Social Pathways from the HIV/AIDS Deadlock of Disease, Denial and Desperation in Rural Malawi

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Executive Summary

Purpose of Study

This study was commissioned by CARE Malawi to explore the livelihood strategies and social forms that have evolved within rural households and communities to contend with the threat of HIV/AIDS. Both qualitative and quantitative research methods were used in three village sites in Lilongwe rural district to study recent social change. The aim was to identify points of opportunity for nurturing social pathways that could propel rural communities towards future well-being.

This report traces community responses to the three main stages of the HIV/AIDS disease cycle: 1) infection and transmission; 2) debility and death; and 3) the aftermath of death encompassing widows, orphans and household reconstitution.

Study Findings

HIV Prevalence

1. While uterine transmission of HIV from mother to child is increasing in rural Malawi, the major form of transmission continues to be heterosexual sex. The tragedy of this situation is that sex has been transformed from being a natural and pleasurable part of everyday rural life, bringing birth and renewal to the community, to its current status as a conveyor of disease and death.
2. The gap between urban and rural HIV prevalence narrowed during the 1990s from a factor of five to a factor of two. The absolute number of rural dwellers who are HIV positive outnumbers urban HIV carriers by roughly three to one.
3. The denial and fatalism prevailing in rural Malawi holds back the adoption of safer sexual practices and perpetuates a high-risk environment in which many people, especially youth, are contracting HIV/AIDS unnecessarily.

Kinship Structure

4. The Central Region, where the study took place, has a large Chewa population representing a mosaic of matrilineal and patrilineal people. Exogamy is practiced which obliges men and women to marry someone from outside of their birth locality to avoid marrying a close relation. Even though the incoming spouse is usually from the region, s/he will always be a ‘stranger’ in the locality of the marital home. In the event of divorce or widowhood, s/he is expected to leave the village and return to his/her home area.

Rural Livelihoods

5. Farming households’ earnings from agricultural exports and remittances declined during the 1990s, engendering rural income diversification, deagrarianization and depeasantization. The famine of 2001-02 and the on-going HIV/AIDS epidemic have been intricately embedded in these processes.
6. Over the past five years during the famine and its aftermath, *ganyu* casual labour has gained in importance as a source of income for all economically active household members, particularly women and youth.
7. Alcohol production notably of *kachasu* and *masese* has been a mainstay of rural women’s earnings. The shortage of grain during famine reduced women’s earnings from alcohol production. The widely reported cases of women and girls exchanging sex for basic foodstuffs took place in the context

of having nothing else to offer in exchange. They were reduced to transacting an 'essential exchange' in all respects: sex for basic food needs.

8. The removal of subsidized fertilizer loans to farmers continues to trouble villagers a decade after their removal. Yields of both food and cash crops have declined and many men and women list the lack of fertilizers as a major problem, along with the declining marketing services of ADMARC.

Sexual Behaviour

9. Children begin to be sexually active at the age of 10 or 11 years. Adolescents vary in their attitude to condoms, but a large proportion do not use condoms on the basis of misinformation and fear of physical harm or immorality. Different media messages are prescribing conflicting sexual behavioural guidelines.
10. In village focus group discussions, villagers felt that sexual relations had not altered in accordance with media messages advocating disease prevention. Many stated a preference for 'skin-to-skin' sex or trusting their marital partner rather than using a condom. Fatalism prevailed in which people felt that they had no capability to control the disease. They identified three main tendencies which continued to spread the disease: village extra marital sex, women's increasing transactional sex and men's drinking and womanizing leisure time activities.
11. Extra-marital sex is a well-established accompaniment to drinking. Serious drinking and womanizing often takes place in the drinking establishments of the market town or some other major population settlement. Youth are increasingly amongst the ranks of heavy drinkers.
12. Traditionally, sexual behaviour was proscribed throughout one's lifetime on the basis of gender and age and these norms were embedded in concepts of community harmony and well-being. Chiefs as ritual leaders and spiritual heads of the community safeguarded sexual morality. The role of the traditional leadership is now crucial to changing sexual attitudes and practices. Enforcement of sexual taboos has been largely in their hands.

AIDS-afflicted Households and Support Services

13. Families with AIDS sufferers try to hide the fact under the guise of TB, malaria or some other chronic ailment for fear of shame and ostracization. Villagers do not question these alibis and tend not to help the family unless they are the immediate relations of the patient.
14. Our evidence suggests that rural medical practitioners tend to refrain from telling patients that they have AIDS based on the obvious clinical symptoms that their patients present. Instead the medical personnel advise the patient to visit a testing centre because of the sensitivity of the inter-personal situation. Patients are generally loath to go because it is usually distant from their homes and they are fearful of the outcome. They seek other health options nearer their homes, which can nonetheless be quite costly. Asset-stripping to cover medical costs impoverishes rural households.
15. More than half the population identify *Gule Wamkulu* as a traditional loyalty and for some as their main religion. Prophetic spirit healing has become a significant force in the rural areas as well over the past century. Rural people's search for medical care is apportioned between traditional healers, spirit healers and western medical facilities. Evidence suggests that the medical

practitioners and healers themselves engage in cross-referral across these different medical systems. Traditional and spirit healing is directed at the remedial reworking of the patient's social relations to attain spiritual balance. 'Well-being' in this sense is spiritual and relational rather than physical or psychological.

16. There is great uneasiness about AIDS patients in the village community. People identify with them at the same time as they are uncomfortable and fearful about them. Village Action Committees[1] have made important contributions to AIDS care, providing much needed practical support and helping to alleviate the feeling of shame that AIDS-affected families experience. They also provided forums for open discussion of the behavioral causes of AIDS.

Aftermath of Death and Household Reconstitution

17. While villagers are reluctant to offer help to AIDS-affected households, their whole-hearted presence and assistance at funerals is an unwavering tradition. To stay away from a funeral would be to disassociate oneself from the community. Bereaved households incur onerous expenses connected with the funerals. Village leaders have tried to mitigate this through encouraging people's involvement in funeral committees that involve annual contributions in cash or kind.
18. In the aftermath of death, families may experience dislocation in terms of the return of an 'incoming' spouse to his/her home village vis-à-vis matrilineality or patrilineality. Since the deaths so far seem to have been biased towards men, it is widows under patrilineality who have been most affected. Not all have returned to their home area, but those who have stayed tend to experience restricted access to the assets of their conjugal homes due to the intervention of their brothers-in-law. This can detrimentally impact on their welfare and that of their children.
19. Twenty-six per cent of our random sample of 141 households was hosting one or more orphans. This amounts to .53 orphans per family on average or 1.79 orphans per orphan-keeping households. The 68 orphans were divided equally between boys and girls. Most were under 10 years of age, with a noticeable dip in the proportion of girl orphans over 15 years of age that may be related to their tendency to marry early. The allocation of orphans to host households depends on extended family arrangements in the first instance, the intervention of the village leadership, or the orphan who seeks refuge in a household where he/she feels accepted.
20. With the increasing incidence of morbidity, mortality and orphanhood over the past decade, households are being reshuffled in size and composition, causing a fundamental re-ordering of household and village life. Matrilineal female-headed households are the most likely household type to take in orphans.
21. Some orphans are marginalized within the host family and suffer from very low self-esteem. They may seek escape from what they consider a life with little future. Boys drop out of school to do *ganyu* whereas girls marry early.
22. The presence of orphans imposes financial costs on the host family. Our survey revealed that roughly 55 per cent of orphans were attending school with girls (70 per cent) predominating over boys (40 per cent).

[1] "Action" is used in some areas as a euphemistic substitute for "AIDS".

Community Economic, Social and Political Restructuring

23. Given the debilitating effects of HIV/AIDS on the village community and the recent experience of famine, the timeframe of villagers' coping strategies has been drastically reduced. Our survey findings indicate that only 15 per cent of households received assistance during the recent famine in the form of food from extended family and only 19 per cent accessed food aid from external agencies. Many now operate on the day-to-day resolution of household hunger through '*kusokola*', looking for food.
24. Besides increasing reliance on *ganyu* labour markets, land markets are appearing in which the local rural people are heavily handicapped given their lack of literacy and numeracy. Male farmers have recently been seeking urban or other patrons to help finance their access to fertilizers and land rentals and sharecropping arrangements have ensued.
25. As the number of distressed households has increased, village community interaction has suffered. Theft has become a major problem and inter-household relations are strained when loan repayment is outstanding, as has been common since the famine.
26. Three types of community organizations operate within villages: 1) locally-initiated organization directed at addressing security problems, death and recreational pursuits such as sports; 2) externally-funded, community-based organizations in which the village headman is almost invariably the intermediary who receives funds or materials and distributes and ensures their usage according to the specifications of the donor; and 3) outward-directed informal associational ties especially important in encouraging inter-village ties. In the first type, resource mobilization is limited except in the case of the funeral committee, where the headman provides the authority and security to mobilize goods, services and cash for funeral committees. The externally funded community-based organizations have proliferated over the last decade as foreign aid in Malawi has increased. Donor-instigated associations are seen to be short-term by nature and villagers feel that there is little purpose in continuing the committees associated with these projects in the absence of external material support.
27. Local leadership has been in a transitional situation that has become increasingly problematic over the last decade, as their administrative work has been extended to the demands of numerous foreign donor agencies and NGOS who have instigated village-level aid projects. Many have very poor educational backgrounds and lack the requisite administrative skills. Traditional leaders are being pulled in two different directions. They attempt to fulfill their age-old function as ritual leaders and moral guardians of the community and as heads of chiefly families. Traditional practices may call for preferential treatment and favouritism in the channeling of goods or services that is at odds with traditional leaders' bureaucratic accountability stipulated by the national government and multi-various donor agencies.

The Future

28. The rural youth of Malawi today face unprecedented challenges. They are the first generation in Malawi's history to be availed free primary education, thus they are already better educated than their parents. In addition to attending school, they are also working for cash incomes and demanding that they have

control over their earnings. Familial work cooperation is in decline and teenage estrangement is surfacing. The death of a parent to AIDS catapults many of them into premature adulthood. Youth, more than any others within the village, appear to be part of a lottery in which their life chances are determined irrespective of their actions in a period of great unpredictability.

Recommendations

29. Rural reform needs to address political and economic realms notably:
    a. the separation of political, economic, cultural and religious roles of village leadership and creation of checks and balances between them,
    b. the democratic election of local government leaders,
    c. education of farmers in relation to land rights, and
    d. re-instatement of fertilizer loans on a trial basis for 5 years.
30. There is need in AIDS prevention, patient care and the handling of the aftermath of an increasing volume of AIDS deaths to:
    a. understand the forces propelling the rural incidence of HIV/AIDS and address it on its own terms rather than as an offshoot of the urban-based experience of AIDS.
    b. continue to give priority to rural household food security to prevent household asset stripping and the further lowering of the bargaining position of villagers in casual labour negotiations.
    c. license and tax local alcohol production and identify alternative forms of income for alcohol producers and alternative forms of entertainment for those who otherwise become entwined in a heavy drinking culture with increased risk of exposure to HIV infection.
    d. encourage more dialogue between medical service providers and traditional healers and Pentecostal spiritual healers to explore how individual and community agency in the prevention of AIDS can be better accommodated in government health messages.
    e. develop media messages beamed at the rural population which begin with the assumption that individual health depends on broader social community harmony, emphasizing that harmony and well-being depends on each and every person taking the responsibility to have safe sex with condoms or no sex at all.
    f. facilitate the spread of the ‘positive living’ approach encouraging dietary awareness. This could be usefully expanded in the context of the existing general view in villages that the duration of time AIDS sufferers manage to stay alive depends on both the quantity and quality of food intake.
    g. conduct research on VCT in the rural areas, taking account of the existing role of counselling performed by traditional and spiritual healers. This could facilitate the design of a rural counselling program that is conducive to the realities of rural medical staffing and villagers’ attitudinal beliefs related to disease.
    h. enlist schools to take a more active part in orphan welfare by discretely reporting cases of orphan neglect or abuse to the village headmen and VAC as well as facilitating out-of-school work opportunities.
    i. mount a ‘choosing to live or die’ media campaign in which rural people of both genders and all ages are left in no doubt that ultimately their sexual behaviour determines whether they live or die as individuals and as communities.

Abbreviations and Chichewa Glossary

ADMARC – Agriculture Development and Marketing Corporation
AIDS – Acquired Immuno-Deficiency Syndrome
APIP – Agricultural Productivity Investment Program
CPAR – Canadian Physicians for Aid and Relief
DFID – Department for International Development, United Kingdom
FGD – Focus Group Discussion
HIV – Human Immuno-Deficiency Virus
JEFAP – Joint Emergency Food Aid Programme
MOHP – Ministry of Health and Population
MRFC – Malawi Rural Finance Committee
NAC – National AIDS Commission
NEC – National Economic Council
OPC – Office of the President and Cabinet
SAP – Structural Adjustment Program
SCUS – Save the Children USA
TA – Traditional Authority
UNDP – United Nations Development Program
VAC – Village AIDS Committee
VCT – Voluntary Counselling and Testing

Chichewa Glossary

chauta – local name for God.
chinjira – friendship between unrelated women involving mutual reciprocity.
chidzeranu – exchanging wives temporarily for sexual enjoyment/experimentation.
chokolo – widow inheritance, usually by the deceased man's brother.
chuma – wealth.
fisi – literally, hyena. Figuratively, a male sexual trainer for female initiates or a surrogate partner who is intended to impregnate a woman when her husband is suspected of infertility.
ganyu – casual labour/piece work.
Gule Wamkulu – religious sect prominent in the Central Region, known for its secret rituals, dances and initiation ceremonies. Also called *Nyau.*
kachasu – home-brewed alcoholic drink; moonshine.
masese – home-brewed beer.
kusokola – practice of searching for food during hunger or famine.
makolo – ancestors or parents.
malilime – prayer healing.
mchape – cleansing an area or group from the influence of witches.
mganga – traditional healer; herbalist.
mizimu – spirits of ancestors; spirit forces in general.
namandwa – a man who "cleanses" a woman sexually after her husband's death.
nchimi – powerful herbalist.
seketera – witch doctors with malevolent intentions or methods.
sing'anga – traditional healer; herbalist.

I. Introduction

For the past 20 years, AIDS in Sub-Saharan Africa has been considered a disease of high mobility largely associated with political strife[2] or urbanization.[3] AIDS in Malawi poses several challenges to existing assumptions about the demographic and social profile of the disease. Malawi registers the eighth highest HIV/AIDS prevalence in the world (UNAIDS 2004) and is one of the continent's least urbanized countries with 85 per cent of the national population living in rural areas. Much of the countryside has a reputation for being 'deep rural' in the sense that it is characterized by a patchy road network and poor physical, economic and social infrastructure. The country has not witnessed civil war and upheaval during post-independence era. Yet, the last estimate of prevalence amongst adults 15- 49 years of age was a high 14.4 per cent (NAC 2003). Urban adult prevalence was 23 per cent in contrast to a rural prevalence of 12.4 per cent. An estimated 80,000 people now annually die of AIDS and another 110,000, mostly young people, are infected. Roughly half a million Malawians have died of AIDS to date in a country of approximately 11 million people (MOPC & NAC 2003: vii).

The gap between urban and rural HIV prevalence narrowed during the 1990s from a factor of 5 to 2. The absolute number of rural dwellers who are HIV positive outnumbers urban HIV carriers by roughly three to one. What are the social and economic forces fuelling the spread of HIV/AIDS in this largely rural country? How has the Malawian rural population become so vulnerable to HIV/AIDS? What processes have been pushing them into the category of a high-risk population? How can these issues be addressed?

Malawi is one of Sub-Saharan Africa's poorest countries. Annual per capita income is US$190 (World Bank 2000). Because the country lacks mineral wealth, agricultural exports have been the country's commercial mainstay, notably tobacco and tea, produced by both large-scale plantations and small-scale peasant farmers. Labour remittances, earned by male migrants primarily in South Africa, have been a boost to many Malawian rural households. However, earnings from agricultural exports and remittances took a downturn during the 1990s with adverse economic effects for most households. It is in this context that processes of rural income diversification, deagrarianization and depeasantization are coming to the fore with various consequences for the welfare of the rural population (Bryceson 2002, Drinkwater 2003).

The recent famine of 2001-03 and the on-going HIV/AIDS epidemic have been intricately embedded in these broad medium- to long-term processes. It is now debatable whether causes and consequences can be disentangled, and if any specific economic, social or health vulnerability can be singled out and identified as a catalyst for any other. Nonetheless, De Waal (2003 cited in Ellis 2003) has spotlighted the role of HIV/AIDS in weakening the rural population and predisposing them to a 'new variant famine', arguing that the sub-optimal climatic conditions prevailing in 2001-2002 were not severe enough to cause the widespread famine that actually occurred.

[2] For example, Uganda, Rwanda, Burundi and the Democratic Republic of Congo.

[3] The rapid spread of AIDS in the more heavily urbanized countries of South Africa, Zambia, and Botswana accords with this assumption. So too, there is much higher HIV prevalence in urban as opposed to rural areas throughout Sub-Saharan Africa.

Whatever the cause-effect relationships, the deteriorating welfare status of the rural Malawian population is not in doubt. Their morbidity and mortality rates are escalating.

This study was commissioned by CARE Malawi to explore the livelihood strategies and social forms that have evolved within households and communities to contend with the threat of HIV/AIDS. Coping mechanisms have had very little time to develop. The AIDS crisis in Sub-Saharan Africa, as a 'long wave' phenomenon, is barely 25 years old. The two per cent HIV prevalence among antenatal patients at Queen Elizabeth Hospital in 1985 led medical opinion to surmise that HIV may have arrived in Malawi during the late 1970s from a point of origin in Uganda or Zaire (Lwanda 2004 citing L'Herminez *et al*. 1992 and Taha *et al*. 1998).

Over the past decade, HIV/AIDS has spread in Malawi against the backdrop of depeasantization and food shortages, devastating local economies and traumatizing communities. These initial years of coping have been accompanied by denial and despair, given the suddenness and extent of the morbidity and mortality experienced. This, therefore, is a study of community responses to the three main stages of the HIV/AIDS disease cycle: 1) infection and transmission; 2) debility and death; and 3) the aftermath of death encompassing widows, orphans and household reconstitution.

HIV/AIDS in Sub-Saharan Africa has often been likened to the experience of the plague in 14-15th century Europe. Roughly 30 to 50 per cent of the population is estimated to have died in affected areas during the European plague. Most Sub-Saharan African countries have not reached that level of disease prevalence. It is believed that peasant populations were the hardest hit during the Black Death and overall one-third of the population of Europe was wiped out (Ziegler 1998, Cantor 2001). However, the plague hit populations irrespective of age and sex whereas AIDS is age-specific, with economically active adults being the worst affected.

The major difference between the two pandemics relates to the scope for human agency in controlling the spread of the disease. Medieval medical science failed to understand the nature of the plague's transmission. It was believed that the disease spread through human contact with people who 'imported' the disease into an area. Thus, public health measures, if and when they were applied, had to do with restricting human movement and denying the entry of 'outsiders' into areas. Even though studies often mention mobility as a causative factor in the spread of HIV/AIDS, policies encouraging reduced mobility would be impractical, deeply resented in Southern Africa's post-apartheid period as an era of economic liberalization, and largely self-defeating.

In any case, mobility is a contextual factor that *facilitates* but does not cause the spread of HIV. HIV infection has three main causes: 1) unprotected sex; 2) mother-child transmission at childbirth and more rarely through breastfeeding (Latham and Preble 2000); and 3) contact with contaminated blood arising from drug-taking, medical injections, or other intrusions into the human body. The major form of transmission in Sub-Saharan Africa is unprotected heterosexual sex.

The scope for individual and local level community agency exists vis-à-vis AIDS in a way that never existed with the plague. HIV/AIDS infection can largely be prevented

through safe sex, notably condom use. Whether people choose to use condoms or not is not simply a matter of individual decision-making based on personal preference. Individual and household survival needs, economic and social aspirations as well as collective perceptions, beliefs and traditions are critical to their decision-making. Recognizing the threat of AIDS and acting to eliminate that threat in one's own life and for others around one are momentous steps towards coping with AIDS. Gender and generational identities are intimately bound up in this painful process of coming to terms with the disease.

II. Background to the Study

The terms of reference for this study specify: 'the use of a qualitative methodology in a limited number of sites in the Central Region, so as to facilitate the focused analysis of social change processes and their underlying causes' including a consideration of deagrarianization and depeasantization. The ultimate objective is to 'identify points of opportunity for the nurturing of social pathways that provide some hope for the future.'

The study was divided into two phases. Phase I focussed on human agency in the HIV/AIDS disease cycle. The field work took place during the first two weeks of December 2003 and included focus group discussions, key informant interviews and in-depth bereaved household interviews in two villages in Lilongwe rural district, Central Region: Dzama in Chitukula TA and Vizimba in Khongoni TA. The second phase involved scaling up the focus from individual and group behaviour in the village to a consideration of the dynamics of the villages' main social institutions encompassing the household, the community and the system of village leadership. Intra- and inter-household relations, formalized associational ties and the changing nature of traditional village leadership were probed through focus group discussions, key informant interviews, in-depth interviews with orphans and their foster carers, as well as a household survey to ascertain household size and composition. This phase again took place in Vizimba village which follows patrilineal descent. We decided to choose a more matrilineally-inclined village adjacent to Dzama as our second case study village to afford matrilineal and patrilineal household comparisons.

All three villages are located off-road. The first, Vizimba, is located 60 kilometres (km) from Lilongwe, involving a drive along the road to Mchinji for 34 km and then an additional 26 km along an unimproved rural road. This village is the TA headquarters and thus a meeting place for people from other surrounding villages. Vizimba has a grain mill, a primary school, and a small health dispensary and serves as a minor commercial centre. Its main market town is roughly 8 miles away at Kasiya, an old former Asian trading center.

The second village, Dzama, is a 40-minute drive from Lilongwe, 20 km north along the tarmac road in the direction of the airport and Kasungu before turning and proceeding along a gravel road for another 9 km. The village is in the shadow of Lilongwe's international airport – a 30-minute walk away for the villagers. However, the villagers derive little benefit from proximity to such sophisticated transport links. There are no bus services. Catching a bus to Lilongwe involves walking to the main road. The village has a large primary school but no health facilities. The closest dispensary is at the airport. There are several small kiosks operated by private

individuals selling small articles like soap, matches, etc. The major commercial centre that villagers gravitate to is Area 25 in Lilongwe city, a 10-mile walk away.

The third village, Chimponda, is only a kilometre further down the rutted rural road beyond Dzama. The village was chosen because the household survey revealed that there were more matrilineal households there compared with Dzama.[4]

None of the village heads could give us total village population figures. The 1998 census records populations of 76,121 and 21,900 for Khongoni and Chitukula TAs respectively. CARE International has had programme interventions in both villages in the recent past[5] and has distributed food relief since early 2002. Following the harvest between June 2002 and May 2003 there were more targeted food distributions under the Joint Emergency Food Aid Programme (JEFAP) to severely affected households. This amounted to eight per cent of the population in both Chitukula and Khongoni TAs. At the time of our study under the C-SAFE programme there were still 1,078 people on food-for-work programmes and a further 600 chronically ill receiving direct food transfers.

The fact that CARE International had a recent programme presence in these villages greatly facilitated the reception of our research teams in all three villages. However it also necessitated vigilance against raising people's expectations that we were visiting for the purposes of reconnaissance for a distribution programme of any sort, be it food, seeds, etc. We stated at the outset of each FGD and interview that our visit to the village was aimed at understanding the villagers' experience of social, economic and demographic changes and was not connected with any past, present or future CARE distribution programme. People seemed to accept this, but nonetheless pleas for one or another CARE interventions were usually made at the end of our discussions.

A field methodology was devised that involved a wide array of focus group discussions and key informant interviews (Appendix 1). Village heads were contacted a few days in advance of our field visits in the hopes of arranging meeting times. The village leadership in both villages were accommodating and not only consented to our visit but ensured that participants for the proposed focus group discussions were assembled at the agreed time and notified key informants of our desire to meet with them. Thus we were able to hold focus group discussions in both villages with attendance as specified in Table 1.

[4] We also learned that Chimponda had been considered the headquarters of the Group Village Headman (GVH) but because of its more Christian-leaning population Dzama's current leader had claimed GVH leadership on the basis of a stronger *Gule Wamkulu* following, the significance of which will be discussed in a later section of this report.

[5] These are part of CARE's Central Region Livelihood Security programme which includes: strengthening organizational capacities and partnerships, increasing agricultural productivity through seed multiplication and crop diversification, natural resource management, and agricultural marketing and enterprise development.

Table 1: CARE Social Pathways Village Focus Group Discussion Attendance

	Dzama Village Chitukula TA				Vizimba Village Khongoni TA				
	No	Age range	Mean age	% Male	No	Age range	Mean age	% Male	Total No.
PHASE I									
Adults (>25 years &/or married)									
Men	13	22-67	n.a.	-	11	32-72	48	-	24
Women	16	26-60	41	-	9	21-65	43	-	25
Youth (13-25)									
Students	12	15-19	17	58	17	13-19	16	65	29
Out-of School	20	13-21	16	35	13	20-25	23	100	33

	Chimponda Village Chitukula TA				Vizimba Village Khongoni TA				
	No	Age range	Mean age	% Male	No	Age range	Mean age	% Male	Total No.
PHASE II									
Adults (>25 years &/or married)									
Men	7	21-36	29	-	13	22-58	40	-	20
Women	9	20-65	43	-	17	19-62	35	-	26
Youth (13-25)									
Students (F)	6	15-16	16	-	-	-	-	-	6
Students (M)	-	-	-	-	-	-	-	-	-
Out of School (F)	7	12-14	13	-	4	13-17	15	-	11
Out of School (M)	-	-	-	-	-	-	-	-	-

Table 2: CARE Social Pathways Village Key Informant Interviews

	Dzama Village	Vizimba Village	Chimponda Village
Headman	Village leader	3 village leaders	2 village leaders
Teacher	Standard 5 teacher, Chitukula Primary	Headmaster, Chifuka Primary	
Religious Leader	1. Presbyterian minister 2. Headman as priest of *Gule Wamkule*	Covenant church of God minister	
Medical officer	None in village & not available in area to speak to	Medical assistant, Kasiya Dispensary	
Traditional healer	None available	Female spiritualist *mizimu*	
Village Action Committee	9 members (6 female) including male chairman	Not present in village	
Bereaved Households	7 (all male HHH deaths)	2 (all male HHH deaths)	

In addition to the focus group discussions and key informant interviews, a small random-sample household survey was undertaken to obtain an overview of the demographic composition of households and their support networks. The household survey, conducted between the 27 February and 3 March, covered 141 households divided between Chitukula and Khonghoni TAs as indicated in Table 3. The households were randomly sampled as described in Appendix 2.

