at the end of a girl's initiation is not to "cleanse" her but to "heat" her, bringing her from the cool state of childhood and initiation to the warm state needed as an adult. In the past, her partner was her actual or promised husband; a replacement man was referred to as *fisi*, literally hyena. Similarly, the role of ritual sexual intercourse with a widow or widower at a specified period after the spouse's death is not to cleanse them from a state of pollution but to "warm" them to allow them to reenter adult life, which necessarily entails sexual relations. Blood has a highly positive valence in Malawian thought, associated with health, vigor, and fertility (cf. Morris 2000). Nevertheless, like sexual intercourse, it has intrinsic power that can have positive and negative effects. Blood can be received in clinics for those severely anemic, translated locally as "lacking blood," but is also sought by malevolent people for their sorcery and witchcraft. Thus, although people willingly submit themselves and their children to receiving blood in hospitals as treatment for various illnesses, periodic fears about collection of blood samples flare up into rumors about vampires (Vaughan 2003), and Satanists, a newer embodiment of evil, are accused of causing road accidents in order to collect blood (cf. Englund 2006).

The flow of "hot" blood in menstruation after a miscarriage/abortion or after a birth carries danger for a man having sexual intercourse. One of the strongest lessons during initiation for both girls and boys is to avoid sexual intercourse in these circumstances, but there is no implication of women's blood being inherently "polluted." The terms of pollution and purification in any of these rites are thus foreign and distorting. This is not just a question of inaccurate translation but of mistranslation introducing a language that has potentially negative implications for women since, in all the cases quoted, the purported "pollution" is found in women. Some of those speaking and writing in English in public media are taking up these misleading

terms of pollution and uncleanness; the Chinyanja terms used to talk about the dangerous states of women—*zoipa* or bad things, *magazi oipa* or bad blood—have been taken to suggest an intrinsic badness rather than a distinction between “hot” and “cold” states.

A striking aspect of the public media discussion is the relative absence of discussion about ordinary sexual relations, unfortunate given that the overwhelming channel of HIV infection throughout southern (and all) Africa is heterosexual relations. The very high rates of HIV infection and AIDS deaths—the highest known in the world—in southern African countries have generated a search for explanations, initially linked to number of sexual partners. However, cross-national data now show that far from having more sexual partners than others, Africans, including southern Africans, have the same or fewer partners than men in other countries (studies cited in Halperin and Epstein 2007:20). Some experts see the simultaneity or “concurrence” of sexual partners as more relevant. Other contributory factors include the high incidence of sexually transmitted diseases that made women particularly vulnerable to infection, a more virulent type of virus in the region than elsewhere in Africa, and most recently, the low rates of male circumcision now found to provide some protection for men. All of these factors occur in a context of severe poverty.

#### CONCLUSION

In the face of the unprecedented incidence of severely debilitating illnesses and of deaths among those expected to be the most healthy, people try to find meaning and to recreate a “normal” life in abnormal circumstances. People do not ignore bio-medicine; on the contrary, clinics and hospitals are overwhelmed with the unfulfilled demand. But, apart from the sheer difficulty of many obtaining the care they need (due to lack of medical personnel, drugs, and effective service), people have also been dismayed by the reported lack of a cure or prophylaxis and, more recently, by the apparent failure of even the few who obtained ARVs (in our sample area in 2006) to live much longer. The pressing demands of ever more sick family members, disrupted families, and orphaned children on a population that is already severely stretched by poverty must also be taken into account in reading people’s responses.