Table 3: CARE Social Pathways Study: Household Survey

Chitukula TA		Khongoni TA	
Village	**No of HHs**	**Village**	**No of HHs**
Dzama	29	Vizimba	36
Chimpando	8	Ntambwa	31
Nkhuntha	3	Nyololo	11
Flatela	1		
Mwenjerere	2		
Masitala	1		
Sasauto	3		
Nkhunthaeneya	3		
Chimombo	1		
Siyenimngoni	4		
Siyenimchewa	4		
Bvumbwe	2		
Mwachirira	2		
Total Chitukula	**63**	**Total Khongoni**	**78**
TOTAL HOUSEHOLDS: 141			

III. Rurality in Malawi: Traditional Tribal Peasant Societies?

Malawi is an overwhelmingly rural country with 85 per cent of its population residing in the rural areas and approximately 80 per cent engaged in rural farming as their main occupation. In 2000, agriculture accounted for 42 per cent of national GDP. With negligible mineral wealth, the country's agricultural production is vital to national well-being. Yet, its enormous peasant agricultural sector is mostly subsistence-oriented wuthout achieving adequate food self-sufficiency for the majority of rural dwellers.

During the colonial period Malawi was an outpost of the Southern African regional economy, an economy dominated by European settler and mining enterprises. Malawi was a source of cheap labour for these enterprises. Its post-colonial years under Hastings Kamuzu Banda[6] were known for agricultural policies that did little to raise the productivity of food or cash crops of rural smallholder farmers nor improve rural infrastructure in terms of roads, schools and health facilities although some of the administrative framework for such infrastructure was put in place and a start was made towards channelling agricultural credit to smallholders. However, rural Malawi's destiny under Banda was to continue to serve primarily as a reserve for male labour increasingly for large-scale, foreign-owned tea and tobacco plantations within Malawi rather than for South African enterprises.

Despite attempts to alter this policy in the post-Banda period and official encouragement and improved infrastructure to facilitate smallholders growing tobacco, Malawi's smallholder agricultural sector stands out in the region as extremely low-yielding (Ellis 2003).[7] On top of exceptionally poor yields the sector is heavily reliant on mono-cropping: maize as a food crop and tobacco as an export crop. Malawi's Central Region takes mono-cropping to its logical extreme. The population is overwhelmingly reliant on maize for its food supply and tobacco for cash earnings. Maize dominates diet, accounting for roughly 65 per cent of calorie intake, estimated to comprise approximately 155 kg of maize per capita annually.[8] Herein lies the area's vulnerability to famine. Severe food shortages and famine occurred in 2001-2002. Food insecurity has continued at the rural household level to the present.

The two most densely populated rural areas in the country are found adjacent to the country's largest cities, Blantyre in the Southern Region and Lilongwe in the Central Region. Population densities in these areas range on average between 200-400 per square km. The case study villages are found in this zone. Such population densities in the absence of agricultural innovation, thriving cash crops and proliferating off-farm earnings raise vulnerability to famine further.

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[6] Banda ruled the country from independence until being ousted by multi-party elections in 1994.

[7] Using 2001 LADDER rural household survey data, Ellis (2003: 18) found that the value of net agricultural output per hectare (ha) was on average only 21 per cent of that achieved in neighbouring Tanzania, Uganda and Kenya with the gap worsening for lower income households: a mere 14 per cent for the lower half and 28 per cent for the upper half. Malawi also distinguished itself in having the highest output differential between its lowest and highest income quartile. It registered a ratio of 6.0, compared with Tanzania's 4.7, Uganda's 3.7 and Kenya's 3.2 ratio, demonstrating the huge disparities in agricultural output that occur within the peasant agricultural sector in Malawi.

[8] http://www.fao.org/giews/english/basedocs/mlw/mlwgen13.stm, 12/1/04.

1. Social Identity and Interaction: Ethnic Ties, Lineages and Households

The character of Malawi's rural areas is a product of economic, political and cultural history through time. The country's high rural population density particularly in the Central and Southern regions have arisen from an extremely favourable agrarian climate with good rainfall and the water resources of Lakes Malawi and Chilwa. The first Bantu-speaking 'Maravi' people migrated into the area more than two thousand years ago. The Chewa, the largest ethnic group, are descendants from this migration. They are identified as part of a broad band of matrilineal Central Bantu speakers. However, Malawi has been subject to considerable ethnic mixing. The 19th century was a period of great upheaval with Yao slave and ivory traders as well as the Ngoni entering the highlands of the Southern Region. Slave trading wreaked havoc on the area. Early European explorers recorded heavily fortified settlements. Both the Ngoni and Yao are patrilineal people. There are still identifiably distinct ethnic groups, but their inter-marriage with the Chewa and other Bantu matrilineal groups has left its mark on lineage formation. Now, while almost all of rural Malawi is characterised by unilineal descent, the South remains closest to matrilineality and the Nothern region is patrilineal.

The Central Region which has a very large Chewa population represents a mosaic of matrilineal and patrilineal people. Many villagers in this area who identify themselves as ethnically Chewa trace descent patrilineally. This was illustrated by our Phase I case study villages, both of which operated on patrilineal lines. One school teacher commenting about the cultural patterns of the village explained to us that the Chewa have always been patrilineal people. Most people consider their descent system as traditional even though it probably switched from matrilineal to patrilineal relatively recently, sometime during the last 100 years. This suggests that lineage societies are not necessarily traditional, but as O'Laughlin (1995) observes the principle of lineality is very enduring.

Lineality is an all-encompassing concept, providing a cultural, economic and political identity and system of organization (Mair 1972). Lineage societies operate to exclude political power nodes not based on lineage descent. Villagers are obliged to recognize the authority of the senior man of the lineage who is accorded the power to allocate lineage resources, notably land. Juridical powers are also vested in the lineage head who settles disputes between lineage members and is often a religious community leader as well. In the Central Region, more than half the population identify the *Gule Wamkulu* as a traditional loyalty and, for some, their main religion. The population of Dzama is strongly aligned with *Gule Wamkulu* whereas neighbouring Chimponda identifies itself as more Christian-leaning.

Schoffeleers (1985) shows how the Malawian countryside has experienced a polarization of religious beliefs. In the early 20th century young households were attracted to Pentecostalism and spirit healing which challenged the gerontocratic leadership within the villages. In reaction, chiefly authorities and older members of the community championed the neotraditionalist *Makolo* Church (Church of the Ancestors) aimed at rejecting Christianity and restoring ancestor worship.

In the post-independence period, several African heads of state chose to dismantle the colonial native authority local governance structure that kept power in the hands of traditional ethnic leaders such as chiefs and lineage heads. Banda, along with most

Southern African heads of state, retained some semblance of indirect rule through the continuation of tribal authorities and lineage heads. This tends to keep local rule in the countryside conservative and traditionalist in outlook. The traditional authorities at village level are usually male elders who rarely have much formal education and are not subject to democratic election. Furthermore, people generally have a restricted local outlook and horizon. A person's property rights and welfare are largely determined by maintaining contact and good relations with cognatic relations in his or her birth locality. The traditionalist outlook is reinforced by the generally low education level of the rural adult population, the legacy of the very late introduction of universal primary education in 1994 following Banda's departure from the presidency.

Under Banda, the traditional authority structure was wedded to the national party leading to an all-encompassing power complex with the President at its apex. This led to a consensual-cum-obligatory system for mobilizing community effort and political support. Now, in the post-Banda era under a multi-party system, rural community figures such as teachers and leaders remark about how it is much more difficult to get community labour or contributions of other kinds for local development projects since people feel freer to opt out.

It is argued that conjugal bonds in lineage societies are necessarily weak. This seems to be supported by evidence from the study area. Marriages are unstable with numerous material and inter-personal grounds for divorce (Kadzandira 2002). Exogamy is practiced which obliges men and women to marry someone from outside of their birth locality to avoid marrying a close relation. In fact this tends to be someone from a village not too distant from one's birthplace, who is usually first encountered at a regional market or some other general meeting place. Even though the incoming spouse is from the region, s/he will always be a 'stranger' in the locality of the marital home. The belief is that this precludes in-comers, be they men in matrilineal areas or women in patrilineal areas, from investing in the area of their marital home. This has been especially noted for men in matrilineal areas, and seen as a constraint on development.

The villages studied in Phase I followed a patrilineal pattern whereby wives are the 'strangers', whereas in Phase II Chimponda, a more matrilineal-leaning village was substituted for Dzama. In the event of divorce or widowhood, wives are expected to leave the village and return to their home area. In areas as densely populated as Lilongwe rural district this begs the question of whether a returning woman will find land and resources for an adequate livelihood if she returns to her home area. Also there is the possibility in the Central Region where matrilineal and patrilineal descent are followed, depending on the specific area, that certain people could be completely disinherited if for example their father originated from a matrilineal area and their mother came from a patrilineal area. On the ground, principles of unilineal descent are not rigidly adhered to and practical and welfare considerations are applied especially in cases of death of a spouse. This is exemplified by the fact that most of the bereaved households that were visited were households where the male head of household had

died and his widow/offspring had remained in the village albeit often with edgy or even hostile relations with in-laws.[9]

While lineages represent strong corporate ties for those born into the area, it should be stressed that these ties are concentrated in fraternal relations regardless of matrilineality or patrilineality. Whether descent is traced through the female or male line, decision-making and power rests with men and is exercised laterally by men as brothers/uncles. Davison (1995) documents that women, even those in the matrilineal communities, individualize their property and work effort to minimize the possibility of lineage claims for sharing labour or property. They have historically preferred to engage in casual wage labour where the payment is established at the outset without the lingering obligations of reciprocation rather than pooling their labour and being held to account by lineage ties.

This helps to explain the historical lack of collective labour forms between households both in the pre-colonial and colonial periods (Phiri 1984, Mandala 1990). Collective labour like work parties and other outside reciprocal forms of labour are not much in evidence (Englund 1996). Rather hired casual labour referred to as *ganyu* has been the main form of inter-household labour exchange between peasant households.[10] This has involved the exchange of labour for specified goods or services in kind or for cash (Englund 1996). In some cases, it simply is a mechanism whereby a labour-short household of any wealth-standing can gain access to additional labour seasonally, but generally it is associated with people from poorer households seeking goods or cash from better-off households through the sale of their labour. Englund (1996) argues that although it may be interpreted as exploitative, the partners to the transactions are often relations (although usually not of the same generation) and there is a moral content to the exchange in the sense that there are hints of patron-client ties between the two parties. Labour supply tends to exceed demand in rural areas and the better-off buyer of labour with access to cash, through agricultural commodity sales or wage employment, extends cash access to the seller of labour through *ganyu.* Englund (1996: 19) explores the nature of this reciprocity:

> *Ganyu* recruiters are self-interested actors whose concern is to protect, and possibly increase, personal wealth. Yet wealth (*chuma*) can only appear through mobilising others for, for example, *ganyu* labour. Wealth which is individual, mobilising no one but the self-interested actor him- or herself, constitutes its proprietor as the inversion of a moral being, a witch...Moral personhood, among "rich" and "poor" villagers alike, is predicated on the decomposition of constitutive relationships by performing deeds for others…two images of moral degradation are equally compelling. One is the image of the accumulator as an individual; the other is the poor villager as a passive recipient of others' wealth and assistance.

[9] It is interesting that although we had requested interviews with any household that had experienced death of an adult since 2000 we were directed to these households. Either most deaths have been of men or the identity of 'bereaved' households is stronger and lingers on longer for households that have lost the male head and have uncertain property rights in these two patrilineal villages. Male widowers may be likely to remarry more quickly and form a new 'intact' household since it is generally believed that men are incapable of managing without a wife.

[10] Vaughan (1987: 105) observes that employers of *ganyu* labour during the 1940s were often 'people with larger than average land-holdings as well as higher than average earnings through employment or trade….This form of employment, [*ganyu*] unlike the formal sort, does not show up in the official statistics, but was of great importance to the local economy.'

Thus *ganyu* labour is very much a product of the Malawian countryside where cash earnings of peasant farmers are needed but hard to obtain. Through historical familiarity with wage labour relations, and an eagerness to keep lineage reciprocal obligations one or two degrees removed, labour contractor and labourer enter into a contractual agreement with immediate pay-offs for both parties. This avoids the moral responsibilities illustrated by the Chichewa proverb '*kupatsa ndiko kuika*' [to give is to place] meaning any favour will be placed in the recipient's memory and eventually the favour must be reciprocated (Englund 1996:7).

Whatever its moral and relational content, in the present era, *ganyu* labour has nonetheless gained a negative connotation associated with deepening impoverishment. Often *ganyu* labour intensifies during peak agricultural seasons and involves the poor casual wage labourer diverting work effort from his/her own fields to that of someone far better off. As Englund (1996) further argues, the reciprocity of *ganyu* contracts disintegrates the more distant the relational ties between labour contractor and labourer. In his Dedza district examples, when contractors hired Mozambican rather than local labour, wages and working conditions deteriorated. The next section explores the nature of *ganyu* labour in crisis situations.

2. Peasant Production Patterns, Constraints, Crises and Coping Strategies

Historically, Malawian rural peasant households have collectively functioned as a long-distance, male labour reserve. This generated a rigid gender division of labour and dual character to the household labour effort. Work in the villages has been and continues to be mostly subsistence-based and lacking a strong orientation towards agricultural commodity production except in some of the tobacco-producing areas. Instead there has been a reliance on the generation of inflows of cash by men working in distant places. Rural women were almost totally precluded from the colonial and post-colonial wage economy. Thus, they faced the structural challenge of attracting their cash-earning menfolk back to the villages to help provision the household. This was facilitated through the tug of men's home-based lineage loyalties and, probably in no small measure, the conviviality of village life and the comforts of home.

A viable local income source for women and a key aspect of village conviviality for men converged in village-based beer brewing. Vaughan (1987), citing survey evidence from the 1950s, notes:

> Apart from producing food in their own gardens, the main occupations of the women surveyed were beer brewing and *kachasu* distillation, and petty trading in agricultural produce. The importance of beer or *kachasu* brewing as a source of income for women was enormous…the overall effect of *kachasu* distillation was to increase the turnover of cash in the village and make available increased quantities of cash for expenditure on a number of other items. (p. 130)

Tellegen's (1997) survey of rural income-earning during the 1990s revealed that women's alcohol production has continued to be a central mainstay of their cash earnings with men as the main consumers. What had changed, however, was that men's long-distance migrant labour pattern was dwindling. Their main destination had been the mines of South Africa, but beginning in the 1970s the flow of Malawian migrants tapered as Banda became concerned about the restricted wage labour

supplies to Malawi's large-scale plantations. During the late 1980s and early 1990s at the instigation of the South African government, which designated Malawi as a high-risk AIDS-affected country, that flow virtually stopped as the apartheid economy was dismantled by the Mandela government (Chirwa 1998). Meanwhile, Malawi's plantation wage labour opportunities were contracting in the face of declining world agricultural commodity prices and adverse economic trends. The male migrant labour system was disintegrating with adverse repercussions for rural cash flows in the Malawian countryside.

At the same time, Malawi was undergoing profound political and economic transformation. Banda relinquished power in 1994. During the 1990s Malawi's plantation sector received less attention. Efforts were made to promote peasant commodity production, particularly of tobacco. Nonetheless, this was done at a time when the World Bank was stipulating Structural Adjustment Programmes (SAP) and economic liberalization policies. The Agricultural Development and Marketing Corporation (ADMARC), the national crop-buying parastatal, was floundering. Marketing and extension services were patchy and it was evident that the tobacco boom amongst African farmers was restricted to an elite of progressive farmers who could operate at a larger scale of production, despite the demonstration effect which served as an incentive for smaller peasant farmers to plant tobacco assuming that economic success could be achieved through tobacco planting.

The broad masses of rural Malawian men, like their counterparts in other parts of Sub-Saharan Africa, faced declining prices and marketing services for their export crops (Bryceson 2000, 2002). With lots of time but little money, men spent more time in their villages and many drank heavily. Tellegen (1997) documents how this generated tensions because men often attempted to evade payment by using 'tasting rights' or demanding credit from women beer brewers with the promise of future payment.

Malawian staple food crop production was relatively good during the early 1990s achieving 90 per cent self-sufficiency between 1987-88 and 1991-92. There was a poor harvest year in 1992-93 when only 50 per cent of national cereal supplies was met by domestic supply and 500,000 tons of food aid was received (FAO website 2004). Thereafter domestic staple food supplies became more erratic ranging from 70-90 per cent self-sufficiency, but a bumper harvest preceded the poor harvest and severe food shortages and famine that occurred in 2001-02. Some commentators have remarked that the famine was out of proportion to the level of the harvest shortfall. However, it must be remembered that it came amidst a deepening problem of rural employment and declining cash earnings in addition to rising AIDS-related morbidity and mortality.

CARE commissioned a study during the famine that indicated that there were cases of rural women and girls resorting to transactional sex in exchange for food (Shah 2002). Comparing the coping strategies that occurred during the severe famine of 1949, as documented by Vaughan (1987), provides some insights into a similar situation of a narrowing range of options that households had for provisioning themselves with adequate food. Vaughan found that women's local cash earning activities, notably *ganyu* labour and alcohol production, were the first to give way. The government prohibited alcohol production to conserve cereal stocks.

> Beer brewing and petty trading were the first activities to cease during the famine, along with most *ganyu* labour. This placed women in a situation of unprecedented dependence on men. Women did not, of course, experience the famine uniformly. Those whose husbands were in wage employment stood a better chance of gaining access to food than did those married to men who were not so employed (Vaughan 1987: 131).

Significantly, male migrant labourers' earnings represented a vital support during the 1949 famine. In contrast, during the 2001-02 famine the cushioning effect of migrant labour was largely absent. Those who had offspring in urban areas had some recourse but most rural households had to fend for themselves. They had to do so amidst the growing debility of AIDS-related illness. Widely reported cases of women and girls exchanging sex for basic foodstuffs took place in the context of having nothing else to offer in exchange. They were reduced to transacting an 'essential exchange' in all respects: sex for basic food needs.

IV. Agrarian Livelihoods and HIV/AIDS: CARE Study Findings

In addition to this study, CARE has commissioned three other recent studies concerned with the intersection of declining agrarian livelihoods and the increasing impact of HIV/AIDS with Lilongwe district as their case study area. Shah *et al*. 2002 was primarily concerned with examining how the experience of HIV/AIDS was impacting on agricultural practices. Pinder 2004 took this further, examining the situation two years hence with a focus on how the rural economy was changing in terms of off-farm labour and debt. Shah 2002 looked specifically at adolescent attitudes to sex and HIV/AIDS. This section schematically overviews some of their major findings.

1. Stigma and Denial of HIV/AIDS in Agrarian Households and Communities

Denial, fatalism and stigma permeate rural dwellers' attitudes towards HIV/AIDS. Both the Shah *et al*. 2002 and Pinder 2004 studies felt obliged to refer to HIV/AIDS as 'chronic illness'. This was a euphemism. Most people were willing to talk about HIV/AIDS in the abstract, but once it referred to them or close family, they were far more comfortable with the chronic illness term. A vicious cycle was set in motion. Families who experienced AIDS-related morbidity or mortality did not talk about it and struggled to cope on their own. Generally villagers pretended not to know who had AIDS as a way of avoiding embarrassment for the affected family. At funerals no one mentioned that AIDS was a cause of death. Thus, AIDS victims and their families suffered in silence and their sense of shame and fear deepened. Ways of coping were not discussed in an open manner, pre-empting collective ways of coming to terms with the disease and straightjacketing individual's and household's active agency to alleviate the suffering AIDS caused and arrest its spread.

2. Agrarian Trajectories of Impoverishment

The coping strategies which people devised when they or family members fell ill with AIDS were conditioned by both timing and wealth standing. Poorer households, whose members became sick during the peak agricultural seasons of planting or harvesting, fared the worst. All households, however, experienced economic setback and a rising proportion of households fell into the category of the absolute poor and

resorted to productive cash and asset-depleting measures like mortgaging their crops, doing *ganyu* labour in return for basic food supplies, and selling household or agricultural assets.

De Waal (1989) documents that the sale of productive agricultural assets was avoided as much as possible during the Darfur famine of 1984-85. People preferred to go hungry rather than sell the means by which they made their living. Whether Malawian farmers conformed to this outlook but had been reduced to unavoidable sales by the coincidence of famine and HIV/AIDS or whether they had a different outlook conditioned by their historical reliance on migrant and casual wage labour is not clear. In most cases, Malawian rural households' asset-stripping was instigated by the need to meet medical or other care costs of AIDS patients. Our study attempted to delve into this further to try to understand the circumstances and reasons for these decisions.

3. Agrarian Labour Loss and Degeneration of Agricultural Productivity and Food Supplies

Whatever the household's wealth status, AIDS represented a serious labour setback given the AIDS sufferer's declining labour capability as well as other household members' labour diversion away from agricultural production to care for the AIDS sufferer. The cumulative effect of household labour loss due to AIDS is a tendency towards: 1) declining planted acreages, and 2) substituting labour-intensive cashcrops and food crops like maize with less demanding food crops like cassava and root crops (Rugalema 1999).

This tendency lends credence to de Waal's (2003) theory of 'new variant famine'. AIDS sufferers and carers alike, shouldering an added work burden and emotional stress, have far less energy to put into agriculture even in the hours that they can devote to agricultural tasks. Agricultural productivity declines accordingly.

4. Adverse Agricultural Infrastructure and Policy Context

The effect of HIV/AIDS on agriculture in Malawi is exacerbated by a process of contracting agricultural infrastructure that has already been set in train. Farmers in the villages studied have not been availed agricultural extension services for a considerable length of time. There is an acute shortage of extension officers in the country in part due to staff members' deaths from AIDS. The last recruitment of agricultural extension officers took place in 1995 (Kadzandira 2004). Furthermore, the AIDS pandemic has caused many staff deaths rising from 48 in 1996 to 100 in 1998 (Malindi *et al*. 1999).

Currently, what most perturbs peasant farmers is the government's removal of the fertilizer subsidy. This occurred in 1994 and although ten years has elapsed farmers still complain bitterly about the prohibitively high cost of fertilizer and their declining yields of both food and cash crops. In this study's village focus group discussions both men and women listed the lack of fertilizers as a major problem, if not their biggest problem.

Meanwhile, government measures to reduce the role of ADMARC, the country's official crop purchasing parastatal, has led to fewer buying posts and longer distances

for peasant farmers to travel to sell their crops. Opponents to the policy charge that it will further undermine farmers' prices and crop sales.

5. Salience of Off-Farm Coping Strategies

All three previous CARE studies have documented a rise in off-farm activities. While the more well-to-do in the village have opened up grocery stalls, the poor are increasing their involvement in *ganyu* labour which has encompassed the exchange of labour for food on quite exploitative terms and has extended to the exchange of sex for food in recorded instances. However, none of the previous CARE studies has focussed on the widespread incidence and changing character of alcohol sales. This sphere of non-farm activities has been largely overlooked and requires in-depth attention given its importance as a productive and recreational activity connected with the spread of AIDS in rural areas.

6. Debt and Social Discord

Focussing on the rural economic consequences of HIV/AIDS in Malawi, Pinder (2004) notes that the famine of 2001-02 was a period of widespread debt expansion. Many people, short of food and other vital basic needs, borrowed cash and goods, promising to pay back as the situation improved. By December 2003, the weather had improved and the rains for planting looked promising. Nonetheless, many farming households remained unable to pay their debts. The earlier depletion of their productive and household assets placed them in an economically disadvantageous position.

This had a knock-on social effect. Many households were calling in their debts. When a debtor household could not pay, the creditor sometimes seized other assets still retained by the indebted household. The charge that this was unfair and that the seized property exceeded the value of the debt was common. The enmity between households created a tense social atmosphere clouding village harmony.

V. Social Dimensions and Agency of HIV/AIDS in Rural Malawi

There is a growing consensus that poverty and mobility are at the root of the AIDS crisis in Malawi. While few would dispute that poverty is increasing with a detrimental effect on rural society as a whole, it is useful to explore the question of whether poverty is the cause or context of the spread of AIDS in the Malawian countryside.

Human behavioural choices help to contain or spread a sexually transmitted disease. Social agency is an essential aspect of controlling HIV/AIDS. However, social agency is very difficult to address given its diffuse nature and the intimate social behaviour associated with the spread of the disease. Sexual practices in most cultures are difficult to discuss across gender and generational divides. In some cultures it is a taboo to refer to sex. Furthermore, double standards abound between what a culture may prescribe as 'normal' or 'acceptable' sexual behaviour and what individuals do based on their immediate desires.

Embedded within proscribed sexual relationships are a myriad of cultural guidelines regarding commitment, duty, and status, on the one hand, and passion and notions of fun and individual fulfilment on the other. Just as sex may or may not be associated

with the long-term commitment of marriage, it may or may not be associated with a sense of social responsibility towards one's sexual partner and his/her circle of family and dependants and the wider community. Thus, the area of social agency and personal decision-making regarding one's sexual behaviour is fraught with ambiguous meaning and moral dilemma vis-à-vis the wider society. Sex is a sphere of human behaviour that revolves around personal autonomy. An individual's decisions represent the blending of or possible trade-offs between short-term physical desires and longer-term emotional and material needs.

The discussion of HIV/AIDS and sexual practices in Sub-Saharan Africa has been rife with cultural and political misunderstandings. Many African commentators, including Thabo Mbeki, see western perceptions in this field as distorted and racist (Lwanda 2004). Indeed many western analyses broadcasted through the media have misunderstood and senzationalized what they see as exotic sexuality in African cultures, while being unreflective about their own society where the internet and pornographic industry have combined to create sexual enticement of an unsurpassed nature. Unfortunately, the contentious positions adopted in this misinformed debate about African sexual attitudes and practices detract from the very real need for more attention to individual and collective social agency in controlling the spread of HIV/AIDS in Africa.

The denial and fatalism evidenced in rural Malawi currently holds back the adoption of safer sexual practices and perpetuates a high-risk environment in which many people, especially youth, are contracting the disease unnecessarily. Youth, who are in the process of constructing their economic and social identities and forming life-long attitudes and habits, face the issue of social agency more than any other. The Dzama Village AIDS Committee observed:

> Young people in this village are having unprotected sexual relations among themselves. They believe that if you do not indulge in such behaviour then you are living an 'old fashioned life', while those practicing risky sexually activity are considered '*otsogola*', those who know fashion or are urbanized. (Dzama VAC FGD, 4 December, 2003)

Campbell (2003) illustrates how denial on the part of youth and mineworkers in South Africa has fueled the spread of AIDS. By contrast, her study found that women prostitutes, whose livelihood depends on the sale of sex, nonetheless were much more receptive to adopting safe sex practices. The fundamental difference between the prostitutes as opposed to the youth and male mineworkers was that the former sought professional safety whereas the latter revelled in risky sexual behaviour. A devil-may-care attitude was part of their persona, giving them a sense of group identity, personal fulfilment and social affirmation of achievement.

The causes of the spread of HIV/AIDS cannot be equated with material poverty. Prostitutes are engaged in a risky occupation for the sake of earning their livelihood, but they appreciate measures to improve safety thereby insuring their livelihood and well-being. Focussing on social identity and agency challenges the simplistic notion that the disease simply results from poverty. It also can help to explain the seeming anomaly that Sub-Saharan Africa's wealthiest countries, Botswana and South Africa, have the continent's highest HIV prevalence.

Sexual practices and mores are a fundamental part of adult group identity, as well as national and local cultures. Without a common understanding and general acceptance of these practices and norms as well as their sub-texts and double standards, inter-personal relations, especially gender relations, would be chaotic. Individual success in inter-personal relations depends on manoeuvring through multiple layers of ambiguous meaning along the multi-various avenues of human activity. Sexual behaviour represents one of the most complex interplays of human activity and meaning. To interpret sexual behaviour and vulnerability to AIDS simply as the outcome of one's economic standing would be reductionist in the extreme.

Human activity can be seen in terms of realms of reproduction, production, recreation, creativity/invention, and destruction. Sexual behaviour, perhaps more than any other human pursuit, can embody all of these realms of endeavour. The vast feminist literature emanating from the 1970s conceptualized sexual behaviour largely in terms of production and reproduction. The 'poverty as the main cause of HIV/AIDS' discourse adopts this approach as well. However, it should not be forgotten when the spread of HIV/AIDS was first noticed in East Africa during the 1980s, it was called the '*raha* disease' (Juma 2001). *Raha* denotes fun and good times in Kiswahili. It was noticed that those men who had the money to spend on alcohol and women were highly susceptible to the disease. This was a very early stage of the disease and it has progressed through further stages involving other agents and sources of transmission, but the recreational sphere of drinking and sex remains a major engine of disease transmission in much of rural and urban Sub-Saharan Africa and is being confirmed in Malawi by on-going research (Kadzandira, Teleka and Thurman 2003). In this sphere agents weigh immediate pleasure against the risk of contracting AIDS in the long term. Interestingly rural people are the first to recognize this (CARE Livelihoods and AIDS January 2004 village interviews).

As time goes on and personal observation and public awareness campaigns reveal that particular sexual behavioural patterns are high risk, nonetheless certain social groups in full knowledge retain a willingness to continue taking the risk. They tend to do so on the basis of affirming their social identity and/or denying that anything they do makes a difference to what they perceive as a life of powerlessness and despair. This defeatism is part and parcel of the 'culture of poverty' that Oscar Lewis (1976) documented in Latin America. Does this return us full circle to the discourse linking the spread of HIV/AIDS with deepening poverty?

There is ample evidence that high-income as well as low-income people are vulnerable to HIV/AIDS in rural Malawi and in Sub-Saharan Africa generally. There is also ample evidence that impoverished rural people in Malawi and throughout the continent are predisposed to engage in a cultural discourse of powerlessness and denial that leads them to both believe and act as if they have no agency to stop AIDS. As a consequence, they may be more prone to engage in high-risk sexual behaviour than others who may have greater self-esteem and confidence. Distinguishing the culture of poverty from material poverty *per se* is key to understanding the spread of HIV/AIDS in rural Malawi. The analytical distinction is helpful in clarifying aspects of human agency associated with HIV/AIDS at various stages of the disease cycle. The following three sections of this report trace human agency during the disease cycle using a culture of poverty perspective to interpret the CARE Social Pathways

study findings on rural dwellers' attitudes and social patterns concerning HIV/AIDS. People's agency in the face of the risk of infection, disease affliction and the material and social voids created by death are considered in turn.

VI. Human Agency in Disease Infection and Transmission

The Southern Region of Malawi is known to have the highest HIV seroprevalence. The Central Region comes second followed by the Northern Region. HIV prevalence and AIDS deaths are inescapable facts for all the population of our study area.[11] Knowing their extent, however, is extremely difficult. AIDS deaths go largely unreported given the stigma associated with the disease and the overwhelming preponderance of deaths at home as a result of the scanty and poor state of medical facilities.

HIV testing is becoming more common thanks to the efforts of the National AIDS Commission.[12] There are now 118 sites performing HIV testing in the country. However, the HIV statistics emanating from these testing sites do not arise from a randomly selected sample of the national population. Rather HIV prevalence is measured in women attending the antenatal clinics, people consciously seeking information on their HIV status, and ill patients, who represent widely different health risk positions and can not be considered to be representative of the overall population. This makes it difficult to ascertain HIV prevalence for male and female populations as a whole.[13]

Table 4 shows HIV prevalence at medical facilities in Lilongwe city and rural district. Taking the 'healthy population' of blood donors and women attending antenatal clinics, figures suggest that HIV prevalence is between 13 and 15 per cent of the adult population. This finding accords with the published statistics cited in the introduction. Assuming that individuals did not have repeat HIV testing and that all those tested were 10 years of age or over, roughly six per cent of the Lilongwe district population was tested. Disaggregation of rural and urban rates has been attempted by separating the urban medical facilities from the rural. This shows urban rates exceeding rural antenatal rates quite substantially by 12 per cent whereas the rural patient rate exceeds the urban rate by 10 per cent. It would be a mistake to read too much into these figures because: 1) the distinction between rural and urban is clouded by large numbers of rural residents who go to urban medical facilities for treatment and testing, 2) the rural centres are all mission establishments which may represent an unrepresentative sample of the rural population as a whole, and 3) there is a huge variation in the quality of testing at various centres. It is apparent that rural centres with small numbers being tested may have different quality control problems from the large urban establishments.

[11] In 2003, the antenatal clinics registered pregnant women's HIV prevalence at 6, 13, and 18 per cent in the Northern, Central and Southern Regions respectively.
[12] Between 2002 and 2003, the number of HIV tests in the country increased from 149,540 to 215,269, a 44 per cent increase over the previous year (Malawi, NAC 2004, 11).
[13] Some of the HIV testing sites have not been regularly collating the data in their medical registers to generate statistics (Malawi, NAC 2004, 9).

Table 4: No. of Persons HIV Tested and HIV Prevalence recorded at Medical Facilities in Lilongwe Rural and Urban Districts, 2003

	Blood donors		Ante-natal		VCT Patients*		Total	
Site	No.	% HIV+	No.	% HIV+	No.	% HIV+	No.	% HIV+
URBAN								
LLW D. HBC	0	0	0	0	27	25	27	25
LLW (CH+LH)	5306	16.0	11823	16.2	5714	56.0	22843	26.1
LLBottom Hospital	208	46.1	0	0	2256	57.0	2464	56.1
Lilongwe Macro	0	0	0	0	16860	12.0	16860	12.0
Lilongwe SOS	0	0	0	0	302	45.4	302	45.4
Likuni MH	1390	15.6	297	17.5	118	77.1	1805	19.9
ABC MH	0	0	0	0	242	141	242	141
LLW Barracks H	-	-	0	0	21	13	21	13
Urban Total	*6904*	*16.8*	*12120*	*16.2*	*25540*	*27.0*	*44564*	*22.6*
RURAL								
Nkhoma MH	-	-	0	0	587	48.6	587	48.6
St Gabriels MH[14]	1650	128	3828	158	1003	333	6481	619
Mlale RH	797	125	111	6	183	36	1091	167
Rural Total	*2447*	*10.3*	*3939*	*4.2*	*1773*	*36.9*	*8159*	*13.1*
TOTAL	*9351*	*15.1*	*16059*	*13.3*	*27313*	*27.8*	*52724*	*21.1*

Source: Malawi, MOH & NAC, 2004, Annex 3

While uterine transmission of HIV from mother to child is increasing in rural Malawi,[15] current evidence suggests that the major form of transmission continues to be heterosexual sex. The tragedy of this situation is that sex has been transformed from being a natural and pleasurable part of everyday rural life, bringing birth and renewal to the community, to its current status as a conveyor of disease and death. The issue of agency becomes paramount. How do people react to this change in the nature of a previously commonplace activity? How aware are they of the risks? If they are aware do they proactively try to curb risk or do they take a fatalist 'what will be will be' attitude? If the former, what are people's risk assessments vis-à-vis themselves, their sexual partners and their family dependents? How do they act on these assessments? These lines of enquiry are considered below.

1. Ebbing Away of Traditional Sexual Practices?

The HIV/AIDS pandemic hit rural Malawi at a time when sexual behaviour was undergoing considerable change. Traditionally, sexual behaviour was proscribed throughout one's lifetime on the basis of gender and age and these norms were embedded in concepts of community harmony and well-being. Chiefs as ritual leaders and spiritual heads of the community were the 'essential link in the chain of [community] continuity and fertility' (Boucher 2002 cited by Makinga and McConville 2003). They had to strive to achieve a ritual balance and avoid the mixing of 'hot' and 'cool'. Adult sexual activity was considered 'hot' whereas sexual

[14] Although it is located in a rural area, St. Gabriel's is a referral hospital with a larger catchment area.
[15] Worldwide, uterine HIV transmission has generally affected about 15-25 per cent of babies born to HIV-positive mothers. In Malawi this figure ranged from 4-35 per cent in 2001 (NAC 2002). In 2003, 65 per cent of the pregnant women identified as HIV positive at antenatal clinics were given nevirapine to help prevent transmission of HIV to their babies at the time of birth (NAC 2004, 13).

abstinence, women in menopause, certain herbs and rituals were 'cool'. These beliefs were associated with a variety of sexual taboos considered necessary to optimize conditions for human reproduction and favour with the ancestors, thereby ensuring community harmony. Chiefs were the lynchpin safeguarding sexual morality in their leadership role in local governance and the promotion of social unity (Matinga and McConville 2003).[16]

The chief plays a major role in assuring the fertility of the women of his village. He opens the source of fertility to all young female initiates undergoing puberty rites. Through the intercession of the ancestors and their mystical chain in which the chief is an essential link, fertility is granted by *Chauta*.

More secular influences exerted by labour migration and urbanization have no doubt chipped away at these beliefs and the authority of chiefs to enforce them. However, the extent to which chiefs and their rural communities continue to adhere to these beliefs varies widely at present. More remote villages tend towards stronger adherence. Headmen even in villages close to town, nevertheless, continue to see themselves as custodians of village morality that is threatened by the corrupting influence of urban areas, particularly on women.

> In my area, cases of sexual immorality are very rare if not non-existent…For example, ever since I became the GVH [Group Village Headman], I have never handled any cases involving sexual immorality…The problem here is just lack of money and food…In the past, women never used to know town and it was the duty of the husbands to tell them what town looks like…Nowadays, the situation is the opposite. Women know town more than their husbands because they are frequently there to look for food. (Dzama Village Headman interview, 4 December, 2003)

Although the ultimate goal of sexual life is seen as procreation, and the pro-natalist outlook of rural societies encourages women to give birth frequently, traditionally there has also been a great deal of attention to the recreational and creative side of sex. Seeing women's sexual role solely as reproducers in the service of the agrarian society's labour needs is a far too functionalist perspective. Traditionally sex was perceived as a joyful activity for all those who engaged in it. Men and women had a responsibility to know how to maximize pleasure for their partner and themselves during the sexual act. To this end there were various ritualized extra-marital events that were scheduled throughout one's lifetime which were considered to enhance the quality of one's sexual performance. These included women's sexual cleansing after initiation ceremonies and funerals by a *namandwa*. In the case of patrilineal societies, *chokolo* widow inheritance was practiced in many areas. Wives of the deceased were expected to marry one of their husband's brothers. The practice of exchanging wives, *chidzeranu,* was found in some places. Young virgins, male and female, traditionally were initiated by a trainer (*fisi*) of the opposite sex who coached them in having sex. Male circumcision was practised although perhaps not as commonly as in many other African countries due to pressure from Christian churches. Furthermore, adolescent girls and boys underwent initiation ceremonies with the chief playing a major role.

[16] Traditionally Chewa villagers were expected to refrain from conjugal relations if the chief was absent from the village (Boucher 2002 cited in Matinga and McConville 2003, 18).

The role of the traditional leadership is now crucial to changing sexual attitudes and practices. Enforcement of traditional sexual taboos has been largely in the hands of traditional leaders and is especially the case amongst the Chewa. In recent decades the Chewa's Nyau cult has resurged as a 'secret society' which performs the *Gule Wamkule* dance as an integral part of Chewa initiation ceremonies. Many traditional leaders insist on the continuation of these practices as mechanisms for ensuring cultural awareness and social cohesion.

Most of these practices have, over the decades, been subjected to one or another criticisms by community insiders and outsiders who were relatively educated or had come under the sway of formal religion, especially Christianity. The AIDS crisis has intensified criticism of these practices. However, under Banda, during the 1980s, the initial spread of AIDS was either denied as 'American Invention Depriving Sex' connected with family planning efforts or blamed on western immorality, homosexuality and foreign travel. Malawian traditional culture was held up as a paragon of virtue by the political elite (Lwanda 2002).[17] Currently, as the pendulum swings between traditionalist and modernist perspectives, traditional practices are on the defensive. The Malawian government, slow to act on condom dissemination, changed course during the 1990s and now tries to follow a more Ugandan-like AIDS policy and open discussion of safe sex practices. Because of this, doing many traditional rituals are being re-evaluated by rural dwellers.

The National AIDS Commission has been holding training workshops for traditional counsellors in villages aimed at adapting cultural practices to reduce risk. Villagers are now generally aware of the dangers of dirty razors in circumcision ceremonies, sexual cleansers and trainers, and *chokolo* widow inheritance. Chiefs are increasingly mindful of safety measure stipulations. Circumcisions and other traditional health procedures are now far more likely to be performed with new razor blades and traditional sexual rituals do not occur as much or may be performed with condoms (Shah 2002).

While members of the rural society have differing valuations of traditional sexual rituals – with younger people placing lower value on these practices than older people – their continued influence is rarely considered threatening or even controversial. It is seen as a legacy of one's cultural past, that is ebbing away gradually. In terms of proactive agency, this could be positive or negative. Traditionally, sexual behaviour was proscribed on the basis of age and sex with ritual occasions signposting the individual's role at various stages of his/her life cycle. For people to see pre-ordained traditional sexual behaviour as less important may bring them to a realization that individual decision-making is now critical to sexual happiness and safety or alternatively it may leave them in a moral vacuum with little appreciation of the social implications of their decisions for themselves and others around them.

[17] Banda and the Malawi Congress Party staged large pageants involving the recruitment of rural women as singers and dancers who spent time from home and were frequently subjected to sexual exploitation while away. This practice is cited as a factor in the rural spread of AIDS (Mkamanga 2000 cited in Lwanda 2002).

2. Eye of the Storm: Current Attitudes towards Marital Fidelity and Sexual Liaisons

In rural Malawi, sex is seen as natural and necessary for survival, illustrated by one male informant's comments that he would not be able to live without sex for more than a week. Certainly it is a vital activity for creative self-expression. In a setting of rural economic decline and lack of promise, sex could be compensatory, a pleasurable escape from the reality of lives availed of little other physical gratification.

The significance of sex in rural Malawi is further demonstrated by the young age at which people start engaging in sex. School teachers and medical personnel confirmed that children begin to be sexually active at the age of 10 or 11 years. Shah (2002) traces this showing that at this early stage it is usually boys and girls of roughly the same age experimenting with their bodies. Sexual intercourse begins in earnest at about 12-13 for girls and slightly older for boys. Girls are likely to have male sexual partners that are considerably older than them. The risk of HIV/AIDS has led men to favour having sex with adolescent girls. This pattern has been linked to rising HIV prevalence amongst younger women.

Combining the everyday 'naturalness' of sex with the legacy of male circular migration for long-distance labour contracts has introduced the expectation that men not only want but also need to have recourse to extra-marital sex if they are away from their wives for any length of time. This 'fact of life' however runs counter to Christianity's insistence on marital fidelity. Adherents to Christian religions are not necessarily the majority in rural Malawian villages. In the Phase I villages we studied there were just as many people practising the traditional *Gule Wamkulu* religion, otherwise known as the Church of Aron. In Dzama village roughly 50 per cent of villagers were *Gule Wamkulu*, 30 per cent Catholic and 20 per cent Protestant. Even though half of the population is not Christian, the entire population is exposed to Christian moral arguments through the heavy evangelical Christian content of the Malawian media. Evangelical and Pentecostal Christianity have a long history in Malawi (van Dijk 2002). Through radio, the press, and possibly sometimes television, villagers, whatever their religious affiliation, are well aware of marital fidelity as a moral imperative for Christians.

Different media messages are prescribing conflicting sexual behaviours.[18] The Christian discourse presents extra-marital behaviour as socially unacceptable. Condoms are understood as devices facilitating extra-marital sex. Those using condoms or in possession of condoms are seen as immoral. This message is counter to the widespread efforts of the government and various donor agencies to popularize condom usage. At present, in our study villages, condoms are disregarded by the majority or rural adults as either immoral or abnormal.

3. Added Hazy Dimension of Alcohol

However, moral issues posed by conflicting media messages fade when sexual encounters take place under the influence of alcohol. During the 1990s, Malawi's rural artisanal alcohol industry ballooned. In the early 1990s, a bag of maize sold to

[18] Health education in the media now tries to mediate between contending factions with the recommendation to abstain OR otherwise use a condom.

ADMARC earned 25 kwacha[19] as opposed to using the bag of maize to brew beer that quadrupled their earnings (Englund 1996, Tellegen 1997). Even higher profits were to be had from distilling *kachasu*. Tellegen's (1997) survey of rural enterprises in the mid-1990s found that the production of alcoholic drinks was the most ubiquitous rural enterprise in rural Malawi. A third of all entrepreneurs were involved in brewing and three-quarters of the female entrepreneurs were engaged in the production and sale of the local brew *masese* or distilled *kachasu*, or both. The inputs and skills are readily available and initial capital outlays are small because sophisticated equipment is unnecessary.

Traditionally beer was mainly consumed at special functions, but an enormous increase in the number of brewers and in the frequency of drinking in rural areas has taken place since the 1970s not unlike what was observed in neighbouring rural Zambia (Colson and Scudder 1988).[20] Beer parties regularly occur and heavy drinking is common. *Masese* is 10 per cent alcohol content, whereas *kachasu*, a distilled maize drink with sugar, is two to four times as alcoholic. *Kachasu* is brewed throughout the year and is consumed primarily by men who prefer it to bottled beer because it is cheaper and makes one drunk more easily because of its higher alcohol content. Drink supply and sales tend to be curbed during periods of famine and annually before the harvest due to shortages of grain for making the drinks and the low purchasing power of people during those periods.

Men encourage each other to drink large amounts of the local brews. Those who manage to drink copious amounts without getting seriously drunk are held in high esteem. Drunkards are made fun of but not excluded. Men, and increasingly women, use alcohol to relax, have a good time and escape from the realities of their harsh agricultural existence:

> We like drinking because it is lots of fun…[and it]…helps us to forget our problems…We forget problems at our home especially hunger. [The bar] is a place for social connections and networking and finding *ganyu*. The social atmosphere…makes you feel nice and it is a place where you discuss things like politics.' (Vizimba Men's FGD, 8/12/03).

Excessive drinking is probably borne out of frustration over declining rural prospects.[21] Drinking with friends who find themselves in a similar situation is compensatory. Youth are increasingly amongst the ranks of heavy drinkers. In fact in focus group discussions they were usually identified as the villages' heaviest drinkers. The production and sale of both drinks take place at a woman's compound: beer is normally not transported to a market but sold and consumed at the place where it is

[19] Now currently worth about 23 US cents.

[20] In rural southern Zambia, Colson and Scudder (1988) documented how the social nature of rural drinking was being transformed: '...the changes in behavior can be summed up by saying that drinking among men has increased substantially with respect to both the amount consumed at any occasion and the frequency of drinking...Overall, involvement with alcohol has increased substantially and now dominates Gwembe social life, a dramatic change that paradoxically has resulted in drinking becoming less integrated with the totality of life in the 1970s and 1980s. Whereas in the past most drinking was well grounded in either ritual or labor activities, drinking has now become an activity on its own - drinking for drinking's sake' (Colson and Scudder 1988, p.16).

[21] In the current poverty monitoring programme, alcohol abuse is cited as an attribute of the poor (Malawi, NEC 2002, p.15).

produced due to its perishability. In Chitukula TA, it was reported that out of 21 villages all but five had *kachasu* drinking places.

Extra-marital sex as an accompaniment to drinking is a well-established pattern. In many cases, serious drinking and 'womanizing' take place in the drinking establishments of the market town or some other major population settlement. In addition to greater choice in terms of finding drinking establishments and meeting people, it also affords more anonymity. This may be especially appreciated by women who are seeking transactional sex.

Villagers acknowledged that the heavy drinking is a catalyst for unprotected sex linked to the spread of HIV/AIDS. In the Dzama men's focus group discussion, however, it was hotly debated whether drinkers or non-drinkers had the most active extra-marital sex lives. The drinkers maintained that heavy drinkers of *kachasu* were incapable of very many sexual liaisons because, despite the stimulating effect of alcohol on their sexual libido, the alcohol had a counteracting effect on their sexual performance, causing 'brewer's droop'. They argued that non-drinkers' sexual conquests were superior to theirs.

4. HIV/AIDS Education: Abstract Awareness, Concrete Avoidance

In Vizimba village, the first AIDS cases appeared in about 1990 according to the headman.[22] Incidents of illness and death mounted over the decade. In Dzama, villagers reported currently attending approximately one funeral per week.[23] The local names for AIDS sufferers are proliferating, as explained by focus group discussion participants:

> *Kaponda fodya* or *kalowa fody*a – trampling one's tobacco field which destroys his income is similar to AIDS since one gets infected then it destroys one's life.
> *Adadaya tsitsi* – someone with dyed hair since the colour of the AIDS patient's hair lightens.
> *Asanyamula magalafawo* and *adanyamula makeni* – someone who looks like he is carrying heavy buckets because the shoulders and arms of AIDS sufferers resemble this posture.
> *Adatenga nyakula* – one who is handcuffed from the back given the protrusion of his shoulders and wastage of the upper torso.
> *Adagwa muufa* – someone who fell in the maize flour which is Malawi's staple food that Malawians cannot live without. The same goes for sex. Maize flour consumption and AIDS affliction are basics that no one escapes.
> *Matenda ya boma* – 'disease of the government' because the government has talked incessantly about this disease and has spent a lot of money informing people about it. In addition a lot of people in the government have the disease.
> *Chikondi* – it affects everybody in the home from parents even to the unborn child, the same way with love, which is limitless.

While there is a general awareness of AIDS sufferers in the village and a bombardment of educational information about the disease in schools and on the radio that people have ready access to, there is nonetheless a pervasive view that HIV (as

[22] The Vizimba FGD dated the first case of AIDS in the village to as recently as 1998.
[23] Nonetheless the men in the Vizimba FGD maintained that there were no AIDS sufferers in their village, only in neighbouring villages.

opposed to AIDS) is something they have to live with rather than deal with. Villagers felt that sexual relations had not altered in accordance with publicized measures to prevent the spread of the disease. Village focus group discussions revealed three main tendencies: village extra marital sex, women's increasing transactional sex and men's drinking and womanizing leisure time activities.

Current extra-marital sex within the village was considered to embody both traditional and new aspects.

> Generally people like having extra and pre-marital affairs in the village. It is an old culture that looks normal and other people are used to it. (Vizimba Men's FGD 8/12/03)

> There is a bad system of sleeping with each other's wives in this village. Mostly it is the rich men who do this to poor men's wives because it offers them money. The women don't refuse due to their poverty. This is spreading HIV. (Dzama Men's FGD, 4/12/03)

Women's transactional sex was considered to be an expanding arena of sexual activity that was being increasingly incorporated into *ganyu* contracts. This tendency had escalated during the recent famine in response to deepening household impoverishment. Lacking commodities or services to sell, women resorted to the 'essential exchange' of sex for food. Women were travelling to trading centres, Lilongwe and other nearby places to earn cash or food. En-route or at their destinations they encountered economic propositions that sexually compromised them. For example, in Dzama the village closest to Lilongwe, the women had in desperation been going to the grain mill in Area 25 to collect the maize bran that was left after the milling process. This often involved staying overnight on site to get access to this resource. Men working at the mill took advantage of this and offered them *ganyu* contracts. The Dzama Village Action Committee described the phenomena as follows:

> We think mostly people are getting infected with HIV/AIDS because of poverty. What usually happens at the household level is that the woman is affected seriously because of her deep concern for her children. She starts looking for *ganyu* opportunities that are not easy to find in the village so she goes to Area 25 where there are different types of *ganyu* like cultivating in people's gardens, doing household chores. Some decide just to go to the mill to look for maize bran that they can use for food at home…There they meet men…(Dzama VAC FGD, 4 December, 2003)

Men in the Dzama FGD explained the situation as follows:

> The men offer them the *ganyu* but also entice them to sleep with them. Since the women are bringing food [maize bran], we cannot object [as husbands].

Men, connected with the market activities and drinking habits previously outlined, often went to pubs for drinks and sexual liaisons.

> Men…go to pubs where they sleep with prostitutes who infect them. (Dzama Women's FGD, 4 December, 2003).

> When men sell their tobacco on the auction floors in Lilongwe they sleep around with lots of women due to the money which they have at that time. Some men go to the extent of seeking temporary marriages elsewhere leaving their families for a little while until all their money is finished. (Vizimba Village Headmen interview, 8 December, 2003).

In addition to the general perception of villagers that extra-marital sex is common, there is a widespread view that condoms are rarely used despite their ready and usual free-of-charge availability at health centres and at village kiosks, sold in packets of three for a few kwacha.[24] Condom rejection is rationalized from various angles. First, an overwhelming perception was that condoms rob the user of the enjoyment of natural sex. Both male and female village FGD discussants quipped: 'you don't take a shower with your raincoat on', 'you don't eat wrapped sweets' and 'you don't eat relish without salt' [*ndiwo zopanda mchere sindidya*]. Above all, it is believed that the sexual act must be natural, meaning 'skin-to-skin'.

Second, some men, particularly young men, felt that the government was inflating the HIV/AIDS problem for their own purposes through their media campaign. They argued that government officials were the ones who had suffered from and were spreading AIDS. In this context, their efforts to encourage condom use were seen to be a government conspiracy:

> We don't normally use condoms here because we know condoms are deliberately infected with HIV by the government in order to reduce the size of the population…We have proof that the condoms are infected…If you bury the condom in the sand for five days you eventually get worms inside. If you don't take the precaution of boiling the condom before using it, the worms infect both of you [sex partners]…and the first sign is in the woman who has open bowels. So women are the first to refuse the use of condoms.

Third, there is a belief that condoms promote promiscuity, voiced particularly by older people.

> Most of us just hear of condoms and we have not even seen them. [Only four had ever seen a condom]…Condoms are not found here but at the trading centre where they sell whilst we hear that at hospitals they are free of charge. The problem with condoms are that they are associated with being promiscuous and nobody would want to be labelled promiscuous. (Vizima Men's FGD 8/12/03).