Some writers on other African countries have discerned an increase in a turn to witchcraft to explain many of the deaths attributable to AIDS (Yamba 1997), even to the degree of producing a state of “internal terror” (Behrend 2007:45). This cannot be said to hold for Malawi, at least not in southern Zomba district. Certainly, fears of witchcraft and sorcery are

common and often invoked to explain noticeable gain or loss, such as one person's maize crop being so much bigger than everyone else's (she must have used means to invisibly remove other people's maize into her own fields), or someone's success in a business compared with others (he must have created a snake to mesmerize people who come to buy his goods and/or to steal the takings from other businesses at night). People also scrupulously examine a new grave to assure themselves that no witch has interfered with the corpse. Media reports about people being killed for certain "body parts" (usually sexual organs, heart, liver, or eyes) have increased too, although it is unclear whether the actual collection of body parts has also increased (cf. Englund 2006:175). Successful business owners and politicians are suspected of using such parts for "strengthening" themselves (*kukhwima*). In addition, a regional as well as a national market has developed for such parts. Some of the deaths that might be AIDS-related, in our eyes as observers, as well as by some villagers, have been attributed by family members of the deceased to witchcraft. However, such explanations have been a small minority. Deaths are more often described in terms of their symptoms or of a named illness, either bio-medical (tuberculosis, scabies, and so on) or indigenous.

Another source of existing cultural interpretations, as discussed above, are indigenous ideas and practices that explain and treat illness. These, as we have tried to show, are part of deeply laid conceptions about proper social relations, individual behavior, and the sources of well-being and ill health. The attempt of many Malawians to situate the proliferation of illness and death associated with "the new disease" within such cultural understandings is perfectly comprehensible. As far as we know, the attempt is ignored or unknown to medical personnel, while the public media's focus on selected rituals serves to reduce a complex set of understandings to a few "cultural practices" and obscures the broader search for meaning among many Malawians.

By setting side by side two "turns to culture," we hope to have revealed the gap separating public opinion and what (some) rural Malawians actually think and do. Both the sense among some that kanyera, a long-known indigenous illness, is either the result of neglecting proper cultural ways (*miyambo*) or that it has been transformed into a more virulent form called *edzi*, as well as the recognition that sexual relations are the main avenue of the new disease, have more important implications for people's responses to the disease, more so than the periodically performed rituals obsessively recounted in the media.

It would be a mistake to see the current discussion among the people in Zomba district described here as merely slotting AIDS or the illnesses associated with it into a preexisting indigenous template of diseases.

As pointed out, while some people, particularly asing'anga, currently hold to an identity between kanyera and AIDS, others are unsure how to deal with the similarities of the two syndromes; yet others insist that they are completely different despite some similarity in symptoms. Although by 2006 we found more people discussing the relation of kanyera and AIDS, there was no linearity. Given the differences in opinion and people's own searches for explanation, it is as likely that kanyera will become more accepted as "the same as" AIDS, as that it will fall back to its specific place as an outcome of sexual contact with a woman in particular "hot" states. The current discussion of kanyera might more reasonably be seen as indicative of a move to name the un-nameable and to avoid the stigmatizing label of AIDS, and as an attempt to come to grips with the most disruptive and distressing conditions of the known past.

We have expressed concern about too quick a recourse to the concept of "stigma" to explain the now well-reported tendency of most Malawians to avoid naming AIDS in cases of illness and death among family, friends, or neighbors. We found no pervasive stigmatization of those afflicted with AIDS or of their close relatives, despite a few cases of reported discrimination. There is public stigmatization of AIDS in setting it apart from all other illnesses as both fatal and due to "promiscuity," a cause that implies blame on the part of those infected. We concluded that the avoidance by Zomba villagers of naming AIDS while, in the vast majority of cases, treating those suffering from the new disease as carefully as any other sick person, might best be seen as an attempt to protect the latter from being blamed for their situation. Since the public stigmatization, even demonization, of AIDS threatened people's "moral experience," by avoiding the name, they insist on treating their loved ones suffering from AIDS as fully moral, fully social beings just like any other sick person. At the same time, scattered evidence that some people are changing some of their ideas and practices about sexual relations suggests that, despite the avoidance of naming AIDS, they are not denying the sexual channel of the new disease but reconsidering the implications for their moral universe.

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