Fourth, there are charges and counter charges across the gender divide that the opposite sex refused to use condoms. Amongst married adults this often takes the form of dismay at the thought that the male or female partner asking to use the condom does not trust the other partner. The youth focus group discussions were mixed sex so girls felt inhibited in expressing their views let alone revealing their condom practices. In one group the boys insisted on speaking for the girls and said that girls refused to use condoms because this would suggest that one or both parties

[24] A few US cents. In Chimponda, discussion in the male focus group discussion revealed that some older men were obtaining free condoms from the health dispensary that they were then using as a currency to pay for *ganyu* labour for younger men and boys. The boys had used the condoms to make footballs. They claimed that putting one condom inside another and inflating it could produce a reasonably functional ball.

could not trust the other. One young man in Dzama village stated he felt it was better to use ARVs than condoms because condoms were immoral. A couple of young men, however, stated that they used condoms and pulled out a condom that they were carrying with them to prove the validity of what they said. The adult women focus group discussants explained that they were willing to use condoms but their men refused and challenged their trustworthiness if they suggested it. The adult men tended to argue similarly but cast themselves as the ones willing to use condoms but who were prevented from doing so by doubting wives.

5. Transactional Sex and the 'Blame Game'

Where did AIDS come from and who spreads it? Although HIV/AIDS probably first entered Malawi across the country's northern border, it is interesting to note that the Central Region has a lower HIV prevalence rate than the Southern Region. This is probably related to the impact of Malawian male labour migration to South Africa. Lwanda (2004) refers to charges that Malawian migrant workers were spreading AIDS in South Africa which were ironic. Contact with South Africa was more than likely an important factor contributing to the concentration of AIDS in the Southern Region, since so many of Malawi's migrants originate from that area.

While the national picture remains highly speculative, it is even more difficult, if not impossible, to reconstruct an accurate picture of AIDS-related morbidity and mortality at village level given the pervasive attitude of denial on the part of the villagers. It would seem that AIDS deaths have been observed in the village for the past 10 years or more. The first AIDS deaths, and indeed deaths until relatively recently, were mainly men. Now, however, published HIV prevalence from ante-natal clinics show that HIV prevalence among women is marginally higher than among of men. Women's deaths are becoming more frequent with a noticeable increase in deaths of children under-5 years of age as well. The latter are generally not recognized by the villagers as AIDS deaths (Interview with Kasiya Medical Assistant, 8 December 2003).[25]

The AIDS deaths have increased and villagers have taken cognizance of the escalating problem. Not surprisingly when discussing causality villagers tend to point fingers at particular social categories who they believe are spreading AIDS. Women blame men's drinking habits and their enjoyment of sexual liaisons in association with heavy drinking. Men, on the other hand, are increasingly vociferous about women bringing AIDS to the community through their *ganyu*-earning activities. Both men and women charge that the youth are especially loose these days with their involvement in drinking and casual sex. Youth, while admitting that they are engaged in drinking and sex, blame adults for not setting a good example. The blame game is currently quite good natured, but it is increasingly misogynist in content on the part of frustrated men who have experienced the injury of lost income-earning opportunities over the last couple decades and now the insult of their wives' sexual activities for basic needs provisioning. Historically, men earned the household income and women

[25] Statistics on HIV/AIDS prevalence and AIDS mortality rates are extremely problematic. With reference to the former, women's antenatal clinic statistics provide a longer and more reliable record than any data source for male prevalence. In a country where medical facilities are so grossly inadequate such that most people die at home and there is a huge stigma about AIDS, AIDS deaths are seriously under-reported. Estimates are bound to be rough guesses.

engaged in subsistence farming. It would be hard for men not to feel a sense of failure and resentment towards their wives' livelihood activities.

The Village AIDS Committee members in Dzama reported that they staged community meetings in which men and women discussed the causes of AIDS.

> Men start the discussion by asking women what they did on their travels to look for *ganyu* in Area 25 and in so doing start advising their wives to be careful whilst women start the discussion asking their men why they are coming home late. (Dzama, VAC FGD, 4 December, 2003)

Villagers, both men and women, are increasingly concerned about *kusokola*, (looking for food), a coping mechanism arising from the famine context that leads women into sexual compromise. The Dzama Village AIDS Committee had been researching the nature and extent of *kusokola*:

> We think that 75 per cent of the households in this village are fond of this habit of going to Area 25 whilst only 25 per cent may be food secure or they just do not want to be involved with doing *ganyu* in town…When our women go to Area 25 they meet men who are ready to release quick money if they sleep with our women which in most cases they do comply because of the magnitude of their food supply problems and its impact on their families and the suffering of the children. This situation is rampant in months like January when the hunger is at its peak. (Dzama VAC FGD, 4 December, 2003)

It remains to distinguish the 'transactional sex' prevalent currently from 'prostitution'. Prostitution refers to men or women who are occupationally earning their livelihood through the solicitation of sex. They participate in a service market and over time become well-seasoned in the dos and don'ts of economic and physical survival in their occupation. As argued by Campbell (2003) for South Africa and by others for Thailand, introducing methods of safer sex to female prostitutes can be relatively straightforward. They have a vested professional interest in adopting safe sex practices and usually are in a position to impose them as a contractual condition of their service to their clients. It would be a gross mistake to conflate prostitutes with women practicing transactional sex of an occasional nature. The latter are not professionals earning their livelihood from the sale of sex. Generally they have accidentally happened into sexual encounters and are ill-prepared to bargain the terms of the sexual liaison proposed to them because of the happenchance of the occasion and more fundamentally the compromises they are compelled to make due to their impoverished circumstances. This, together with the diffuse nature of transactional sex, which may happen anywhere and anytime, makes safe sex practices very difficult to address.

VII. Human Agency in Disease Debility and Death in Rural Malawi

Approximately three months after initial HIV infection, anti-bodies can be detected in the blood (Malawi, NAC 2003, 29), but the period of time that elapses between HIV infection and the onset of full-blown AIDS is very variable and can be as long as fifteen to twenty years. However, in Sub-Saharan Africa it is usually considered to be between seven and ten years. Once AIDS sets in the duration of the disease depends very much on the nutritional status of the patient but the average is about one year (Barnet and Whiteside 2002:168). In Malawi, the recent famine probably hastened the

death of many people. Comments in the village like 'AIDS sufferers die fast these days' were commonly heard. Under these circumstances, AIDS patients may only be able to live one to two years before succumbing to the disease. During that period they and their families experience fundamental changes in their social and economic life.

1. The 'Shame Game': Stigma and the Conspiracy of Silence

AIDS is seen but not heard in the villages we studied. People do not like talking about it, particularly in concrete terms. Households with AIDS sufferers try to cope with the situation as best they can, quietly and on their own. The illness of their loved one is presented as malaria, TB or some other chronic ailment. They dare not publicize that it is AIDS because they fear shame and ostracization. Villagers do not question these alibis. Everyone is aware of the classic symptoms of AIDS: shingles, diarrhoea, loss of weight, pale hair colour and general weakness. They do not wish to embarrass the family.

Part of the affected family's concern with projecting a brave face is that they do not know who else may be infected in the family. Will the surviving spouse be HIV positive? His or her future marriage prospects and long-term economic survival would be dashed if it was rumoured that s/he was also fatally ill. Women as widows are especially vulnerable as revealed by what one 40-year-old widow confided during one of the bereavement interviews:

> Some people said that my husband died of HIV/AIDS. But after one year since his demise, some men have started approaching me for marriage after seeing that I am looking OK. I haven't been ill since then, only the skin lesions that I am having now as you can see, which some people are mocking me saying that they are the early signs of AIDS. But if I want to marry I will get the man to HIV testing. I have my sister – the one who came to greet you [very thin, weak-looking woman with pale hair] – whose husband really died of AIDS. And you can see the way she looks – is that not AIDS? That is why people refer to our family as AIDS-infected. (Interview with Duncan Kochelani, 4/12/03)

2. Doctors' Diagnostic Dilemmas and Affected Households' Depleting Assets

Medical treatment for AIDS patients is dilemmic. Distances to dispensaries and hospitals tend to be very long. With few bus services, or inability to pay bus fares, people walk or at best go by bicycle. Upon arrival, they find the medical centres are poorly stocked with medicines. Traditional healers are usually more readily at hand, but they also cost money. People are frustrated in their search for medical attention. Even in Dzama, which is reasonably proximate to Lilongwe city, health care is a problem.

> Most people in this village go to Area 25 [suburb on the outskirts of Lilongwe] health centre for medication....The health centre is really very far. Actually this year we have had seven incidences of people dying on their way to the clinic. Unfortunately, though we go to the clinic the only medicine being provided is aspirin no matter what disease you are suffering from so that makes people just stay at home with their sickness. Sometimes we just go to the store to buy the medicine whilst others go to the traditional doctors. The unavailability of drugs [at government health facilities] is because we feel that the staff is selling medicine or using them in their own [private] clinics though we do not have proof. Then again, due to over-population, drugs do not

> last long at the health centre. Sometimes the staff at the clinic advises us to go to the traditional doctors if the illness is serious but when we go there nothing really improves because most of these traditional doctors are after money. (Dzama VAC FGD, 4 December, 2003)

In the frustrating and costly search for medical help, most AIDS sufferers die without being given a clear diagnosis that they have AIDS. As in some neighbouring countries,[26] medical practitioners, for the most part, appear to refrain from telling patients that they have AIDS based on the obvious clinical symptoms that they present. Many AIDS symptoms are similar to other diseases like malaria. The very nature of AIDS as an immune deficiency syndrome means that the patient is likely to be suffering from other diseases as well, especially tuberculosis. The incontrovertible proof that someone has AIDS comes from an HIV blood test.

Most Malawian medical facilities do not have the lab equipment and clinical staff to offer this test. At the time of the study 70 medical facilities provided voluntary counselling and testing services (VCT) and 118 provided HIV testing throughout the country (Malawi, MOH and NAD 2003b). Compared with many other districts, Lilongwe rural district is well-endowed with 11 sites offering HIV testing. Thus, a doctor or other medical personnel treating a suspected AIDS patient tends to suggest that the patient visit one of these establishments for testing. Nonetheless, according to our interview data, patients are loath to go because it is usually very distant from their home villages and they are fearful of knowing the outcome (Coombes 2001) (see Table 4 for the total numbers getting tested in Lilongwe city and district).[27]

In Dzama, the widow of one of the bereaved households interviewed showed us a document from the Central hospital saying that her 59-year-old husband was HIV positive, noting AIDS as the cause of death. She was a woman of approximately 50 years who could not read and had not had the document explained to her and therefore seemed unaware of the AIDS diagnosis. She told us later that she was experiencing the same symptoms as her husband and thought she was going to die, but she never mentioned AIDS as a possible cause.

At the time of the study, the government was sending out media messages to encourage people to attend AIDS voluntary counselling and testing (VCT) at the medical hospital. In one of our study villages a small group of young men had collectively decided to go to Lilongwe for testing after hearing a radio advertisement. They saw it as an adventurous thing to do. But they were in an extremely small minority. According to the medical practitioner we interviewed at Kayasi dispensary, very few people go for testing even if they are specifically advised to do so by medical personnel. The physical effort as well as the desire to avoid knowing the worst kept them from doing so.

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[26] Personal communication, Dr. T.N. Maletnlema, Childgrow, Dar es Salaam, Tanzania, November 2003.

[27] Even with the substantial increase in voluntary HIV testing during 2003, only 149,540 people were tested, about 1 per cent of the total population. At the MACRO testing sites, those volunteering are mostly men (71 per cent of the total). It is not known with certainty why this is the case (Malawi, NAC 2004: 6). It is also highly likely that the testing is heavily biased to urban as opposed to rural dwellers. Differentiation in levels of education, accessibility to the centres and transport access are undoubtedly important factors influencing attendance.

Our interview with a medical practitioner at a local health dispensary indicated just how sensitive giving an AIDS diagnosis could be. There were a number of problems that could occur in the aftermath of the patient receiving such a diagnosis. First, the patient may get very upset and even threatening with the medical personnel giving him/her the diagnosis. Second, the patient tends not to want the medical diagnosis to be conveyed to his spouse or other family member. On a few occasions when the medical practitioner witnessed the spouse (all wives) being told the diagnosis by their husbands, some of the wives were irate and started condemning the man and his past behaviour with 'I told you so'. Having witnessed such scenes, the medical assistant had decided always to be exceptionally discrete, not revealing diagnosis to family members of the patient for fear of causing marital instability. He worried that telling the spouse may also jeopardize his/her willingness to further care for the patient at home.

While there are obviously a large number of ethical and practical reasons for extreme discretion in providing AIDS diagnosis to patients or their families, there is nonetheless a problem that such extreme reticence will contribute to household impoverishment as patients continually seek a medical cure for an ultimately fatal disease, incurring medical and transport expenses. Many of the women in the focus group discussions expressed the view that these were largely futile expenses that weighed heavily on rural households' already precarious financial and economic resources. Pinder (2004) documented this problem and our interviews with bereaved households confirmed its extent. The sale of household assets like radios, furniture, and livestock to pay for medical expenses was common (Table 5).

Table 5: Medical Expenses

Ill Person	Caretaker	Medical Expense	Cost	How financed
Man, 59 farmer	Wife, 50 farmer	Mtengo private hospital, Dzomba	K2,000[28] K4,000	Sold goat Loan
Man, 54	Wife, 40	Dzenza private hospital	K3,100	Sold radio & chairs

Most people, in their quest to find a cure, sought both western and traditional medical sources. Evidence suggests that cross-referral is common between the two systems. Often, the 'serious cases', which meant terminal cases, were being referred to traditional doctors. Fundamental religious and spiritual beliefs, which have been a part of one's upbringing, tend to come to the fore when people face death. Four out of the seven bereaved households interviewed cited bewitchment as the cause of their deceased loved one's illness.

Traditional medicine is a deep-rooted element of AIDS patient care in rural Malawi, not just because the disease is terminal. As one headman metaphorically and pragmatically explained:

> The traditional healers have their own x-ray machines and 'illness detecting processes' with which they are able to detect the cause of the illness including witchcraft…most people in this area believe in them because they offer the cheapest alternative in the absence of proper treatment in government health facilities. (Dzama Village Headman interview, 4 December, 2003).

[28] For current values in US dollars as of the writing of this report, divide by 109.

Lwanda (2002) argues that sexually transmitted disease care from traditional practitioners is the norm given the shortage of western medically trained personnel.[29] As evidence of the pervasive role of traditional medicine in rural health care, he cites the *mchape* witch-cleansing instigated by an elderly rural man, Goodson Chisupe, as recently as 1994, representing a longstanding tradition of witch-cleansing. There is a medical duality even amongst educated Malawians that is not comfortably accommodated in national policies at present. National health policies are directed at 'regulating' and 'professionalizing' traditional health practitioners with efforts to enforce precautions to prevent the further spread AIDS. There is less attention and appreciation of their role in the care of AIDS patients both psychologically and spiritually. In AIDS health care in particular, emphasis is placed on curbing traditional medical practitioners' claims for cures to AIDS and potentially risky AIDS-spreading practices like using dirty razor blades.

Van Dijk (1992) elaborates that in fact the range of choice in medical treatment goes beyond a duality between western[30] and traditional medicine. He identifies two types of religious-based prayer healing (*malilime*) as an intermediary between the two. The first is the prophetic spirit healing under the auspices of the Zionist and Apostolic churches which dates back to the early 20th century. They specialize in cleansing, sometimes of an entire community, as a way of addressing misfortune and affliction. On the other hand, Born-again healers, who are a product of what has been primarily a youth movement beginning in the 1970s, take a more individualist approach. They are antagonistic to traditional influences and the ancestors. Healing is part of recruitment into the Born-again way of life in which they must renounce their belief in the traditional medical system. Both of these forms of spirit healing are contemptuous of western medicine. As van Dijk (1992:113) explains, these perspectives may act on AIDS patients' medical-seeking behaviour:

> '[D]ue to its lack of charismatic inspiration, it is believed, Western medicine is not able to penetrate to the heart of the matter, namely, the battle against the Devil and his accomplices, the evil spirits…Even AIDS (*Edzi* in local parlance) is thought to be caused by evil spirits and therefore incurable by Western 'injections', but nevertheless overpowerful by the Holy Spirit.'

Traditional healers can also be split into more than one type. The *mganga* or *sing'anga* herbalists are the more acceptable face of traditional medicine to westerners. The *nchimi* are considered more powerful, demonstrated by their ability to undo afflictions caused by stranger spirits, *vimbuza*, through cleansing. The *seketera*, on the other hand, take a more offensive approach and engage in vengeful witchcraft at the request of their clients (van Dijk 1992: 111-12).

Despite the fact that so many people consult spirit or traditional healers, often starting and ending their medical search in disease treatment with them, it was not easy to find such practitioners in the villages we studied, possibly because this is not the face of

[29] In the1980s Malawi had approximately 50,000 registered traditional practitioners compared with 500 medical doctors (Lwanda 2002).

[30] The health sector focussed on western medicine in Malawi is tripartite in nature. The Ministry of Health and Population (MOHP) is the largest health service provider. The Christian Health Association of Malawi (CHAM) is second largest, and finally there is a small private sector growing in importance in the cities that operates for profit.

the village that the village headmen and villagers want to present to outside development agencies and due to defensiveness on the part of the practitioners. However, one woman who dealt with spirit mediums was identified and agreed to be interviewed. She was 46 years of age and had started working as a healer five years ago when she first heard voices in her dreams. She gained a reputation amongst the villagers of being possessed with spirits (*mizimu*) that enabled her to heal people. Her work involves diagnosing diseases and removing all the magic (*vipasi*) and bad omens to cure patients. She claims to see roughly 1,000 clients every month, male and female, old and young. Many of her patients have sought treatment elsewhere in medical hospitals and dispensaries before coming to her. Her fame has, according to her, led some medical personnel from the local rural hospital to send her their patients. In turn she says that she refers some of her clients to conventional health facilities if they are complicated cases like anaemia or dehydration.

Her medical diagnosis and treatment relies on spirit possession especially with one spirit called *Yohane* who speaks to her in a language no one else can understand (*muchigiriki*). She stated that most of her clients have given up on health facilities because they are so often without drugs.[31] She considers her healing methods preferable because they rely on spirits that are natural forces unlike using medical equipment which is subject to human error. She has received training both as a traditional birth attendant and healer. She has treated ten AIDS patients, nine of whom were women who are still alive, and one man who has died whom she described as follows:

> After becoming aware of the HIV status of a patient, I give the client the right herbs which do not kill the virus but suppress its further multiplication and reduce diarrhoea and breathing difficulties and deal with most of the opportunistic infections. The herbs generally are active for 9-12 months and then become powerless. The patient then dies regardless of whether s/he comes back for further treatment. The herbs cheat the virus but after their effect wears off, the virus becomes super-active so that the person dies shortly thereafter. (Interview with Rex Chapota, 8 December, 2003)

One of her main problems is that many of her patients come to her without any family to look after them and without money. She normally charges a base fee of 20 kwacha for diagnosis and treatments usually range from 250 to 500 kwacha. When 'hospital' admission is required patients must pay 350 kwacha on discharge. However, during the famine, she had patients who could not pay and had to eat. She had to try to feed them as best she could, even though the chief refused to avail her food during the free distribution of famine relief food. This suggested a dedication to her patients' well-being well beyond remuneration and professional considerations.

Food requirements of AIDS patients translates into a financial worry for those with families as well. There is a general appreciation that the duration of time AIDS sufferers manage to stay alive depends on both the quantity and quality of their food intake. It is widely believed that AIDS patients required special foods, notably expensive meat and lots of soup to soothe their illness. Other foods like rice cooked with oil are to be avoided because the patient will vomit or suffer acute diarrhoea.

[31] Malawians generally expect to receive some medication or injections and tend to feel they are being inadequately treated otherwise.

One woman related how her household finances were severely taxed by her husband's need for good food.

> I also sold our radio and clothes to pay for my husband's medical bills and his necessities. He loved meat so much. (G, bereaved widow 50)

In the Vizimba women's focus group discussion it was admitted that the recent famine had severely strained women's ability to care properly for AIDS patients within their households:

> If there is someone in your household who is chronically ill, it is difficult to offer proper care because everyone in the household is busy looking for food. In such cases even relatives do not offer a helping hand because they also do not have food. (Vizimba Women's FGD, 10 March, 2004)

In concluding this section, the evidence we gathered from various sources suggests that AIDS patient care is characterized by different stages of household social care and economic investment. During the early stages, medical attention from various quarters is sought. A great deal of time, effort and cost is invested in this on the part of family members, with usually debilitating long-term economic consequences for household welfare. As the disease becomes more acute, the search for a cure is replaced by efforts to simply comfort the patient, be it through spiritual rituals or material treats liked cooked meat. This stage is usually less financially draining for the family as observed by one village headman:

> Yes people eventually do resign themselves to their fate…Even the sick person may sometimes tell his/her family that 'I am dying whatever the case and you do not need to spend more pennies on me otherwise it will just be wasteful'. This normally happens after efforts to get treatment from the formal and informal health facilities have proved futile and the traditional healer has been consulted but instead of the illness subsiding it intensifies. (Dzama Village Headman, 4 December, 2004).

This final stage is emotionally very taxing, made more difficult by the deep stigma associated with the disease such that the ill person does not want to admit the cause of his or her suffering.

> Relatives of the sick person are able to discuss and agree that their relative has HIV/AIDS but they cannot say so in his/her presence. Thus the relatives just offer words of encouragement and continue to care for him or her. (Dzama, Village Headman interview, 4 December, 2004)

3. Cultural Parameters of Community Altruist Care and Concern

Time and again it was readily apparent that the brunt of care for AIDS sufferers fell on the immediate family. Our focus group discussions suggested that AIDS-afflicted households rarely received help from other households. Some of the observations were as follows:

> Most people are very poor and struggle to feed themselves. They can't therefore support others. (Interview with religious leader, Vizimba, 8 December, 2003)

> The community was not helpful during my husband's illness. It is not common to assist someone when he is ill. Assistance comes during the funeral. (50-year-old woman)

> The community did not help while my husband was sick, but they did assist during the funeral. This is due to lack of love. He was considered a well-to-do person so people thought the he had a lot of resources to see him through his illness. (40-year-old woman)
>
> The community was not helpful during my husband's illness maybe because we are new in this village. (60+ year-old woman)
>
> My late husband was sick for almost two years…It was indeed a terrible time and nobody bothered to assist my family and we were living just to see what tomorrow holds. We actually lost hope because we saw that he was not getting healed after being sick for two years…Nobody assisted me during the illness apart from my eldest son. I am not sure what people were thinking. We were living in my husband's village but really nobody bothered…I am not sure why his relatives did not like him. (65-year-old woman)

There is a great uneasiness about AIDS patients. People identify with them but feel fear:

> Seeing somebody that is HIV-infected makes us afraid since we know that it will be us one of these days passing through the same situation because we are also sexually active. Sometimes we just feel sorry for them because they really look so sick and we just look at them as people who really need support from their relatives. (Dzama, VAC FGD, 4 December 2003).

The assistance that AIDS-affected families arose mostly from close relations, usually brothers, who, given the lineage structure and inheritance patterns, had 'interests' in the unfolding situation. Why are communities not forming mutual support networks in the face of this welfare crisis?

Englund (1996:7) observed that amongst Chewa rural villagers in Dedza District 'altruism is…a very rare sentiment…Moral persons are *interested*, the legitimacy of their interests being judged from the extent to which they are able to manifest their constitutive relationships in their performance.'[32] In other words, doing something for others incurs the need for reciprocation. Providing unsolicited help to someone may be an unwanted imposition because it obliges that person to return the help in the future.

On another but related issue of inter-household relations, Vaughan (1983) writes about the ideal of household self-sufficiency in rural Malawi illustrated by women's individual ownership of granaries that are seen as a guarantor of self-sufficiency. Yet, within compounds, relatives from different households ate together and shared food. This communal consumption activity was not considered to be transgressing the household self-sufficiency ideal since it did not register in people's minds that they were sharing. This hospitable 'unconscious co-operation' was simply subsumed into the act of eating.

[32] Englund's (1996: 9-10) post-modernist perspective pivots on the 'analytic notion of the composite self' in which persons appear as the outcomes of others' contributions and are, in turn, morally obliged to act in view of these relationships. Interests are embodied in a multitude of acts and contingencies, none of which are reducible to any one actor.'

Englund (1996) criticizes Vaughan's view of household self-sufficiency, exclusive possession and economic independence, arguing that these notions of 'particularism', rather than separating households, gives rise to social relatedness, empowering some to give and some to receive. In passing, Englund notes that the human agency involved in this economic reciprocation is neither calculating nor controlling.

> …a lack of control characterises the moral economic process; a lack of control over the meaning of particular acts, and over the interests that emerge as these acts unfold.' (Englund 1996:10)

Vaughan (1983) documents the *chinjira* relationship that constitutes a mutual support relationship between two women formed independently of kinship ties that can be called upon in instances of illness. The relationship she describes had evolved in the specific context of a plantation/village border zone in which women (often Mozambican immigrants whose husbands worked on the plantation) formed relationships of economic complementarity with local women living in villages. They exchanged gifts from time to time. The local women invariably gave the immigrants local agricultural produce or allowed them the space to brew beer which they were otherwise prohibited from doing living on the plantation. The immigrants in turn gave purchased items that they could more easily access through the plantations' distribution system. These gift exchanges stopped far short of economic inter-dependency. The gifts were primarily symbols of bonding signifying that the two women could call on each other for support and care in times of illness. During an illness, be it that of one of the women or their family members, her *anjira* could run errands and provide food if hospitalization had taken the affected woman away from her hearth. It is unclear if this form of community mutual health support was or is found elsewhere in Malawi. It is noteworthy that it always took place between non-kin and adhered to principles of balanced reciprocation.

This digression into rural social cohesion in the face of inequality may help to shed light on the social dynamics of everyday village life as well as household coping strategies in times of crisis. Daily economic and social exchange is very fluid in the Malawi rural village context, propelled largely by necessity in the here and now rather than according to any pre-ordained divisions of labour and property defined socially by class or juridically by labour and property laws. This has contradictory implications. On one hand, Malawian rural dwellers' agency is left extremely open-ended. Individual actions are not bound by overly elaborate codes of conduct and delimited spheres of activity. People act without fear of judgement or moral censure by the wider community. On the other hand, they are deeply constrained by the intuitive reckoning of balanced reciprocity of individuals within households, within lineages and within village communities. Actions causing an imbalance in reciprocal exchange can be expected to engender dire consequences. These tend to come in the form of witchcraft with its oblique finger of blame and inevitable misfortune.

Thus, Malawian rural agency directed at social assistance or economic gain has to be embarked upon with caution. Moral reckonings are finely tuned such that people dare not take a step in the wrong direction. Households consciously keep to themselves to avoid adverse consequences but often unconsciously help each other by virtue of their pursuit of an interactive social life in spheres of consumption and recreation.

4. Role of Village AIDS Committees

In our sample of three villages, one had a Village AIDS Committee (VAC) that had been initiated in 2002 by the village headman who had attended a meeting and learnt about VACs operating in other villages. The VAC that was formed consisted of both genders and ages up to 50 but there was a prevalence of women, perhaps in keeping with women's traditional role as household carers in the event of illness. The committee's chairman was a young man of 26 years. Members had received training from Canadian Physicians for Aid and Relief (CPAR) about basic HIV/AIDS education and care for the sick within the home. CPAR also provided them with gloves to use when bathing AIDS patients.

The committee sought to provide HIV/AIDS education, home-based care for AIDS victims, and to extend help to orphans, widows and old people following AIDS deaths. Their health education role involved engaging villagers in discussions about the behavioural causes of HIV/AIDS and talking to AIDS-affected families about patient care, as well as giving out family planning information. In HIV prevention they sometimes distributed condoms when they were supplied by CPAR. They have been given a parcel of land by the Village Headman where they grow beans, maize and vegetables which are used in kind and in cash sale proceeds for AIDS sufferers, widows and orphans.

Their main effort was directed at offering supportive care for the chronically ill. Having divided the village into zones they were alert to the presence of the sick in their zone:

> We do not visit everybody but only those that we know are seriously ill and really need support. We take them some flour since we have our own garden and sometimes we sell the maize and buy clothes for the elderly people in the village. If we know somebody is suspected of being infected we do counsel them and try to give them hope. (Dzama VAC FGD, 4 December 2003)

The VAC is a very positive development in Dzama. Villagers seemed to appreciate its work, which addressed both the denial and stigma associated with AIDS. They were providing forums for discussing behavioural causes of AIDS as well as compensating for the reluctance of households to help one another during illness. The members of the committee are volunteers committed to being of assistance to families under duress who are their neighbours and with whom they identify.

> The work we are doing is voluntary because we are concerned with the HIV/AIDS situation. Just by estimating we think 12 out of the 38 households in this part of the village have a seriously ill patient or have lost one of their members to a chronic sickness. Our work is being made simpler because out committee is recognised by the chief but most of the time villagers just watch us do the work since they think we are doing it on their behalf so they do not do anything. It is very unusual to see somebody who is not a close relative visit the chronically sick people. We feel it is not good that that is what happens. (Dzama VAC FGD interview, 4 December, 2003).

VIII. Human Agency in the Aftermath of Death and Renewal of the Disease Cycle

As earlier mentioned, statistics on mortality due to AIDS are very difficult to obtain given the stigma attached to the disease. What is evident is that funerals are now extremely common events within the villages. We were told that there was usually one funeral per week in the small village of Dzama.

1. Funerals as a Community Event

While villagers are reluctant to offer help to AIDS-affected households, their whole-hearted presence and assistance at funerals is an unwavering, well-established tradition. Everyone feels obliged to attend the funeral because it is an affirmation of community solidarity and support for the bereaved. Also many explained that if they did not attend, it would surely be noted and attendance at their own funerals could likewise be poor. In effect, funeral attendance is proof of membership in the community. To stay away is to disassociate oneself from the community – something that very few would ever want to do.

The bereaved households are given material support in the week after the death. People may bring foodstuffs to them and express their condolences. However, at the funeral it is the bereaved family that is expected to extend hospitality generously to the villagers. Many bereaved households borrow heavily to fund the event and may fall seriously into debt as a consequence (Table 6).

Table 6: Examples of Village Funeral Costs

Deceased	Spouse	Type of funeral	Duration of funeral	Attendance	Items	Costs	Finance of costs
Male farmer, 59	Female farmer, 50	Church	2 hours	n.a.	Goat Cloth Coffin	K800 K400	Loan
Male traditional doctor, 54	Female ganyu labourer	Non-church	2 hours	500 people	Maize Goat Cloth Coffin	K1,350 K700 K1,800 K1,500	Relatives paid
Male farmer, 45	Female farmer, 45	Church	4 hours	n.a.	Maize Groundnuts Cloth Coffin		Uncle
Area 25 Male trader, 60	Female trader	Pente-costal church	2 days	n.a.	Goat Maize Coffin		Wife & husband's relatives paid

Loans are taken out to finance the funeral costs. One widow was facing a court case because she had failed to make her regular monthly payments on the goat that she had purchased to feed the guests attending her husband's funeral. Dzama's village headman had recognized the inordinate economic strain that funerals were imposing on households.

> Nowadays the road to the graveyards is always clear of grass unlike in the 1970s and 1980s…I now advise my villagers to reduce their mourning period to two or three days unlike in the past when people mourned for a week or more depending on the status of the deceased. I have asked the gravediggers to reduce their demands for money and huge amounts of meat because families are in problems with frequent deaths. (Dzama, Village Headman, 4 December, 2003)

Funeral committees are very active in the villages. In Vizimba, all households are required to pay 100 kwacha. In they do not pay this amount, they are not helped with their family's funerals. Headmen are trying to mitigate funeral costs by initiating communal maize farms where villagers are obliged to produce for consumption at funerals. In one of the study villages, this initiative had been abandoned. The villagers were not happy with the headman's accountability regarding the agricultural output. Another trend is for headmen to start funeral clubs on the basis of *ganyu* earnings.

Bereaved families are also attempting to scale down. Rather than buy ready-made coffins, they are buying the timber (400-500 kwacha for an adult) and the coffin makers often made the coffin for free. The erection of a tombstone (*chizangana*) traditionally some weeks or months following the funeral is being rationalized. The ceremony is now usually delayed for a year or more after the funeral and fewer people are invited with more restricted distribution of beer and food. Sometimes economizing has extended to grouping a number of individuals' tombstone ceremonies into one celebration on a clan basis.

2. Lineage versus Conjugal Family Welfare: Pride, Prejudice and Property

Kadzandira (2001) documents what is expected to happen in patrilineal/patrilocal and matrilineal/uxorilocal communities in the aftermath of divorce or death. The general principle is that the spouse who marries into the village as a 'stranger' is obliged to return to his/her birthplace. There s/he expects her lineage kin to 'make room' in terms of gaining access to land and help with productive resources in order to earn a livelihood. The children are obliged to fall in line with lineage norms. Children in patrilineal systems should stay with the father in the case of divorce or father's brothers in the case of death and in matrilineal systems they go to the mother or the brothers of the mother. The one proviso is that when children are very young, they are be expected to stay with their mothers.

In circumstances of occasional divorce or death within communities and reasonable agrarian resource availability, unilineal systems are unambiguous and able to guarantee the welfare of the spouses and children involved. However, in circumstances when mortality rates become exceptionally high, lineage systems are prone to welfare crises. Vaughan (1987) documents that the 1949 famine engendered a serious problem in matrilineal communities of the Southern region. Husbands who migrated in search of food sometimes abandoned their wives and children to matrikin, fending for themselves and their home community.

In the current AIDS crisis, the sheer number of deaths has caused a crisis of conjugal household welfare and local identity. The villages we studied were a mixture of patrilineal and matrilineal practices. Since most of the deaths so far appeared to be of men rather than women, the issue of what happens if a wife dies seemed

unproblematic. The children were likely to stay with their father and he would generally try to remarry as soon as possible. If the father also dies, the children would stay with their fathers' or mothers' brothers depending on patrilineal or matrilineal practices. There was, however, an issue of what happened to women following patrilineal customs when their husbands died. Many observers, including headmen and teachers, stated that inheritance practices were changing to allow for the welfare of widows and children of the deceased rather than his brother.

Certainly when we started looking for bereaved households to interview this observation was confirmed. We were directed mostly to women who were matrilineal, or if patrilineal, they had been allowed to stay on in their deceased husband's village. However, other wives of deceased men had left the village following patrilineal customs. They were frequently mentioned as a problem and it was not certain if there was sufficient land and resources back in their natal villages for them to access. We did however manage to interview a woman who had been widowed and had returned to Dzama, her birthplace. She is facing a rather lonely and insecure old age:

> *M, 65 year-old woman married 40 years to deceased husband, who moved back to her natal village Dzama after her husband's death*
> My husband died in 1999 and we were not living here at that time. We were living in his home village. My husband left no will but after his burial, his relatives allowed me to continue to stay and cultivate the 2-acre land that my husband and I used to own and I did so for two seasons, but thereafter his relatives grabbed the land. The one who was in the forefront of grabbing the land was my brother-in-law. That is basically why I am here. I decided to move to my home village. I moved here two years ago to be close to my relatives though some of my older sons are still in their father's home village with their families. I could not have continued to stay in my late husband's village because I needed support that I could only find in my home village…My brother assisted me with an acre where I am cultivating now. I live on my own here though at times my neighbours [sister around 60 years of age, brother who is also in his 60s and her last born daughter of 22 years] assist me with food. This is so because I am old and I cannot take care of myself at all times with household chores and even farming. All my neighbours have their own families to look after and their own problems to overcome so basically I live on my own. Sometimes when they have cooked, they invite me to eat with them. My daughter is married and has one child. (Interviewed by Rex Chapota, 4/12/03)

Of the women who managed stayed on in the village after their husbands' death, usually their household labour patterns, agricultural usage and income were markedly altered due to the change in the family labour supply. Cropping patterns changed. For example, if the dead person was a man, he may have grown crops like tobacco which the family did not have the skill or wherewithal to grow in his absence. Most widowed women spoke of a struggle for assets as indicated by the following experiences of bereaved widows:

> *G, 50-year-old widow in Dzama with children from another marriage (aged 6, 16, 28 and 32 years) whose husband's AIDS illness lasted 3 years*
> My husband did not make any arrangements about property or land in the event of his death. My husband's relatives struggled to get a lot of property since they said that I did not have any children with him. But I strongly objected and they only got away with clothes. They took away the land since it did not belong to us so I am not able to farm and hence we have little food. My children are complaining of the changed living status of our household. Food and other necessities are no longer abundant, but none of

my children have moved away. One dropped out of school due to lack of financial support…I see my future as short. I seem to also suffer from my husband's disease. I cough, get ill often and I think that I will never recover. I am seeing the same symptoms of my late husband which means I have the same disease of my husband [She never mentioned AIDS]. (Interviewed by Duncan Kochelani, 5/12/03)

D, 40-year-old widow in Dzama with two children (12 and 14 years old) whose husband died of suspected AIDS
My deceased husband arranged for me to get goats from the village for the children. But my husband's relatives grabbed all eight goats. The deceased's wish was not followed. (Interviewed by Duncan Kochelani, 4/12/03)

N, 55 year old widow in Dzama with 3 children (13, 16, 20 years old) whose husband died 6 years ago but she remained in his village:
My father-in-law played a big role as regards property sharing. The major property under discussion was the blue gum tree plantation that we agreed that it could be used to support my children but what is happening now is contrary to what we agreed. Every time my children go to him to get some money from the tree sales they are never assisted. So far one of my children has dropped out of school in Form 3. I am not very surprised because my husband used to tell me that his relatives are troublesome. I am not happy about it but there is nothing I can do since the plantation is situated at my husband's place…I feel my husband's relatives have penalized me because I refused to be inherited (*chokolo*). They say that "you refused us so how can we assist you". (Interviewed by Rex Chapota, 4/12/03)

There was an entirely different pattern revealed by a widow who had been engaged in trading enterprises with her older husband. The couple had constituted a trading partnership that sometimes took them to the Zambian and Tanzanian borders as well as involved them in joint investments in farming. Unusually this woman continued to live in her natal village, Dzama, during her marriage such that the death of her husband was not such an economic disruption for her. So too, her husband's relatives had so far been supportive to her.

E, widow of 41 living and farming in natal village Dzama during marriage to older urban-based trader from Area 26
My husband used to do various businesses like selling second-hand clothes, salt and also buying maize using *zitenje* cloths and reselling maize during the lean months. He could make more than 10,000 Malawi kwacha every year and he had a plot in Area 25. He was looking after 7 orphans from his relatives who were staying at the Area 25 plot. When we harvested we could produce 11 oxcarts whereas now I just produce 1 oxcart. But all these enterprises were lost with his death…As regards property, his cousins played a major role in making sure that everything was left in my hands, but the plot in Area 25 was released to be used by the 7 orphans since they had nobody to help them. Currently none of his relatives visit me and I am afraid of what will happen during his tombstone construction because it is when things will be discussed in full to the extent that they may decide to take away some of the property. But I am not worried because this is my home village and I am settled and know that one day I will start doing the business if capital will be found. (Interviewed by Rex Chapota, 4/12/03)

Amongst patrilineal Chewa, the norm is for household assets to be distributed by the relatives of the husband. Normally the woman takes household utensils and all the big assets remain with the children. Parents of the husband usually are given some small things. When children decide to follow their mother, they are forced to leave most of the assets. Disputes over property are referred to the chief. During property

redistribution the chief is the only witness together with the original marriage negotiators (*ankhoswe*) from both sides. Any appeals over the redistribution are referred to the Village Headman who may refer it to the Group Village Head and then to the TA for assistance. Individual wills, written or otherwise, are very rare, though in some cases a father while still alive may give away wealth to his offspring at the time of the offspring's marriage.

3. Orphans' Plight

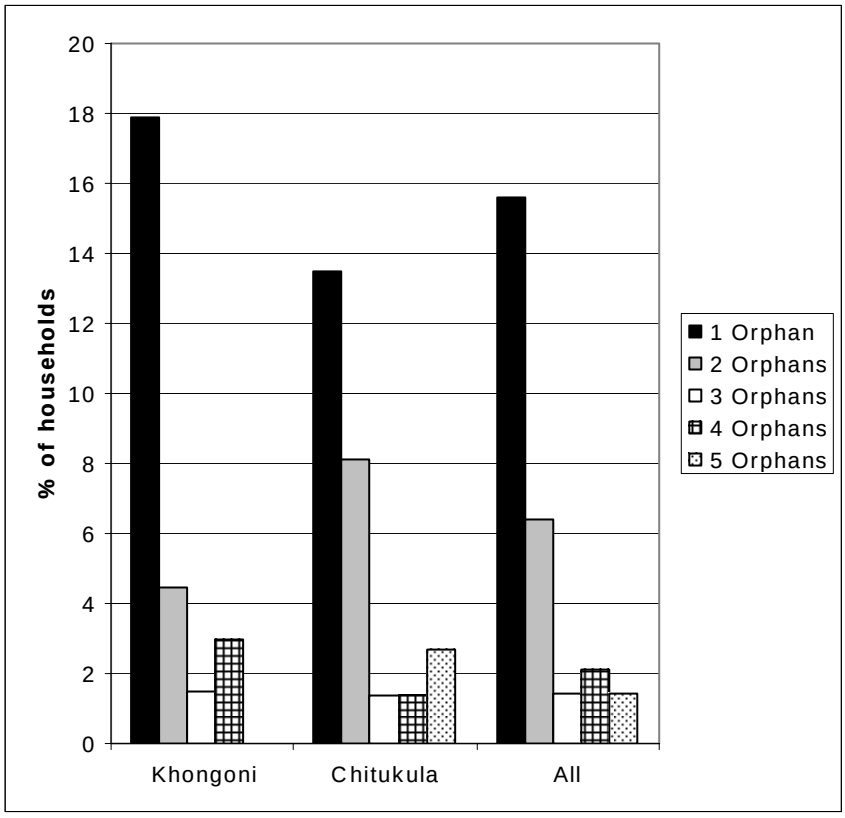
The AIDS crisis has resulted in more than 150,000 orphans in Malawi (Malawi, OPC & NAC, 2003: vi) but there is variation of opinion on what constitutes orphanhood. The government defines an orphan as a person under 18 years of age who has lost one or both parents. In our survey of Khongoni (Vizimba village) and Chitukula (Dzama and Chimponda villagers) we found 26 per cent of the 141 households randomly sampled stating that they had orphans. This amounts to .53 orphans per family on average. Within the households keeping orphans, the average number is 1.79 orphans per household with several households having between two and five orphans (Table 7 and Figure 1).

Table 7: Orphan-keeping in Surveyed Households

	Both villages	**Khongoni**	**Chitukula**
Households surveyed	141	67	74
Average household membership	5.49	5.44	5.54
Average resident members	4.94	4.87	5.00
% of Households with orphans	27	27	27
Average no. of orphans per household	0.48	0.43	0.53
Average no. of orphans per orphan-keeping households	1.79	1.61	1.95

Source: CARE Social Pathways household survey, February 2004

Figure 1: Number of Orphans per Orphan-keeping Households

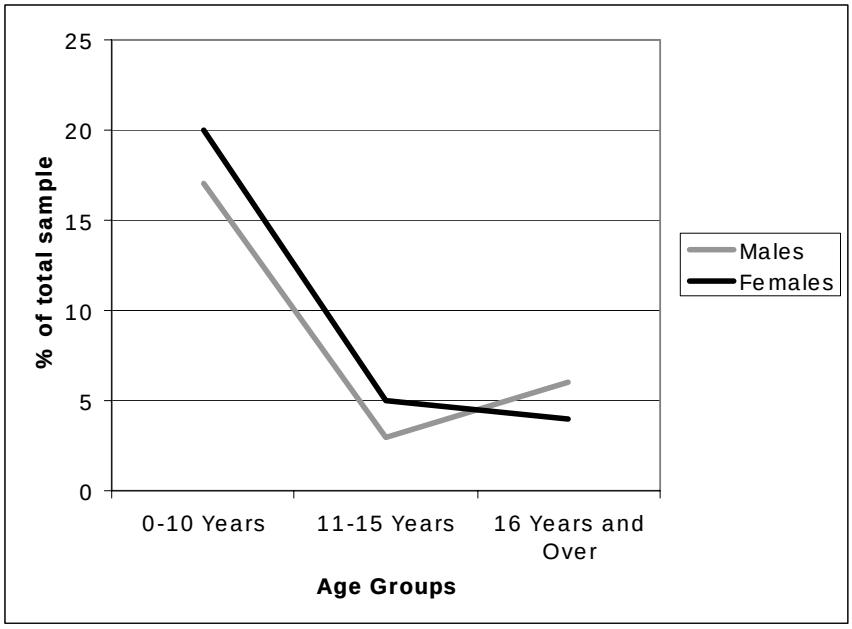


Source: CARE Social Pathways household survey, February 2004

There were 68 orphans in total equally divided between boys and girls. Of those, we know the ages of 55.[33] Most orphans were under ten years of age (Figure 2). There was a noticeable dip in the proportion of girl orphans over 15 years of age which may be related to their tendency to marry early.

[33] There was a general problem of obtaining age data throughout the interviews and surveys. Many people did not know which year they were born, which is related to the lack of record-keeping and low levels of numeracy and literacy. During the survey great care was exercised in trying to get people to relate ages and years to known historical events which enabled the survey team to approximate ages, e.g. WWII, the great locust influx (*zombe)*, the great famine of 1949 and national independence.

Figure 2: Age Distribution of Orphans



Source: CARE Social Pathways household survey, February 2004

The government is developing an orphan policy that is committed to:

> Ensure that orphans living with HIV/AIDS are not discriminated against in access to health care; in education; or in access to fostering, adoption or placement in institutions. (Malawi, OPC & NAC 2003, 14)

> Ensure that orphans are not denied access to primary education, whether by virtue of their inability to pay, their age or their gender. (OPC & NAC 2003, 16)

The newly installed Group Village Head of Vizimba village was especially concerned with the welfare of orphans. He had an interventionist approach that included allocating orphans to households and taking them into his own household in the event that there was no other household that would have them. He also allocated land to orphans to farm.

Most of the orphans that we interviewed were 'half-orphans' in the sense that they still had one parent living. Of those who were full orphans the allocation process by which they found adoptee families varied as described in the interviews below.

> *12 year old full orphan boy in Chimpando*
> My mother died and later she was followed by my father six years ago. My older brother [11 years his senior] took over my care in the family house so I was not separated from my original home. (Interviewed by Emmanuel Nasho, 15 March 2004).

> *15 year old full orphan girl in Vizimba*
> My sister passed away in October 2002. My father died in February 2003, then my mother in October 2003. After losing my parents and sister I was left alone. I was taken in by my aunt to this new home [20 kms from her father's village where she previously lived]. I had nowhere else to go after losing my whole family. (Interviewed by Maggie Msukwa, 11 March, 2004)

58 year old grandfather caring for two grandchildren aged 13 and 15 years old left behind by their parents during the famine plus two other grandchildren 8 and 10 years old whose mother remarried and moved away leaving her children with him and his wife in Vizimba

My daughter was married and living with her husband about 15 km away from Vizimba. The couple left in 2002 during the food crisis. My wife and I were told that our two grandchildren were left there but were suffering. They had no proper care and no food so I decided to bring them into my household and they agreed to come [where they have been ever since because their parents never returned and there has been no news from them]. (Interviewed by Constance Mzungu, 11 March, 2004)

In polygamous households, the welfare of half and full orphans can be affected by the presence of polygamous wives who, with the death of an orphan's mother, i.e. a co-wife, are called upon to become step mothers. Sometimes this arrangement does not work out, as illustrated by the following cases:

12 year old full orphan boy in Vizimba

My father died and then my mother. I was their only child. My mother's death led to my father's second wife assuming care for me. But it was not long before I started to be beaten and tortured by my new stepmother which forced me to leave my natal home. I ran away to my uncle's household for refuge [45 kms away]. My uncle recognises that I have nowhere to go and shoulders responsibility for me but his wife insists that I should leave the household because I do not belong here. I do lots of household chores like sweeping and running errands. I do all these tasks wholeheartedly to make sure that I stay with them for a longer time. I need to have them like me, especially my uncle's wife. I don't attend school. I dropped out of school two months ago in order to help the family with their food shortage crisis. (Interviewed by Emmanuel Nasho, 11 March, 2004)

13 year old half orphan girl in Dzama

When my mother died I wanted to join my sister's household because she got married soon after our mother's death but my father refused and gave me no choice. I had to move [approximately 2 kms] from my mother's village to my father's village and stay in the house with his two other wives. When the family is having meals, I am given my own plate while the rest of the children eat from one plate and my father eats with his two wives. This makes it difficult for me to forget my mother…I do almost everything, sweeping the kitchen and yard, washing plates, fetching water, preparing porridge, fetching vegetables and sometimes washing my father's and his first wife's clothes because she is my step mother. I am expected to prepare lunch for the family three times a week. My father's two wives take turns preparing meals. When it's the first wife's turn, she waits for me to do it if it's lunch and it's a school day because she is my stepmother. My father gives me some money to drink tea from a nearby tearoom before I start preparing the meal. Now my father's second wife also wants me to do the same for her and because I don't want to, we always quarrel. (Interview by Constance Mzungu, 15 March, 2004)

Whether orphans or half orphans staying with their surviving parent or full orphans staying with relations, their presence imposes financial costs for basic needs such as food, clothing and bedding as well as for their schooling. One headmaster explained how AIDS-afflicted households struggled to keep their children in school.

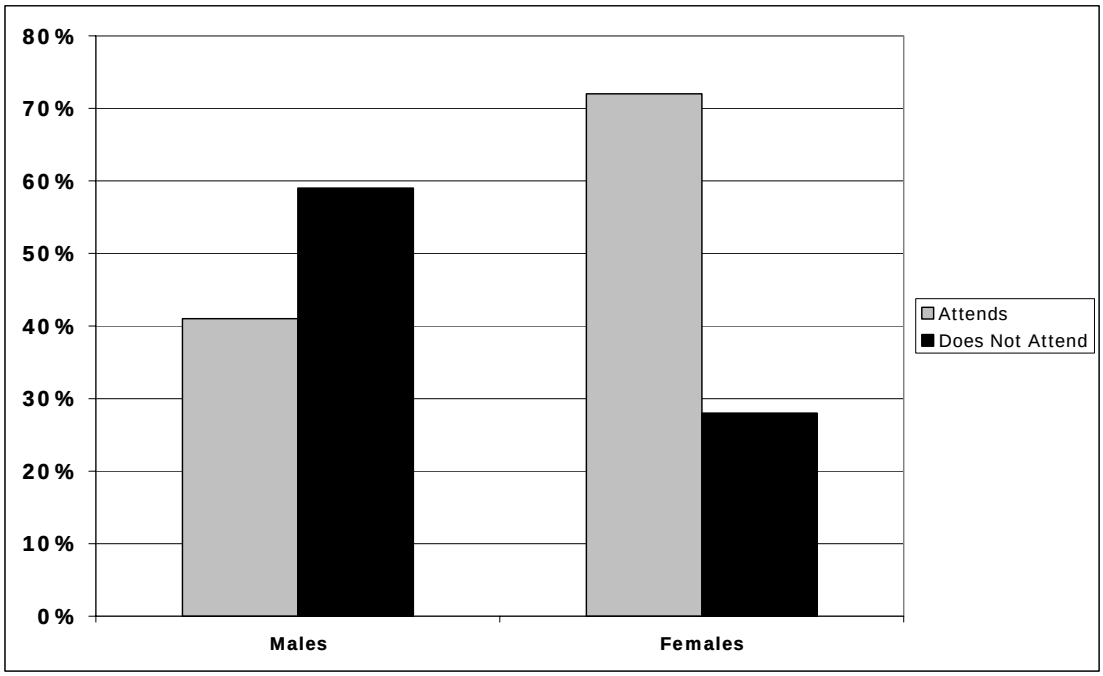
There is a lot of AIDS here and a lot of orphans. About 10 per cent of our pupils come from affected families. By affected I mean a family that has someone who is very sick. These kids are more likely to drop out because they don't have anyone to care for them.

> If AIDS takes both parents away, the kids are sometimes forced to do *ganyu* to survive and then cannot go to school. About 5 per cent of our pupils are orphans. The school doesn't do anything special to assist orphans. It gives all pupils free notebooks and pens. The community members sometimes see orphans as someone to work in their homes so their own children can keep going to school. (Headmaster, Vizimba, 8 December, 2003)
>
> Most of the orphans have stopped going to school because of lack of support and also most households are spending their resources on medication…most of the assets at home are lost during illness and thereafter when the man dies then the whole household is in dire problems. (Dzama VAC FGD, 4 December, 2003)
>
> *15 year old full orphan girl, Vizimba*
> The most difficult aspect of being an orphan has been to get money to buy clothes and other necessities. I did not have clothes to wear to school and there was hunger in my [adopted] household so I dropped out of Standard 3 last year. When I grow old enough, I want to get married to a rich man. (Interviewed by Maggie Msukwa, 11 March, 2004)

There is a general awareness that orphans should not drop out of school. Some primary schools no longer charge fees so that orphans are not forced to drop out due to insistence by the schools. Rather it is a combination of orphans lacking material support at home either because they are living in a single parent household that is struggling financially or in a 'blended' household where funds are also short or where the orphan is made to feel that s/he must pay her/his way. Under these circumstances, orphans who come to school wearing tattered clothes or lacking books feel self-conscious and want to quit.

In the Vizimba area, the headmaster estimated that about 50 per cent of the orphans did attend school, helped by the fact that there were no school fees charged for primary school. However, at secondary level, the fees were considered to be too high by many households. Our survey data roughly supported the headmaster's estimate but there was a strong gender and age differentiated pattern. Girl orphans were more likely to continue at school than boys. Roughly seventy per cent of girls were in school as opposed to about 40 per cent of boys at school, although by 15 years of age girl orphans tended to drop out (Figure 3).

Figure 3: School Attendance of Orphans by Gender



Source: CARE Social Pathways household survey, February 2004

Teenage orphans, especially the boys, join the working world by doing *ganyu* labour such as cultivating cassava fields for well-to-do farmers in their local area. They feel the onus to become as self-supporting as possible, forced to become worldly wise and forfeit their childhood. Interestingly, some of the orphans expressed a preference for doing *ganyu* work for strangers rather than relations.

> We prefer working for strangers rather than relatives because they [relatives] offer lower wages as well as make upsetting remarks concerning the death of our parents. A stranger can offer twice as much money as a relative for washing clothes. (Orphan girls, FGD, Chimpando, 12 March 2004).

Several informants referred to the welfare plight of orphans. Orphans were often recognizable by sight, given that their clothing was below standard. Orphans themselves, as well as others, referred to a state of extreme deprivation and shame that some orphans endure, that of not having adequate bedding. General discussion about orphans tends to dwell on the way that full orphans have a lower standard of living from the other natal children in the family. Some saw internal family relations being coarsened by this double standard and the treatment of some orphans as sources of cheap labour within the household itself. Our interviews with orphans rarely revealed extreme circumstances but it was readily apparent that orphans did feel the strain of having to prove their worth by working hard on household chores or alternatively earning money through *ganyu* so that they lessened their financial burden on the household.

Group discussions with orphans revealed that not all of their *ganyu* earnings were spent on basic necessities. Many of the teenaged boys enjoyed drinking which they felt helped them to forget their problems. This ‘time out’ behaviour appeared to be very important to the orphan teenage boys who otherwise entertained little in the way of positive expectations about the lives they had ahead of them. The focus group

discussions with orphans, as opposed to the school-going students, were revealing. Boys attending school aspire to be teachers, doctors, and police officers, and one even said he would like to become president of Malawi. Girls typically want to become nurses. In contrast, the orphans just shrugged when asked because they tended not to see their lives leading anywhere.

Girl orphans see marriage as a way out of their predicament. Early marriage becomes a way of escaping the welfare gaps and lowly status of being an orphan. Previously a girl might expect to marry at 18 years of age. Now it is normal for a girl to marry at 15 or 16 while boys might marry at 17. Sexual activity as a prelude to finding a marriage partner begins even earlier, and in this way, orphans who have already lost so much from AIDS face relatively high risks of contracting HIV themselves.[34]

> A problem that orphans face is that they have nothing of their own. The girl orphans might try to get money or other things by having a sugar daddy. The boys might look after cows to make money. (Headmaster, Vizimba, 8 December 2003)

Tragically, orphans face the renewal of the AIDS disease cycle:

> There is …a tendency for orphans to indulge in sex for payment because they are looking for support and other men reach the extent of giving them money to start brewing *kachasu* [for] business so that any time they can have free access to them (Vizimba Male FGD, 8/12/03).

> Poverty leads to hunger that leads to unprotected sexual encounters that leads to HIV/AIDS that leads to an increased number of orphans that leads to hunger again. This is a vicious cycle we are enclosed in. (Dzama VAC, FGD, 4 December 2003)

IX. Household Adjustment to Sudden Shocks

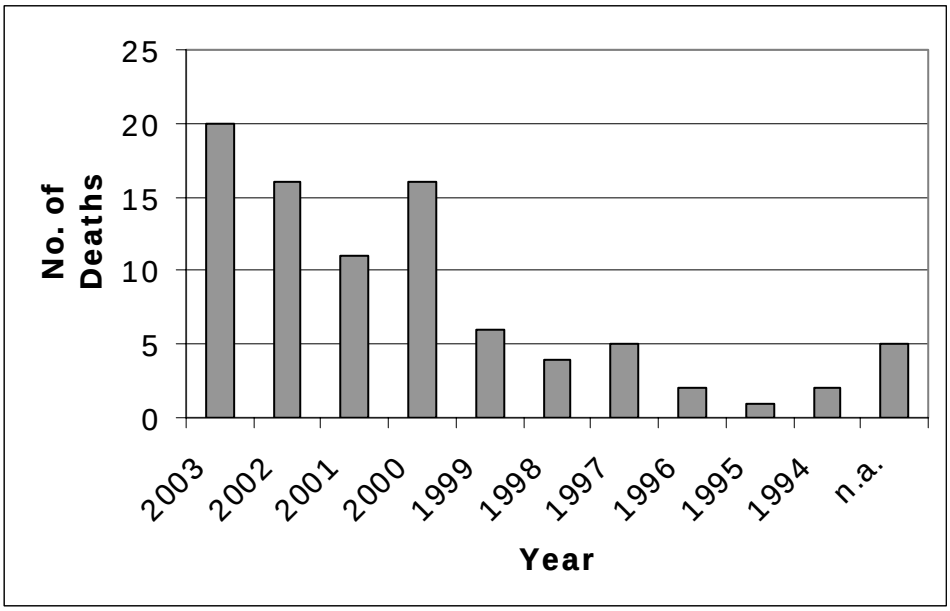
This section explores the survey and interview evidence we collected to reveal more about the nature of change at household level in response to the AIDS epidemic and the famine of 2002/2002. Over the 1990s, AIDS began infringing on their lives, followed by the severe deprivation of a famine and a far more pronounced AIDS impact. The ways households coped socially and economically are explored here.

1. Demographic and Social Upheaval

There is no doubt that mortality rates have increased in the area. In our household survey we asked about the deaths the household had experienced over the previous decade. Amongst 141 households there were 88 deaths reported. The cause of death was not specified so we do not know what extent these deaths are AIDS related. Figure 4 shows that the deaths were concentrated in the most recent period between 2000 and 2003 although this may be in part be due to the better recall for more recent years.

[34] Currently Malawian law has set the age of consent for girls to marry as 14 and 16 for boys. However, the Law Commission is now considering raising the age by two years for both sexes (Matinga and McConville 2002: 19).

Figure 4: Reported Mortality within Surveyed Households by Year



Source: CARE Social Pathways household survey, February 2004

Age breakdowns indicate that the deaths were changing in nature. During the 1990s almost all the deaths were of very young children as expected in a developing country with high infant and child mortality rates. During the last four years the deaths of people in economically active ages have been notable (Table 8).

Table 8: Household Mortality by Year and Age at Time of Death

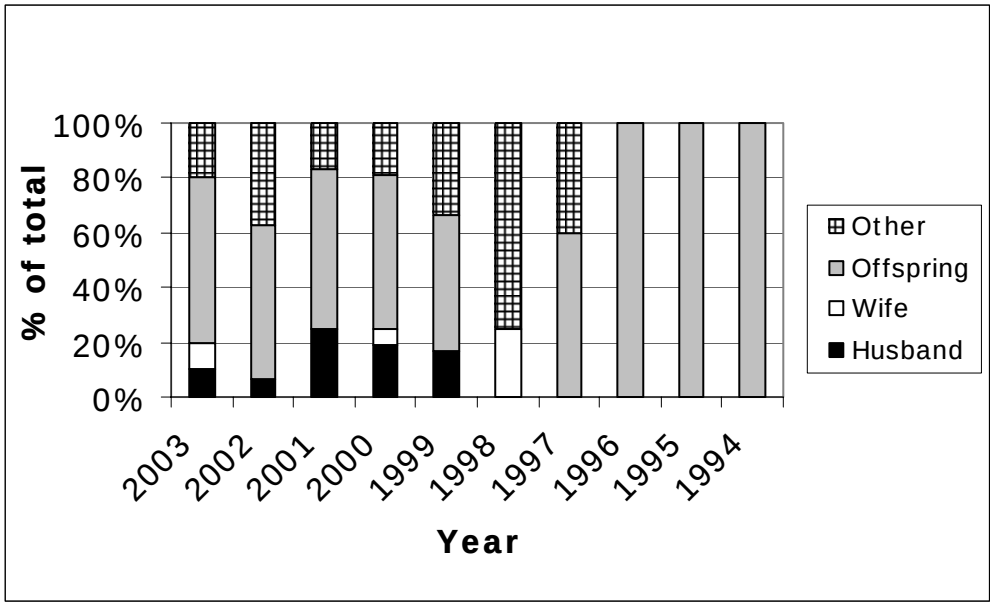
			% of total in the following age ranges:				
Year of Death	**No of Deaths**	**Age Unspecified No.**	**<5**	**5 - 15**	**16 - 25**	**26 - 50**	**> 50**
2003	20	16	56	6	-	31	6
2002	16	15	60	13	-	-	27
2001	11	8	62	-	13	13	13
2000	16	13	54	8	-	23	15
1999	6	4	100	-	-	-	-
1998	4	2	-	-	-	100	-
1997	5	4	100	-	-	-	-
1996	2	1	100	-	-	-	-
1995	1	1	100	-	-	-	-
1994	2	2	100	-	-	-	-
Unspecified	5	-	-	-	-	-	-
Total No.	*88*	*66*					

Source: CARE Social Pathways household survey, February 2004

Figure 5 showing the incidence of death by relationship of household member indicates that dependent children or the elderly dominated mortality in the mid-1990s, but from the late 1990s onwards husbands and wives became part of the death toll. Orphan generation and the beginnings of a household welfare crisis date from that time. While it would be foolhardy to read too much into this data, given the relatively

small size of the sample and the lack of information on cause of death,[35] nonetheless, one possible interpretation of our data would be that there was a rapidly changing mortality pattern from infant mortality to mortality among 'other family members' who, beginning in 1997, may have been AIDS victims returning from towns or elsewhere to die, followed in 1998 by the deaths of one or the other of the adult reproductive couples at the centre of the household. Infant and child mortality would be expected to increase in an AIDS epidemic given the possible mother-to-child transmission of the virus.

Figure 5: Deceased's Relationship to Surviving Household

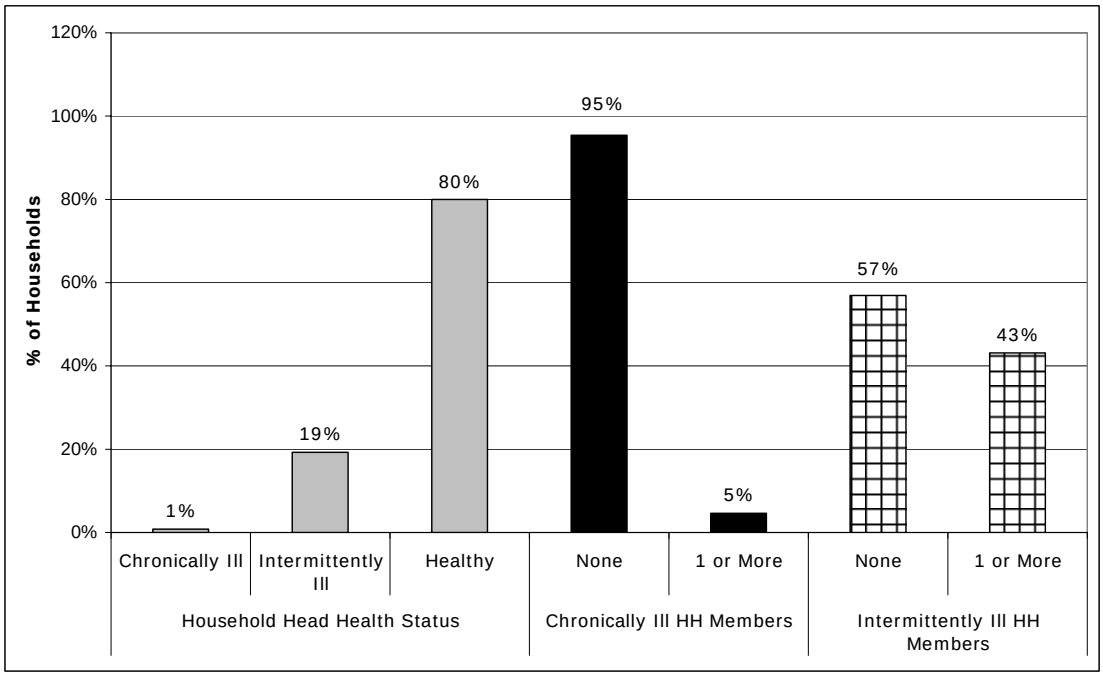


Source: CARE Social Pathways household survey, February 2004

In our survey only one per cent of households had household heads who were chronically ill, but 19 per cent of households had intermittently ill heads. Five per cent of the households had one or more chronically ill household member(s) and 43 per cent had one or more intermittently ill member, indicating that the general level of morbidity was high.

[35] We decided that it would be unwise to ask pointedly about the cause of death given the sensitivity and stigma attached to AIDS.

Figure 6: Health Status of Household Head and Household (HH) Members



Source: CARE Social Pathways household survey, February 2004

With the increasing frequency of morbidity, mortality and orphanhood over the past decade, households are being reshuffled in size and composition, causing a fundamental re-ordering of household and village life. Table 9 outlines household lineage and headship types by those with and without orphans.

Table 9: Surveyed Households by Presence of Orphans, Gender of Household Head, Lineality and Tribe

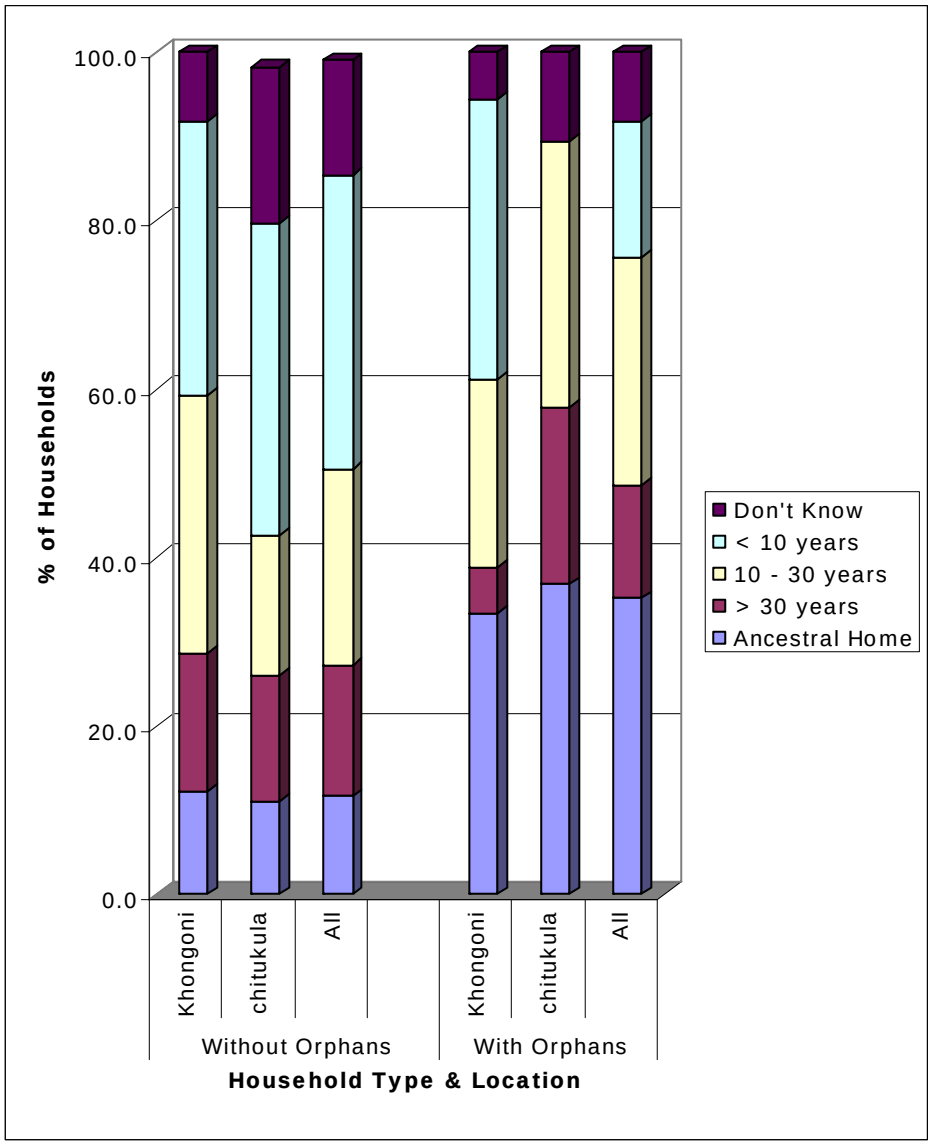
	All Households			Without Orphans			With Orphans		
	Khongoni	Chitukula	All	Khongoni	Chitukula	All	Khongoni	Chitukula	All
Total HH No.	67	73	140	49	54	103	18	19	37
By Gender	***% of Total***								
Male Heads	76.1	74.0	75.0	81.6	74.1	77.7	61.1	73.7	67.6
Female Heads	23.9	26.0	25.0	18.4	25.9	22.3	38.9	26.3	32.4
By Lineality	***% of Total***								
Patrilineal HHs	35.8	26.0	30.7	40.8	24.1	32.0	22.2	31.6	27.0
Matrilineal HHs	64.2	74.0	69.3	59.2	75.9	68.0	77.8	68.4	73.0
Male-Headed	***% of Total***								
Chewa Patrilineal	22.4	16.4	19.3	24.5	16.7	20.4	16.7	15.8	16.2
Chewa Matrilineal	50.7	54.8	52.9	53.1	55.6	54.4	44.4	52.6	48.6
Ngoni Patrilineal	3.0	2.7	2.9	4.1	1.9	2.9	0.0	5.3	2.7
Female-Headed	***% of Total***								
Chewa Patrilineal	9.0	2.7	5.7	10.2	3.7	6.8	5.6	0.0	2.7
Chewa Matrilineal	13.4	19.2	16.4	6.1	20.4	13.6	33.3	15.8	24.3
Ngoni Patrilineal	1.5	4.1	2.9	2.0	1.9	1.9	0.0	10.5	5.4

Source: CARE Social Pathways Household Survey, February 2004

Female-headed households in general, and particularly in Khongoni, are more liable than male-headed households to have orphans. So too matrilineal households are more likely to be taking care of orphans compared with patrilineal households. Those households that combine female-headedness with matrilineality, especially amongst the Chewa, have proportionally the most orphans. These patterns may arise from a number of factors including: first, that women have more decision-making power in these household forms and in their role as child carers and nurturers they may be more willing to take in orphans; second, that male adult deaths seem to have superceded female adult deaths so far, leaving female-headed households to shoulder the responsibility of orphan care; and third, given that we were surveying Chewa villages and the Chewa are traditionally considered a matrilineal people, that it is logical that deaths of either a father or a mother would result in the orphans left behind, residing in the village of their mother.

The importance of lineality with respect to orphan care is evident from Figure 8 which shows that households with orphans tend to be locationally well-established, residing in their ancestral homeland or living in the area for over 30 years. This tallies with the fact that the older generation is assuming greater responsibility for childcare and they are the most likely to be residing in a long-established home area.

Figure 7: Duration of Household Residence



Source: CARE Social Pathways household survey, February 2004

2. Household's Economic Survival Strategies

Throughout Sub-Saharan Africa, the last 25 years have been trying for rural smallholders but this is especially so in Malawi during the past five years when the direct impact of the AIDS epidemic and famine have combined to severely undermine household welfare. Malawian smallholder peasant farmers have been experiencing a general trend towards deagrarianization and depeasantization (Bryceson 2002 a & b). Shifts in their household assets and livelihood portfolios have veered towards:

1) the switch from self-sufficient unpaid labour performed within the household (especially by women and children) to cash-earning work which takes the form of *ganyu* in Malawi.
2) the switch from agriculture to non-agriculture with income-earning turning increasingly to trade and services. In Malawi this has also encompassed the so-called 'essential exchange' of sex for food.

3) the switch from household to individualized labour whereby every able-bodied person works including women and youth who seek to earn cash to cover their subsistence needs. This has generated a tussle between youth and their parents, especially between mothers and their offspring, who feel that youth should be helping them to earn ganyu income rather than doing ganyu on their own account. They are expected to help work in the family garden as well as do weaving and rope-making without remuneration, but when they do ganyu increasingly they want to have control over the income they earn.

There is however a critical difference between depeasantization in Malawi as opposed to its unfolding in most other parts of Sub-Saharan Africa. In Malawi depeasantization is going on without the relatively secure subsistence fallback that African smallholder households have so heavily relied upon elsewhere (Bryceson 2002a). Malawian rural dwellers face acute food insecurity because of extremely low agricultural productivity combined with relatively high rural population density and land shortage. There is little or no land frontier. The removal of the fertilizer subsidy undermined farmers' food production. They no longer have enough land and agricultural productivity to ensure basic household food needs on a year round basis. Qualitative poverty assessments identify food insecurity as the number one indicator of poverty (Malawi, NEC 2002, p.15). Village heads in Khongoni estimated that well-off households have year-round food self-sufficiency, households occupying the middle stratum have sufficient maize to last five to six months after harvests whereas poor households have one month or less. This food insecurity, both its extent of shortfall and its year by year repetition, has led Malawian households to despair. Food security is equated with social respect.

> One has to have enough food for people to respect you. A household with no food is not respected. (Women's FGD, Chimponda, 12 March, 2004)

The search for alternative non-agricultural forms of income-earning amongst peasant farmers elsewhere in Sub-Saharan Africa has been cushioned by the household subsistence fallback. In Malawi, a large proportion of rural households have no semblance of a reliable subsistence fallback. They are forced to operate with the shortest of time horizons, seeking to provision their needs one day at a time.

> We rely on *ganyu* and cannot carry out income-generating activities because we have no capital since the little we earn from *ganyu* must be spent on food. (Women's FGD, Chimponda, 12 March, 2004)

Besides the increasing reliance on *ganyu* labour markets on exceptionally poor bargaining terms, factor markets are appearing in which the local rural people are even more handicapped given their lack of literacy, numeracy and market savvy. To date these factor markets are not readily apparent in the Malawian agrarian literature. However, our interview and survey suggests that male farmers have recently started seeking urban or other patrons to finance their access to fertilizers. In return they are compromising their existing productive assets, notably their land. It appears that they enter into agreements with these patrons by word of mouth and are given the inputs but are required to sell to the patron on terms he sets. Sharecropping, land leasing and contract labour agreements are being negotiated. The urban patron leases the farmers' land, pays the farmer to do the labour and keeps most all of the harvest for him/herself.

Evidence of this emerged during the household survey, when members of the survey team were approached to act as patrons financing farmers' access to fertilizers and other inputs. The survey team leader describes his realization that all is not what it seems to be in the lush tobacco fields of our study area.

> This first village [Vizimba], to a newcomer, gives a false impression that most are really well-to-do. Almost every household has a barn of tobacco nearby. When you talk to them, you get a revelation that rich men from Lilongwe or Mchinji town give money for fertilizer, pesticides and almost all necessities so that when this tobacco is sold, their earnings mostly go back to the investors. When this period is over [after the harvest], they are surprisingly more poor…[In the next village, a similar situation prevailed]…memories of the great 2001/2002 starvation which killed many villagers, is still rife…The recovery period for these people seems to have been gruelling since inflation-related problems arose rendering most basic commodities unaffordable. These people are observably quite spirited and no wonder the deals with town people on tobacco seem, of course, exploitative, but better than nothing…Everybody is keen to strike such deals. This could be one catalyst in their hospitable attitude towards visitors. Of course, traditionally these people are hospitable. (Gift Hara, survey team leader, 27 February, 2004)

Closer to Lilongwe in Chitukula TA, evidence suggests the role of external agents in tobacco production may have progressed further with the development of land leasing.

> These villages, which are near the town, give a very confusing picture since rich town people rent these gardens and cultivate these crops which look promising. Villagers are mostly doing *ganyu* for these town people. The villagers' real gardens [that they farm on their own behalf] are mostly pathetic. (Gift Hara, survey team leader 3 March, 2004)

In his thought-provoking book, *Famine that Kills*, de Waal (1989) argued that during the Sudanese famine of 1984/85, farmers in Darfur preferred to go hungry rather than sell off their livestock, which they knew would ensure their long-term survival prospects:

> …people's principal aim during the famine was to preserve the basis of an acceptable future way of life, which involves not only material wellbeing but also social cohesion (de Waal 1989, p.227).[36]

The rural households we interviewed appear to have taken a different course of action during the famine and its aftermath. Their belief in and commitment to peasant smallholder farming as a livelihood and way of life seems to have experienced serious erosion. This may be because they had always heavily depended on migrant labour that was no longer at hand to support the rural homestead. It may be because of the declining yields they experienced since the removal of the fertilizer subsidy. Furthermore, the debilitation of the family labour force due to the encroachment of

[36] De Waal (1989:238-243) however cautions that this reaction was specific to Darfur peasants of the mountains and savannahs, who highly valued their self-sufficiency and agrarian traditions. He goes on to contrast the peasants of Darfur with the people of Dar Binga, who are not principally farmers but who farm a little, keep livestock, do hunting and gathering, trade, engage in seasonal wage labour and have a client relationship with their northern neighbours. They are considered to be in a perpetual state of famine, such that their reaction to the 1984/85 famine was not one of safeguarding assets.

AIDS may have played a part. Most likely all these factors have combined with the poor weather conditions to create a state of demoralization that continues to the present day.

Certainly, we were told time and again that the most fundamental problem faced by the villagers was hunger.

> HIV/AIDS is not very threatening compared to the hunger which most households face. In fact it is hunger which is contributing to the rise in HIV infections in the area. (Religious leader in Vizimba, 8 December, 2003)

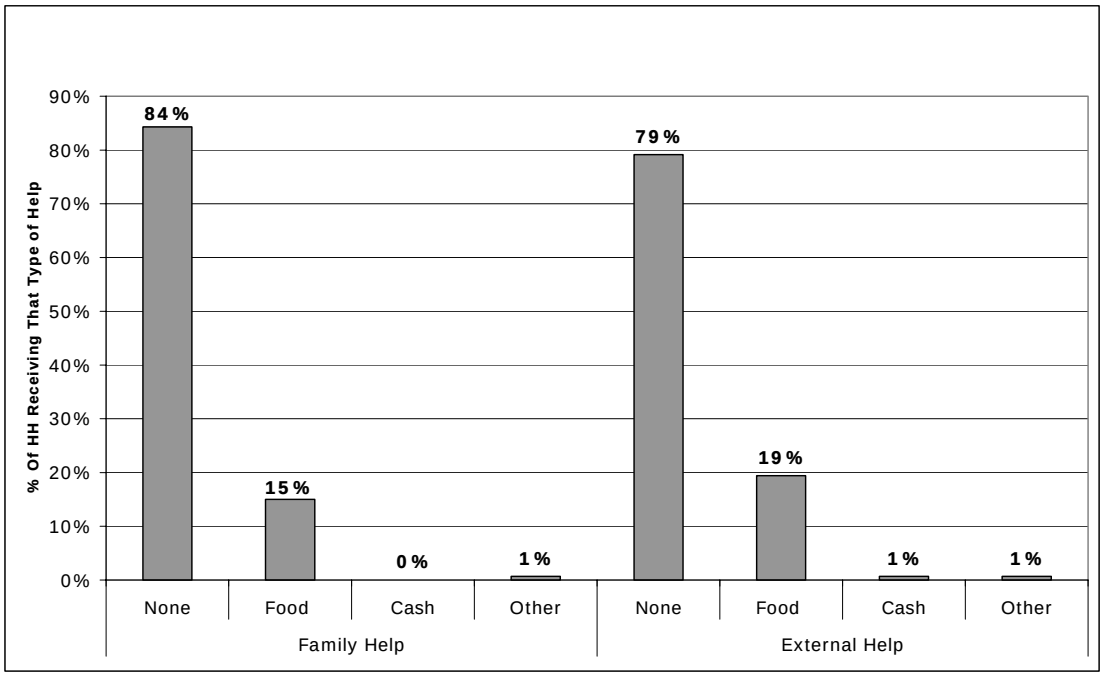
Villagers have reached a watershed in terms of the management of their agricultural assets. Given the removal of the fertilizer subsidy and the declining role of ADMARC in marketing, they are giving priority to the day-to-day resolution of hunger. Women in the Chimponda focus group discussion told us that all their working time was devoted to 'looking for food'. It was close to harvest time and they were surrounded by ripening crops but increasingly these crops were not theirs. 'Looking for food' was a euphemism for *ganyu*.

No one saw *ganyu* as a long-term solution. The new GVH of Vizimba explained that he discouraged people from *ganyu* which he felt only served their immediate needs:

> Cash from casual work is like the dew in flowers at dawn. It doesn't last long. (J. Kadzandira's Interview with Vizimba GVH, 12 March, 2004)

Our household census data revealed the pattern of help received from family members or externally in the aftermath of harvest shortfall. In 2002, only 7 per cent of respondents reported an average or better harvest, while 93 per cent reported a poor or very poor harvest (total number reporting = 138). This indicates that the vast majority of respondents may have had difficulties after the harvest. However, most of them did not receive assistance either from family members or otherwise (Figure 8).

Figure 8: Help Received from Family and Externally



Source: CARE Social Pathways household survey, February 2004

Only 15 per cent of households received assistance during the recent famine in the form of food from extended family and only 19 per cent accessed food aid from external agencies. The vast majority of households had to fend for themselves.

Thus, the villagers no longer had a viable subsistence food production fallback at home, nor sufficient recourse to extended family or external agency assistance. The men were therefore bargaining their land for cash and the women were bargaining their labour on casual, usually exploitative terms, leading to an extremely uncertain hand-to-mouth existence. Furthermore, households had reached a highly individualized state whereby they did not dare seek one another's help. Unfortunately, the self-reliance and price embedded in this response was flooding the local labour and factor markets driving down prices and contributing to their impoverishment.

> The people in these villages seem not to depend on one another. Each household fends for itself. Their answers [to survey questions] show that in case of material need, their solution is to do piece work rather than beg from fellow villagers or relatives. It seems that there is a general notion that everybody in the village is struggling to survive so no one wants to be a burden on the other. (Observations about Chitukula TA, Gift Hara, survey team leader, 3 March 2004)

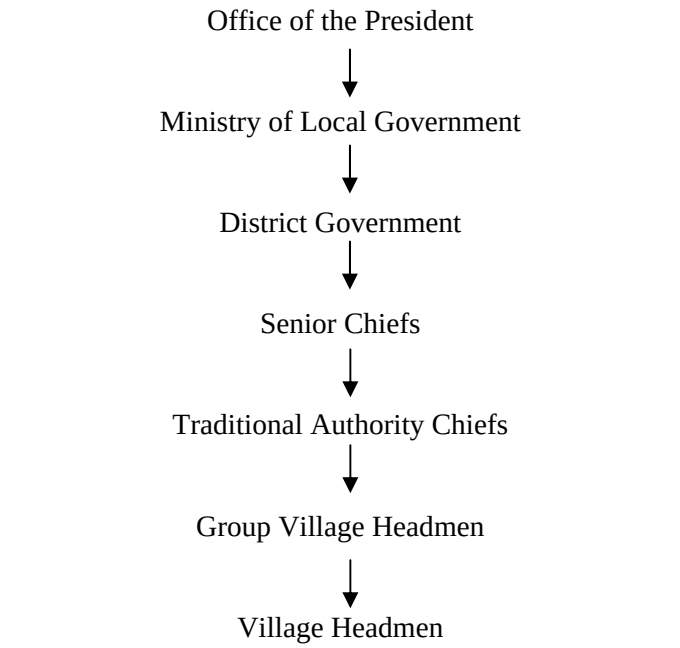
X. Community Coherence and Confidence in an Era of Uncertainty

It has been argued that Malawian rural dwellers have been experiencing an extremely distressing period, coupled with many externally-induced political and economic changes. With respect to the analysis above and as a prelude to a consideration of possible policy avenues, this section analyses the workings of social institutions at the village level beginning with a consideration of the role of traditional leaders. Schools are then examined in terms of their potential for instigating change. Finally, the range and nature of villagers' own local organizations will be reviewed.

1. Chiefly Concerns

The ritual role of the local traditional leaders has already been outlined in a preceding section. During colonialism and the post-independence period under Banda and Bakili Muluzi[37], traditional leadership structures have been consciously reshaped to facilitate political stability, balance power and accommodate bureaucratic administrative needs. At present an administrative hierarchy has developed that has its apex in the Office of the President (Figure 9).

Figure 9: Traditional Leadership Structure



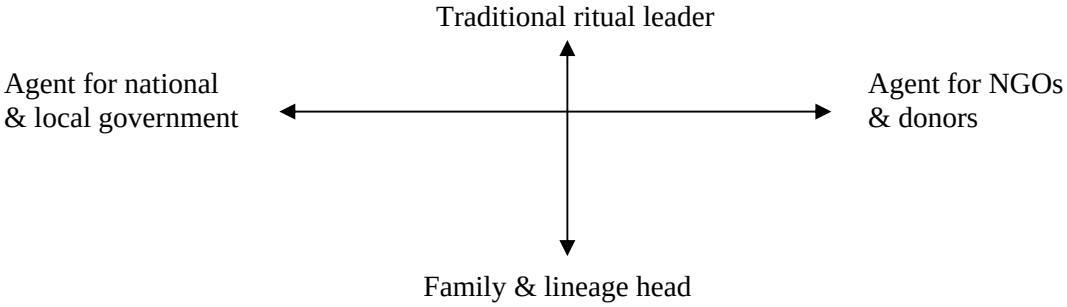
While there is some government interference in appointing or promoting chiefs especially at higher levels of chief selection, Group Village Headmen are chosen through the convergence of decision-making from above and below. Village headmen are chosen at the local level by chiefly families and elders on the basis of matrilineal or patrilineal descent, as well as the opinions of other village headmen who may be women. Within the villages there are Councils of Elders composed mostly of men (Matinga and McConville 2002:17). Male members of the Nyau secret society may also be making decisions on law and justice within the village. Thus, the selection of traditional leaders and the continuation of traditional structures combines national and district administrative considerations with local customs, norms and preferences. This may generate a leadership that is able to meet the expectations of both the government and the villagers or alternatively it may generate leaders who are sub-optimal for both parties, neither attuned to villagers' needs nor administratively capable. Furthermore ambiguity in the selection procedures can result in longstanding disagreements and deadlocks over leadership positions.

[37] Muluzi was the first president elected in multiparty elections, defeating Kamuzu Banda.

Local leadership has been in a transitional situation that has become increasingly problematic over the last decade since Banda's tradition-minded national government relinquished control. Unlike some of the neighbouring countries, Malawi opted to incorporate its traditional leaders into local government after independence. These leaders' moral, ritual and political roles were increasingly encompassing administrative tasks. Over the last decade, their administrative work has been greatly extended to the demands of numerous foreign donor agencies and NGOs that have instigated village-level aid projects or regional programmes. Under these circumstances, and in the less traditionalist political environment of the Muluzi government, it has become apparent that many traditional leaders have very poor educational backgrounds and lack the requisite administrative skills. Their leadership roles have stretched beyond logic and practicality to embrace both old and new responsibilities, some of which are incompatible or even conflict with one another.

As Figure 10 indicates, traditional leaders are being pulled in two different directions. They attempt to fulfil their age-old function as ritual leaders and moral guardians of the community and as heads of chiefly families. In these roles, their ritual beliefs and notions of causality and time may often be at odds with their administrative functions. Furthermore, traditional practices may call for preferential treatment and favouritism in the channelling of goods or services that is at odds with the traditional leader's bureaucratic accountability stipulated by the national government and multi-various donor agencies. Their role in local dispute settlements on the basis of traditional beliefs and conceptions of moral order may directly conflict with Malawian laws. Can these worlds be reconciled?

Figure 10: Role Conflict of Village Leadership



This is clearly a sticky question with no single answer. Certainly the Malawian government is trying to strengthen the administrative capacity of traditional leadership. Training courses for chiefs have been offered. In May 2002, a Council of Chiefs was inaugurated comprising a senior chief from each district. It remains to be seen how active and how effective this body will be (Matinga and McConville 2002).

Government reform with respect to traditional courts is illustrative of the problems that can be encountered. In 1994, the traditional courts that had been strengthened during Banda's regime were abolished in their own right and integrated into the lower level of the Judiciary. An analysis (Schärf *et al*. n.d.) of their operation indicates that there was no legislation to harmonize the integration and confusion reigns over interpretation of the original reform legislation. No one is certain if there is a

legislative mandate to implement the integration. What absorption of traditional court staff has taken place points to the serious problem of wholesale incorporation of untrained, largely incompetent staff. In effect the traditional courts were officially abolished without any replacement. Thus in this void traditional authorities largely carry on as before, but with their authority now in question and a huge backlog of appeal cases straining the judiciary and undermining its efficiency. This state of play imposes constraints on the human rights approach that many donor agencies are incorporating into their projects at village level.

2. Youth in the Village: School and Ganyu Training Grounds for the Future

The rural youth of Malawi today face unprecedented challenges. They are the first generation in Malawi's history to be availed free primary education. Thus, they are already better educated than their parents. This is an extremely positive development but it could serve as a barrier to communication between the two generations. Certainly there were hints of this in our focus group discussions. Women in Chimponda remarked:

> Youth [from 13 years of age onwards] don't respect their parents these days and they say its due to human rights. Youth now want to do *ganyu* on their own account. They ride bicycles recklessly in the village, sometimes straight at adults without any apologies or concern. (Chimponda women's FGD, 12 March, 2004)

> Over the past five years older children have become unruly. They do not want to help us with our *ganyu* labour as they used to. (Vizimba women's FGD, 10 March, 2004)

There is a general feeling amongst many rural people that all the uncertainty of political and economic change during the last decade can be encapsulated in the term 'human rights' which national policy makers and donors alike have seen as both a rationale for change and a goal in itself. At village level, many older people equate human rights with the perceived individualistic behaviour of youth at the expense of age-old moral values of the collective community.[38]

There are two major changes in the youth of today. In addition to attending school, they are also working for cash income and demanding that they have control over the earnings. This is part and parcel of the depeasantization process described above. Whereas before women and youth would have been mostly operating as unpaid family labour in household agricultural production, now *ganyu* has become the chief occupation of many village women and youth. Since the famine, women are spending more and more time working away from home. Much in the way that their husbands previously expected them to work unpaid on the family farm, now they expect that their children will work with them on *ganyu* tasks after school and on the weekends to boost the household income. Youth are increasingly unwilling to do so. Thus time spent together and familial work cooperation are in decline. Teenage estrangement is surfacing, not unlike that ongoing in western societies. The pressures of employment

[38] Very similar charges were being levelled at rural youth in Guinea Bissau prior to the country's coup in 1998. Adults blamed the country's democratization for instigating the generational gap. Balanta village elders remarked to the anthropologist Roy van der Drift: 'It's a new world coming in. This is normal for every young generation. But today's youth are getting too loose, and they are supported by democracy. We know that their heads are still too weak to cope with it.' (van der Drift 2002: 191)

are such that there is a widening gulf between parents and children as described by Hersch:

> It is a problem not just for families but for communities when the generations get so separated. The effects go beyond issues of rules and discipline to the idea exchanges between generations that do not occur, the conversations not held, the guidance and role modelling not taking place, the wisdom and traditions no longer filtering down inevitably. (Hersch 1998: 20)

Can local schools bridge the generational gulf or are they contributing to it? Matinga and McConville (2002) argue that primary and secondary schools are islands, which are distanced from village. In part this is due to the fact that most teachers are outsiders to the community. They do not always understand let alone sympathize with local beliefs and mores. Furthermore, they see themselves as educated people set apart from villagers. Their housing has become an issue in some places. Schools have been built without adequate provision for teachers' housing and the teachers have been campaigning to the education authorities and the village leaders to obtain improved housing. Thus, in the eyes of the villagers these are 'other' people aspiring to higher living standards than themselves. Furthermore, perhaps both a cause and effect of the wariness with which villagers see them, many teachers have been discredited with charges that they are having sex with their students.

Any sexual misconduct on the part of teachers undermines their potential to provide a forum for sex education and guided discussions about morality amongst school peers. This is deeply unfortunate in view of the spread of AIDS to rural areas. Instead many schools are embarrassed about offering sex education.

> Our school has an AIDS Toto club that teaches kids about HIV/AIDS. Some students are afraid of AIDS but others are meeting in private places to have sex and they don't want to change their behaviour. Condoms are not readily available. I think it costs 10 kwacha [about 9 US cents] for a packet of three. But students are not interested in condoms because they think there's HIV inside or that they will burst…It's a problem for teachers to teach about condoms because they feel embarrassed. What if they're teaching their own kids in the class! Also, people in the community would complain saying, "What are our teachers teaching the kids? They're teaching them something that they shouldn't be". (Headmaster, Vizimba, 8 December 2003)

A moral vacuum is coalescing through the absence of parents from home and discredited teachers at school who are embarrassed to offer sex education. On the threshold between childhood and adulthood, youth, more than any others within the village, appear to be part of a lottery in which their life chances are determined irrespective of what they do in a period of great unpredictability. [39] The death of a parent to AIDS catapults many of them into premature adulthood. With only partial shelter that their adoptee families can offer, most must materially fend for themselves. As argued previously, alcohol and sex often become pillars of their lives. Out of school, bars become social forums for boys where they can interact with others their own age and where they may commonly engage in unprotected sex. Girls, meanwhile, may be barmaids or brewers and are on the lookout for early marriage prospects, given their materially uncertain position. In these circumstances, youth eagerly, if not

[39] The lottery is even more apparent for those who are taken into orphanages or receive individualized foreign sponsorship so that they can continue at school.

recklessly, seek sexual encounters as their destiny, without a sense of their own personal agency in making choices about life and death.

3. Community Organizations: Inside and Outside Tensions

A strong sense of community is retained through a shared tribal identity. The majority of people in the villages were Chewa with a sprinkling of Ngoni. Nonetheless, as outlined in the previous section on community responses to AIDS, there is a general wariness about asking neighbours for help and there are signs of growing mistrust within the community. Theft was identified by one woman's focus group as the number one community problem. This is confirmed by second grade magistrates court cases where theft accounted for 51 per cent of the cases (Schräf *et al*. n.d.: 33). Previously during Banda's rule, the Young Pioneers ensured security. With their removal and the heightened sense of need during a famine, theft of livestock and maize is rampant. In Vizimba, people believed that certain villagers who knew others' regular patterns of movement were conniving with outsiders to steal livestock.

The following sub-sections examine how the community coheres through formal organizations which are either locally or externally initiated.

• *Locally-initiated community organizations*
We found three main types of community-initiated and maintained organizations that were all pointedly directed at immediate needs of the community. They mainly addressed security problems, death and recreational pursuits such as sports.

A neighbourhood watch had been established in Vizimba somewhat along the lines of the Young Pioneers. These were operated on a no-nonsense basis, mobilizing the population to take security precautions. As was explained in the male FGD: "if they say everyone should be at home at 9 pm they enforce it".

Funeral committees are the most common form of joint effort on the part of the community. These are traditional committees that have grown in importance as the mortality rate has increased. The village headman is in charge of them and, as explained earlier, s/he has been involved in organizing various ways of raising money for them, notably by engaging villagers in maize production in a collective field and more recently in *ganyu* where their earnings are pooled for funeral expenses. Not all the money is spent on food and drink for the celebration and coffins for the burial. In Chimponda, money was also allocated for the purchase of plates and cutlery for the feasts.

Football and netball are popular sports that tend to be organized by youth. They arrange practice times as well as matches.

The main feature of these community-maintained organizations are that they are built on voluntary involvement or at least compliance of the villagers. Resource mobilization, in terms of money or materials, is minimal except in the case of the funeral committee, where the headman, provided the authority and security to mobilize cash for purchase of goods needed in funeral ceremonies.

• *Externally-funded, community-based organizations*

These organizations distinguish themselves from the above in that they function on the basis of resources that are received from an external agency. Almost invariably the village headman is the intermediary who receives the funds or materials and who distributes and ensures their usage as per the specifications of the donor. These are of two types depending on the purpose and intended duration of the funding. The first is associated with emergency relief, notably famine relief, of the sort that CARE has been extensively engaged in since 2001. The purpose and time limitation of this intervention is generally clear to people. The second type are the development-oriented programmes and projects especially in agriculture and health, which donors expect will involve sparking the villagers' efforts around the provision of materials and/or training and eventually lead to village self-reliance and the exiting of the donor.

During the 1990s as foreign aid to Malawi increased, and especially over the past five years of famine and AIDS programmes, headmen's role as fundraisers on behalf of their villages has come to the fore. It was readily apparent in our case study villagers that the headmen were not only on the lookout for funds but they kept detailed records in their minds about the history of each donor agency that came to their village, how their projects had performed and whether they had fulfilled their promises. They were especially critical of those agencies that had stopped their projects despite the continued need, being particularly scathing about those which had offered fertilizer and agricultural input loans. All of these had ceased to operate. The Chimponda women had a long list of local associations which had given them loans for agricultural inputs but then stopped doing so. These included the Agricultural Productivity Investment Program (APIP), which had disappeared in 2000, Farmers' World, and the Malawi Rural Finance Committee (MRFC). MRFC was memorable in their minds for having taken their goats to compensate for their loan defaulting.

Villagers were astute observers of the comings and goings of donor agencies. Headmen and villagers alike were keen to attract donors to their village to work in various fields. Agricultural and health support were the areas in which they most expected and hoped for help. Nonetheless, there was an air of realism about external support. Donor-instigated associations were seen to be short-term by nature and villagers saw little purpose in continuing the committees associated with these projects in the absence of the external material support. They felt there was nothing to deliberate about or to involve themselves in, once donor interest was removed.

When we asked about the type of villagers who were needed to volunteer their services in committees associated with external funding, they stipulated people who were willing to work hard and be impartial. Some saw committee work as the preserve of people leading model lives of development who were sufficiently materially endowed:

> For a household to join a committee it must have a pit latrine, a rubbish pit and do things others can learn from. Also they should have a big house to accommodate visitors. (Chimponda women's FGD, 12/3/04)

Clearly there is a disjuncture between the majority of villagers' capabilities, lifestyles and expectations and what villagers see as the normative views of the donors who are endeavouring to make material improvements to their lives.

• *Outward-directed Informal Associational Ties*
In addition to the formal 'traditional and 'modern' village committees described above there are various associational ties based on informal group efforts at sub-village level which give meaning and possibly security to villagers. For example, in Chimponda, a group of women have informally befriended a group of women from another village that they encountered at a nearby market settlement. They exchange gifts or cash with this group and in this way they feel a sense of mutuality. The sums involved are usually very small, from 5 to 10 kwacha, but if a critical mass of women from one village contribute this sum, it amounts to a noteworthy offering from one women's group to another. This practice is called *zibongo* and was initiated in 2001. Presumably with women's increasing mobility and market involvement it is useful for them to bond with women beyond their village, who they could turn to for assistance, information exchange or conviviality.

XI. Social and Economic Pathways out of the HIV/AIDS Disease Cycle

This section addresses possible pathways away from the AIDS disease cycle. Emphasis here is on the inter-connectedness of medical, social, economic and spiritual fields.

1. National Social and Economic Direction: Shaping Deagrarianization and Depeasantization

Malawian smallholder farmers are at a crossroads both economically and politically. Their agrarian way of life has seriously eroded over the past two decades. Urban migration is now an alternative. After several decades of very low urbanization by Sub Saharan African standards, Malawian urbanization is now rising. Many youth are finding their way to the cities and trying to make viable non-agricultural working lives. But there are hundreds of thousands who remain in the rural areas facing the uncertainty of their rural livelihoods, knowing that urban migration does not offer a panacea.

Following the May 2004 elections, several important policy choices have to be made to provide positive economic and political directions in the countryside. In their absence, people will drift along with continually eroding agrarian livelihoods forced to engage in asset depletion and the experience of declining returns to labour. Their livings standards are likely to deteriorate further as the AIDS pandemic afflicts more rural households. The following section aims at encapsulating some of the basic rural policy issues before turning to the next section's focussed consideration of a rural HIV/AIDS policy.

• *Political Dilemmas*
Presently, village headmen face an impossible task. They must be guardians of moral and religious tradition, heads of prestigious lineages, leaders of their village communities, efficient local government bureaucrats and efficient administrators of donor agency funding. All of this is required of men and women with a wealth of local experience but relatively little education. Besides this overload of responsibility, some of these roles directly conflict with one another. Traditional values of honour and hierarchy can pull in the opposite direction of bureaucratic duty and responsibility.

While the national government has tried to raise the level of training and halt traditional authorities' judicial roles, the effort has not been adequate nor met with much success in terms of offering viable institutional alternatives. Emergency situations such as the recent famine expose the full depth and extent of the problem. Donor agencies, such as CARE, delivered emergency food aid and needed accurate and timely targeting to the most needy, a task they entrusted to village headmen and chiefs. Time and again we heard complaints from villagers that the food aid did not percolate to the poorest and was only distributed to a narrow circle of family and associates around the headmen.

There is a need for far-ranging government reform founded on three key principles: first, the separation of roles and allocation to different personnel based on ability; second, the creation of interacting checks and balances between different local government agents; and third, the popular election of local leaders to represent villagers in local government.

Local government elections at village level would be a step forward in keeping with the demands of local leadership of the present day. Traditional leaders, belonging to chiefly lineages, are repositories of a wealth of cultural and religious knowledge which makes them respected community leaders in a cultural sense. Their selection as cultural/religious leaders following traditional tribal customs must continue for as long as local people feel a need for such leadership. However, if chiefs and headmen want to be local government officials, it would be advisable for them to submit themselves to electoral procedures. The electoral procedures could entail vetting of candidates by national and regional party/government officials for basic suitability before going to the local polls.

Donor agencies should urge the new national government to further reform local government along these lines. Such reform is a long-term process that would take at least a decade to implement fully. In the meantime, cultural and political attitudes are bound to change as rural people more generally obtain basic schooling and are subjected to more media and urban influences. They will become less traditionalist in outlook and supportive to less autocratic local leadership and the separation of responsibilities amongst village leaders. Cultural pride is important to people's identity but it should not distort political and economic accountability. Chiefs should remain cultural figureheads but their long term authority in this capacity will be better secured through separating culture, religious and political power now. This timely policy move could prevent rural people's, especially youth's, growing frustration and disillusionment with an increasingly obsolete traditionalism within the rural areas.

• *Economic Trajectories*

Commercial agricultural prospects for smallholders have been declining over the past decade in Malawi, as elsewhere in Sub-Saharan Africa. However, in Malawi this trend has been accompanied by the serious erosion of self-sufficiency of rural household food supplies, undoubtedly abetted by the incursions of AIDS on family labour supplies. AIDS-afflicted and bereaved families have been reducing their cultivated acreage and resorting to low-labour, less nutritious crops like cassava. To what extent the 2001/02 famine was a so-called 'new variant famine' is

indeterminable, but it is clear AIDS played a role in the famine's occurrence and prolongation in many households.

Starter packs of maize seeds have not proved to be a sufficient kick-start in the wake of famine. Lack of confidence in the adequacy of farming to ensure a self-sustaining livelihood has come to the fore. Farmers feel that they can no longer achieve their households' basic food security from their small plots following the removal of fertilizer loans. They now feel the need to continually supplement or even replace their farming efforts with *ganyu* casual labour earnings. Day-to-day food security becomes a question of obtaining immediate cash for food purchase through *ganyu* labour.

Asset-stripping of non-agricultural assets has become a notable feature of the AIDS epidemic. Now, complicated, opaque and interlocking contracts involving land and labour markets are emerging. Predictably land leasing and sharecropping arrangements are surfacing in a polarizing economic process in which so many smallholder farmers are becoming impoverished to levels of desperation while others, often urban-based patrons, are achieving sizeable rural asset accumulation.

Farmers are both politically as well as economically disadvantaged in this process. Their low levels of education and lack of awareness of the complexity of law, in a situation where customary law is now in a state of confusion, make them very vulnerable. The media should start to highlight the dangers of land leasing and basic education in land law should be offered through various media, be it schools or churches.[40] Rural households need to be aware of their rights as farmers and as citizens and be given bolsters to avoid having to relinquish productive control over their land to become hired labourers earning paltry wages on their own land. Efforts should be made to shift smallholder farmers from a position of depreciating their agrarian assets and renting or selling them far too cheaply to a position of deprecating asset accumulators and the circumstances which allow them to take advantage of their economic distress to amass wealth.

Rural smallholders as a whole saw the removal of fertilizer subsidies during the 1990s as a betrayal of their hard work and dedication to increasing harvested output. Smallholders need the government to recognize that the retention of peasant agriculture as a vast livelihood-provisioning sector is at stake. The fundamental fact is that broad swathes of farmers no longer have sufficient agrarian assets to secure their basic needs. Under these circumstances, subsidy of the rural smallholder farming sector is not only necessary but inevitable to avert humanitarian disaster. The choice at hand is subsidizing pre-harvest production costs in the form of fertilizer loans or subsidizing post-harvest consumer food distribution. Seen in this light, fertilizer loans are not only economically cost-effective, but they are the preferred political option averting the humiliation and demoralization of further famine relief. To reverse the rapid rate of deagrarianization and the downward slide of Malawian smallholders currently on-going, fertilizer loans need to be re-instated for a minimum of five years then reviewed as regards farmers' productive output and loan payback performance.

[40] It should be noted that the role of chiefs and headmen in land matters is traditional and may harbour a great deal of vested interest at this time. Farmers may not want the headman to be aware of their land negotiations in any case.

Furthermore, the liberalization trajectory that the Malawian government has been following in the last few years needs to be re-assessed. ADMARC, however imperfect in terms of its service to farmers, should continue to operate a dense enough network of buying posts to serve as an effective buyer of last resort, setting reasonable floor producer prices. These various measures are vital to the economic viability of the majority of Malawians who remain reliant on farming for their physical survival. In addition, retaining Malawi's maize-producing capacity in peasant hands will help to ensure urban food security nationally.

Rural households' diversification into non-agricultural activities, prompted by the short-circuiting of labour migration to South Africa and the declining prospects of tobacco as a viable cashcrop for smallholders, was given an enormous shove with the 2001/02 famine. Food insecurity is currently propelling most non-agricultural activity, as indicated by villagers reference to their 'looking for food' activities. Income-earning is now dominated by financially unrewarding *ganyu* casual labour as argued above. Women and young girls face even tougher *ad hoc* labour negotiations than men with the inclusion of transactional sex in *ganyu* contracts. The demoralization involved in this hand-to-mouth work life drives men and youth to alcohol thereby further fuelling the market for casual sex. It is in this environment of despair that AIDS is spreading. The pathways away from these circumstances are therefore outlined below in the discussion of changing rural attitudes and responses to HIV/AIDS.

2. Rural Communities Choosing to Live or Die: Getting HIV/AIDS under Control through Human Agency, Responsibility and Rights

A national AIDS policy was launched in October 1999 and updated in 2003. President Muluzi was strongly behind this policy initiative, stepping up efforts in the run-up to the May 2004 election. He directed his efforts at the stigma associated with AIDS. The plan has been broad based, aimed at: 1) mainstreaming awareness of HIV/AIDS in the public and private sectors, 2) health education and prevention programmes through advocacy of behaviour change interventions and 3) a comprehensive HIV/AIDS care and support programme beginning with the drawing up of guidelines and training manuals for the implementation of voluntary counselling and testing, community home-based care, use of anti-retroviral therapies and the treatment of AIDS-related diseases, notably tuberculosis.

The Malawian government has made tremendous strides in confronting the AIDS problem over the last 10 years. From too little attention, they now face a huge coordination challenge. Many foreign donors, NGOs and religious agencies are now involved in the fight against AIDS. The National AIDS Committee has the task of coordinating efforts and has received substantial funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. So political will and funding is firmly behind it. Ultimately, however, the prevention of AIDS depends on the entire Malawian population and their individual choices regarding sexual behaviour. The continuing stigma associated with disease, as described in this report, and the lack of reliable statistics on AIDS mortality and HIV prevalence, necessitate a lot of 'groping in the dark' in terms of efforts to prevent the spread of HIV/AIDS.

With regard to the rural incidence of HIV/AIDS, there is a particular need both to understand the forces propelling it and address it on its own terms rather than as an

off-shoot of the urban-based experience of AIDS. In the future, the majority of Malawians suffering from HIV/AIDS will be residents of rural areas with different lifestyles than their urban counterparts. Reaching them with effective AIDS prevention messages will require in-depth understanding of their prevailing attitudes and behavioural patterns.

Despite the political will, agency commitment and funding that have been mobilized, field evidence from this study and other current research suggests that there will be a continued steady spread of HIV in the Malawian countryside given the level of condom rejection and persistence of heavy drinking and transactional sex. With the escalating welfare crisis connected with widowhood and orphans associated with rising AIDS mortality, the level of human misery is likely to increase before it decreases. There is an urgent need to initiate a health education strategy directed at the rural population that will help them appreciate the power of their own agency and act to curb the spread of HIV/AIDS.

The following is intended as a sketchy outline of a possible health education strategy aimed at Malawian rural dwellers which could best be termed 'choosing to live or die'. The aim is for villagers to confront their own fatalistic beliefs and denial behaviour and discover that there are viable and even enriching alternatives. The discussion is organized around nine attitudes expressed by the rural population of Lilongwe district that we interviewed. Taking these as baseline views, we attempt to demonstrate how the denial and stigma that they reflect can be arrested and replaced with positive agency on the part of different segments of the rural population. The nine attitudes cover aspects of prevention, patient care and the aftermath of death in HIV/AIDS-afflicted households as follows:

1) *We all die sometime and we have no control over our death.*
2) *Dealing with the here and now of hunger is what matters.*
3) *Drinking is fun and helps us forget our problems.*
4) *Condoms are a government conspiracy.*
5) *Its better to use ARVs than condoms.*
6) *Its better not to know than know one's HIV status.*
7) *AIDS diagnoses cause individual patient distress and family discord and must be avoided.*
8) *Orphans' and widows' lives inevitably decline at the mercy of their extended families' good or bad will.*
9) *AIDS is here to stay.*

• '*We all die sometime and we have no control over our death': Confronting rural defeatism and spiritual fatalism*

Rural people's attitudes towards disease causality are heavily influenced by traditional and spiritualist beliefs that relate disease to disharmony and discord between the individual and the wider community that may or may not have been due to an individual's own action. A diseased body is thus an indicator of imbalance that needs to be cleansed to be rid of the pollutant and to place the individual back at one with his/her social environment. To those who see disease in this light, AIDS-related public health messages emphasizing sexual behavioural change to prevent disease do not strike many meaningful chords.

Traditional healers as well as Pentecostal spiritual healers, who are in many ways antagonistic to one another, have similar epistemological assumptions about disease. Given that they amount to an enormous cadre of personnel influencing rural people's perception of AIDS prevention and care, there is need for the government health services to have more dialogue with them to explore how individual agency in the prevention of AIDS can be accommodated in their health messages to rural people. Religious sanctions against condom usage should be discussed further in an attempt to eliminate the deadlock in which condom usage is portrayed as sinful.

It is not only religious beliefs that stand in the way of people's behavioural change to prevent disease. In a country with high mortality rates, recently compounded by famine, people live with death year after year, and feel powerless to do anything to prevent it. They must be challenged to overcome this defeatist attitude.

• *'Dealing with the here and now of hunger is what matters': Food security first*
This attitude is more than just fatalism. It reflects a practical reality for many rural households. The inadequacy of basic food supplies is such that people are forced to prioritize 'looking for food' which may entail compromising sexual behaviour. The issue of food security has been considered in the preceding section such that it is sufficient to reiterate its importance here to preventing the further spread of AIDS.

• *'Drinking is fun and helps us forget our problems': Finding alternative productive and recreational activities*
It is revealing that the link between heavy drinking and AIDS so rarely is mentioned, although most villagers readily make the link themselves (Bryceson 2002, UNDP 1999). It is well-known that complete prohibition of beer brewing and distilling would be entirely counter-productive, driving heavy drinking underground and making it even more uncontrollable in terms of its public health risk as well as the criminality which would ensue.

Alternatively, licensing and taxation of these activities communicates the message that drinking in excess is socially undesirable and economically punitive. The tax money could be invested in the village for other recreational activities such as sports, dancing, music, drama, etc. Playing fields could be better maintained, balls and other sports equipment purchased, and money could be on hand to fund teams to visit other villages for competitions. Villagers very much enjoy making contact with people outside of the boundaries of their villages. Thus if competitions could be organized for the best village singing and dancing groups, the best debating societies, the best drama society, and so forth. there would be a large number of social reasons for meeting with others besides drinking.

Income-earning alternatives to beer brewing and distilling, particularly for women, must be found. Besides their participation in road-building public works programs like the ones CARE has sponsored, it would be useful to broaden the range of productive activities that they, do making public works an opportunity for skills training as well as earning cash. There are also several services that women could offer without new training. In many West African rural areas there is a thriving market for food snacks. Rural women could start to create such a market. Other services that could be offered for cash based on their existing skills are sewing, hair dressing, midwivery, and others. The proliferation of such services could contribute to

enhancement of people's living standards and enjoyment of life amidst providing labour absorption in a flagging agrarian economy.

• *'Condoms are a government conspiracy to reduce our population': Alleviating the tension between traditionalism and modernism in local government*
This view of condoms, as elaborated in Section VI, is a take-off from rural people's historical aversion to family planning but also a view of the world that pits villagers against the outside world. It is a defensive attitude in which new ideas and practices introduced by the national government, or outsiders more generally, are seen to threaten the village's traditional ways. The village headman and local government are at the crux of the traditionalist versus modernist tensions that are so acutely experienced in rural Malawi. They are expected to carry out national government policies directed at modernization at the same time as they safeguard traditional customs. This muddled and untenable position is bound to generate irrational attitudes such as the view that condoms are a government conspiracy against the rural population. The discussion above about disentangling the roles of local leaders is pertinent here.

• *'Its better to use ARVs than condoms': Disentangling rural and urban health messages regarding prevention versus 'living with AIDS'*
The rationales for not using condoms are various. This statement sums up the 'back-to-front' reasoning. Religious authorities do not sanction condoms, which they see as part of licentious behaviour. Meanwhile ARVs are being hailed as a great step forward in terms of giving quality of life back to AIDS patients. Beginning in 2004, ARV therapy is being scaled up. Hitherto there were only nine sites offering ARVs, but in 2003, 3,700 patients started ARV treatment with a 3-in-1 tablet, bringing the total number of patients ever started on ARVs to 6,414 (Malawi, NAC 2004, 14).

However, a poor, rural-based country like Malawi is unlikely to be able to afford ARV drugs in sufficient quantities to reach a majority of its AIDS sufferers despite the now greatly reduced price of ARVS. Furthermore, the remoteness of the population, their lack of education and the extremely small number of western-trained medical personnel make the distribution of ARV drugs problematic even if they were generally affordable.

For the latter reasons it is likely that urban AIDS sufferers will be the first to benefit from ARV drugs and they will have far easier access. Media coverage has left matters of distribution vague. In the minds of rural Malawians these practicalities are subordinated to the fact that ARVs are now available and make AIDS a far less dreadful disease. To the list of rationales for not using condoms, the arrival of ARVs can be added, amounting to a profound misunderstanding harbouring dangerous false hopes.

At the moment, there are other media messages that are clearly aimed at an urban audience which unwittingly impart false hopes or fatalistic attitudes to rural people. This is especially the case with AIDS public health messages broadcast on the radio, the most accessible media for rural dwellers. One AIDS health education message broadcast on radio in March 2004 aimed at removing the stigma surrounding the disease. It gave a short biography of a beautiful girl, popular with everyone, who had done well in school and was a church chorister with a marvellous singing voice who

happened to be HIV positive. The message was that anyone can contract HIV. Unwittingly, this was reinforcing the view that HIV infection, disease and death can happen to anyone regardless of what they do in life, even those who lead model lives. This was no doubt a valuable message for an urban audience wracked with denial and in need of greater tolerance and sympathy. However, to rural ears it reinforces their fatalism and belief that nothing can be done to prevent the disease because it strikes with a will of its own.

There needs to be more media messages beamed at the rural population which start with the assumption that individual health depends on broader social community harmony, emphasizing that harmony and well-being depends on each and every person taking the responsibility to have safe sex with condoms or no sex. The notion that sex with condoms is unnecessary or a breach of trust between marital partners or people in love should be dispelled. Condom usage should be portrayed as a common sense survival measure akin to not crossing a road in front of an on-coming lorry. Of course, to mount such a campaign it would be necessary to ensure first that condoms were readily and abundantly available everywhere in the countryside, which is not the case at present. Condoms are commercially available but for those without money a packet of three condoms for 10 kwacha may be a prohibitive price. Free distribution of condoms through VACs in each village is advisable.

The 'positive living' approach that some local NGOs[41] are popularizing is relevant. This approach tackles physical as well as emotional and spiritual elements of living with HIV/AIDS. It is being introduced to HIV/AIDS service providers such as home-based care groups and counsellors. The approach deals with individuals, households and communities in the following spheres:

- Coming to terms with HIV infection through spirituality and emotional support from relatives, friends and church members.
- Future planning and goal setting which focuses more on what can be done rather than what cannot.
- Practical training in caring for an HIV positive person's health, covering proper nutrition, home gardening and low-labour irrigation and water/sanitation techniques.
- Advice on health-seeking behaviour, including appropriate and timely medical care and avoiding alcohol and tobacco.
- Guidance on exercise and relaxation to reduce stress levels and strengthen immunity .

• *'Better not to know than know one's HIV status': Confronting the reality of VCT programmes in rural vs. urban areas*

Rural people are neither eager nor readily able to get their HIV status tested given the relative inaccessibility of testing centres. The Malawi government has very stringent guidelines for VCT:

> Voluntary HIV Counselling and Testing (VCT) is the process by which an individual voluntarily undergoes counselling enabling him or her to make an informed choice

[41] Notably Umoyo Networks through Save the Children USA. There is still a long way to go before 'positive living' is included in national-level policy. CARE's Central Regional Livelihood Security project is planning to incorporate this approach.

> about being tested for HIV. According to UNAIDS Technical Update, May 2000, this decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential. Full VCT services involve pre-test counselling, HIV testing and post-test counselling. Consent for testing should be sought from clients before testing. Pre-test counselling and post-test counselling are considered mandatory. However, clients can decide not to be tested if not ready. Post-test counselling reinforces behaviour changes, provides support and discusses appropriate referrals. Some clients may come to VCT for information on HIV/AIDS or for ongoing counselling support (Malawi, NAC 2003:19)

There has been a leap forward in the number of VCT sites with 47 more sites added in 2003 allowing for an increase in the testing of antenatal attenders and hospital patients. However staffing of these sites remains fairly skeletal. There are 120 trained lab staff in 57 health facilities of which 59 per cent had previously received formal training in how to conduct whole blood rapid HIV testing. Testing facilities and testing procedures (one or two tests using parallel or serial tests) varied from place to place. Only 10 hospitals had HIV testing protocols visible in the lab, one had external quality control and in 15 per cent of hospitals visited test kits were sometimes out of date (Malawi, NAC 2004).

There are only 420 active VCT counsellors; 48 work on a full-time basis and 372 part-time. This number actually decreased from 2002 when there were 456 counsellors. Nonetheless, the number of HIV tests performed in 2003 had increased by 44 per cent (Malawi, NAC 2004: 16-17). Clearly staffing will have to be raised in the future. The guidelines indicate that the intention is to create a professional cadre and considerable hospital staff training is scheduled to take place from April to June 2004 (NAC 2003: 25).

In future, with the extension of the VCT sites still further it is intended that their location will be made in view of:

> …population density, high transmission areas, easy geographical access, distance from other services, potential for linkages to a network of providers for essential care and support services, inexistence of any other site in the immediate catchment area of 10,000 people in urban areas, and an 8 km radium in the rural areas. (NAC 2003: 17)

These are promising plans but widespread HIV testing in rural areas has yet to happen. The VCT policy of the Malawian government has set high standards of counselling that seem impossible to fulfil with the current staffing, let alone when VCT sites are extensively expanded geographically. It may be helpful to conduct research on VCT counselling in the rural context, taking account of the existing role of counselling performed by traditional and spiritual healers. This would help to design a counselling program that was conducive to the rural realities of medical staffing and rural people's attitudinal beliefs related to disease.

• *'AIDS diagnoses cause individual patient distress and family discord and should be averted': Shortcircuiting the impoverishing experience of households' medical search*
Rural medical personnel suspecting AIDS may choose to avoid telling patients their suspicions and instead advise them to get tested at a VCT site. Many rural patients are loathe to do so as mentioned above. The patient and his/her family generally are engaged in a succession of consultations with various traditional, religious spiritualist

and western medical personnel in which solace and hope rather than confirmation of infection and certain death are sought. As argued in Section VI, this search can be extremely financially draining on the household.

The more that VCT becomes physically accessible to rural dwellers the more opportunity households have to know the health status of the patient and better manage their meagre resources to meet the needs of the patients as well as their own future needs as family survivors of the bereaved. However, the physical accessibility of VCT is only one step. The current dilemma is rooted in the deep denial and stigma that still surrounds the disease. The patients' willingness to go for testing and their families' support vitally depends on the medical information derived from VCT being couched in a cultural context that people find acceptable. This should involve traditional and spiritual healers as facilitators in one or another capacities.

• *'Orphans' and widows' lives inevitably decline' at the mercy of their extended families' good or bad will': Promoting productive support for widows and orphans*
Not all extended families are able to cope with the full financial and humanitarian burden imposed by the AIDS welfare crisis. While many are managing admirably despite severe material constraints, others are failing to provide adequate food, clothing and shelter and may even be exploiting orphan labour or crushing their spirit with humiliation as second-class family members.

Schools need to be enlisted to take a more active part. They could provide an orphan welfare alert system reporting cases of abuse to the VAC and village headman for remedial attention. More proactively they could be used to launch a special job training and job-organizing service to enable orphans to earn income as an alternative to low-paid, demeaning *ganyu*. Such work could take some of the financial burden off their host families and give the orphans some status within the village community.

The basis for job-training would be to start provisioning villages with a far wider range of goods and services approximating that available in urban areas. The groundwork for this would be to get a fleet of bicycles owned by the school (or some other viable arrangement) that the orphans rented in order to provide villagers with a taxi and cargo hire services to and from their village and market centres or towns, along the lines of what exists in terms of the now famous *boda boda* bicycle taxis of Uganda (Bryceson *et al*. 2003). The bicycles would be fitted with special seats, carriers, and could even be adapted as a bicycle ambulance to transport the sick to medical centers.

Such transport services could boost trade as well as provide a stimulus for other services. Orphans could be trained in various occupational skills ranging from hair-dressing, large-scale catering for weddings and funerals, furniture-making, making children's toys, etc. The array of goods and services that are not available in villages at the moment make the list seemingly inexhaustible.

The issue of lack of purchasing power necessarily arises here. Public works programs help to pump cash into a community. An exchange voucher scheme could be set up in which villagers who joined a cooperative would receive coupons that acted as promissory notes of a particular denomination of currency that they could use to exchange local goods and services amongst each other. More generally, such a

system, if properly administered, could help to build the local economy, community interaction and alleviate exploitative *ganyu* practices as people would have an economic alternative to relying on exploitative wealthy patrons.

• *'AIDS is here to stay': Fighting AIDS in Malawi depends on every single person doing their part*

The fatalistic attitude voiced by rural youth that AIDS is here to stay has to be confronted with a coordinated program that gives everyone a salient role to play in the struggle against HIV/AIDS. At the national level, media messages and programs must take account of villagers' attitudes and circumstances. Village leaders need to be clear about their role as guardians of cultural mores and sexual morality that are conducive to AIDS prevention. School teachers need to be more involved in AIDS prevention instruction and providing educational and occupational support to orphans. Traditional healers and religious leaders, which the rural population refer to for medical treatment or counselling, need to be given more legitimacy and guidance on how to contribute positively to AIDS prevention within rural communities. Finally the rural people of both genders and of adolescent ages upwards should be left in no doubt that ultimately their sexual behaviour determines whether they live or die as individuals and as a community.

XII. Conclusions and Quandaries

The majority of Malawian population are HIV negative and live in rural areas on the basis of insecure agrarian livelihoods. They, however, face a high risk of contracting HIV/AIDS. Convincing AIDS prevention messages tailored to their circumstances, attitudes and capabilities need to be beamed at them in various innovative ways. Furthermore the people who form the local service network in the fields of health, education and spiritual guidance need to be full participants in this process. Currently, traditional leaders labour under the accumulated burden of conflicting traditional and modern roles that they cannot possibly fulfil adequately, whereas traditional healers have been largely circumvented.

Meanwhile, one of the big quandaries is not having reliable statistics to know what direction the disease is taking in terms of the evolving pattern of HIV prevalence and AIDS death. Regular random-sample medical surveys with supporting social surveys could provide a better indication of the changing nature of the pandemic and facilitate the design of disease prevention and AIDS patient programs.

As HIV/AIDS rural morbidity and mortality spreads and affects proportionately more and more women and children as well as men, the family welfare crisis is bound to deepen in the countryside. Malawi's national, regional and local policies have to be multi-faceted and ever more sensitive to ways and means of circumventing the erosion of Malawi's agrarian communities by providing measures to: first, effectively prevent HIV/AIDS through unambiguous health education messages that the rural population can understand; second, encourage the moulding of rural norms around 'positive living' and compassionate community interaction to deal with HIV/AIDS morbidity and mortality; and third, guide communities to restructure their rural land, labour and capital assets in the aftermath of AIDS death in a way that sustains agrarian livelihoods for the next generation.

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Appendix 1: CARE Social Pathways Project Field Methodology

Study Objectives: Overall

To provide documentation with regard to the stages of HIV/AIDS progression and the negative effects of denial, i.e. the 'conspiracy of silence', is having on:

- Fueling the transmission of the disease;
- Exacerbating the suffering of patients and their families during the disease infliction; and
- Perpetuating the social stigma on the family survivors of the AIDS victims

To find pathways leading away from the above 3 undesirable outcomes towards informed decision-making and active agency based on the social responsibility embedded in a human rights approach.

Consultation with several categories of village residents:

1) VILLAGE LEADERS – 30 minutes
2) HEADMASTERS – 90 minutes
3) PRIMARY SCHOOL STUDENTS – over 13 and articulate – 60 minutes
4) ORPHAN NON-SCHOOL ATTENDERS – over 13 and articulate – 60 minutes
5) DETAILED CASE STUDIES OF RECENTLY (1-3 MONTHS) AIDS BEREAVED FAMILIES – 120 minutes
6) VAC INFORMANTS – 120 minutes
7) COMMUNITY FGD OF MEN – 120 minutes
8) COMMUNITY FGD OF WOMEN – 120 minutes
9) CONVENTIONAL MEDICAL DOCTOR - 60 minutes
10) TRADITIONAL MEDICAL DOCTOR – 60 minutes
11) RELIGIOUS LEADERS (representing the most heavily subscribed religion in the area) – 45 minutes

Study Objectives: Specific Objectives, by Progressive Stages of the Disease Experience and Its Long-term Aftermath

Stage 1: Disease Transmission

Objective 1: To explore psycho-social and economic causes and consequences of HIV/AIDS individual denial and fatalism amongst the following segments of the population:

- men
- women
- students

Interviews involved:

1) HEADMASTER INTERVIEW
2) VAC GROUP INTERVIEW
3) COMMUNITY FGD OF MEN
4) COMMUNITY FGD OF WOMEN
5) RELIGIOUS LEADERS INTERVIEW

Objective 2: To explore recreational patterns, including alcohol consumption, related to the spread of HIV/AIDS amongst:

- men
- women
- youth

1) HEADMASTER INTERVIEW
2) STUDENT INTERVIEW
3) ORPHAN NON-STUDENT INTERVIEW

Stage 2: Disease Affliction

Objective 3: To document the loss of livelihood arising from the disease with reference to suffers and carers:

- loss of labour time in agriculture
- loss of other income sources (remittances, trading, etc)
- loss of productive & household assets

Interviews involved:

1) VAC GROUP INTERVIEW

Objective 4: To explore the medical diagnosis/referral system and its relationship to asset-stripping in the households of AIDS sufferers:

- common diagnosis of AIDS symptoms at different stages of the disease
- paths of AIDS sufferers' medical consultation by gender and age

Interviews involved:

1) CONVENTIONAL MEDICAL PERSONNEL
2) TRADITIONAL MEDICAL PERSONNEL

Objective 5: To document the economic costs of funerals incurred by families of AIDS suffers and the incidence of streamlining adjustments over time.

Interviews involved:

1) DETAILED CASE STUDIES OF HH'S EXPERIENCES OF AIDS DEATH
2) VAC INTERVIEW
3) COMMUNITY FGD OF MEN
4) COMMUNITY FGD OF WOMEN
5) RELIGIOUS LEADERS INTERVIEWS

Objective 6: To explore changing inheritance patterns related to the weight of HIV/AIDS deaths with reference to:

- land and household assets
- who makes the inheritance decisions
- their immediate and long-term effects on nuclear families vs. lineage members

Interviews involved:

1) HEADMASTER INTERVIEW
2) COMMUNITY FGD OF MEN
3) COMMUNITY FGD OF WOMEN

Stage 3: Aftermath of the Disease and the Creation of New Family Forms

Objective 7: To explore the pattern of decision-making intervention in family reconstitution in the aftermath of AIDS death in relation to the three basic outcomes:

- reformed single-headed households
- reformed child-headed households
- dispersal of original household members and absorption into other families

This will entail tracing the role of key actors e.g. the original marriage negotiator (brother or uncle) in matrilineal and patrilineal systems, village heads, and other specified actors.

Interviews involved:

1) HEADMASTER
2) ORPHAN NON-SCHOOL ATTENDERS
3) COMMUNITY FGD MEN
4) COMMUNITY FGD OF WOMEN

Objective 8: To identify the range of new family forms and their per cent representation in the village.

Interviews involved:

1) VILLAGE HEADS INTERVIEW
2) HEADMASTER INTERVIEW
3) RELIGIOUS LEADERS INTERVIEWS

Objective 9: To explore access to public services (health, education & extension) by different family forms.

-Village heads interview
-Headmaster interview
-Conventional medical personnel

Interviews involved:

1) COMMUNITY FGD MEN
2) COMMUNITY FGD WOMEN

Appendix 2: Household Survey Questionnaire

Q1 HOUSEHOLD LOCATION/RESIDENTS

Survey No.		Interview Location	
Date		Years HH in present location	
Enumerator		No. Resident in HH	
Interviewee (Sex/Age)		No. Absent HH members	
FAMILY SURNAME			

Q2 HOUSEHOLD NON-IMMEDIATE FAMILY		***Orphans*** (Write information in rows 1-8 below)					School	
Others	***Write #***	no	*Sex/Age*	*Entry mo/yr*	*Relation to HHH*	*Work activity*	*Attend*	*Level*
Live-in servants		1						
Lodgers		2						
Others (specify)		3						
		4						
		5						
		7						
		8						

Q3 IMMEDIATE HOUSEHOLD COMPOSITION
(list members beginning with HH Head, Senior Wife, then in order of age, marking spokesman with *)

MARK* Spokesman	FIRST NAME (optional) list members' names in order of age beginning with HH Head, Wife, etc	SEX	AGE	*WHERE RESIDENT* H-in HH OR-other rural OU-other urban **OF-other foreign**				Months AWAY	RELATION to HH Head	BIRTHPLACE (District)	Year of ARRIVAL in village	ETHNIC GROUP (Matrilineal or Patrilineal)	Attends School	EDUCATION LEVEL attained	HEALTH (CI, II, OK)	CASH and IN-KIND EARNING ACTIVITIES (List all over last year in order of income earning magnitude)
				H	OR	OU	OF									
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																
13																
14																
15																

Q4 WHAT HAS BEEN THE HOUSEHOLD'S MAJOR JOY OVER THE LAST 5 YEARS?

Q5 WHAT HAS BEEN THE HOUSEHOLD'S MAJOR SADNESS BEEN OVER THE LAST 5 YEARS?

Q6 FAMILY DEATHS OVER LAST 10 YEARS

	Deceased's Year of Death	Sex	Relationship to HH Head	Age at Death	Duration of Illness [months]	After Effect on Household?
1						
2						
3						
4						
5						
6						
7						
8						
9						

Q7 HOUSEHOLD EXPERIENCE DURING HARVEST YEARS OF 2001/02

Quality of Harvest (good, poor, etc)	
Did HH undertake Remedial Measures? What?	
What family help did HH receive?	
From whom? (Relationship to HHH? From in or outside village?)	
What external (non-family) help did the family receive?	
From whom? (Specify agency)	

Q8 WHEN HOUSEHOLD IS IN NEED OF HELP WITH FOOD, WHO DOES IT FIRST SEEK HELP FROM? SPECIFY RELATIONSHIP
