



The Effects of Increasing Rates of HIV/AIDS-related Illness and Death on Rural Families in Zomba District, Malawi: A Longitudinal Study

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Summary

The research, conducted from January to December 2006, investigated the effects of the HIV epidemic on a Zomba District sample of households that has been studied since 1986. The sample families follow matrilineal and matrilocal patterns of organization: descent and inheritance are traced through the mother's line, and husbands move to their wives' village on marriage. Land is inherited by female heirs and sons are expected to use their wives' land. The research used multiple methods - ethnography and questionnaire surveys. Results included that 50% of the sample households had had at least one death due (certainly to likely) to HIV/AIDS; and 29% were taking care of orphans during 2006. A central conclusion is that the matrilineal family continues to be the major, frequently sole, support to bereaved households. Without the mobilizing power of the matrilineal family, there would be far more homeless orphans, and far more acutely distressed individual persons and households. That the extended matrilineal family is able in most cases, so far, to absorb most of the very high costs, material and otherwise, of the epidemic should not be assumed to be 'the' case for all of Malawi, still less for Africa. Many extended matrilineal families are already very stretched, and, in light of the increasing numbers of sick and dying people, without improvements in the services to help them increase their income level, their capacity to care for the increasing numbers of sick and of orphans, and to gain more equitable access to medical care, some may find it difficult to maintain their roles as primary caretakers.

The study supports those that have found considerable heterogeneity across households in terms of their ability to deal with the HIV epidemic, and a very low rate of household dissolution. The better-off households (with higher levels of resources and income) have, on average, been more able to absorb the effects of AIDS illness and deaths. About a quarter of adult deaths attributable to HIV/AIDS were of the principal couple – the key woman and husband. The immediate impact of such deaths is often acute, with reduced cultivation time and harvests, loss of other sources of income, and rising costs, financial and other, in caring for seriously sick people and in organizing funerals. However, in the large majority of cases, the households did not dissolve and were taken over either by a surviving wife who often remarried within a few years, or by adult daughters, sister's daughters and a few sons. Any orphans were shared out among relatives and land was taken over by the female heirs. There were no cases of 'land-grabbing'. While there was ambivalence and tension around deaths attributable to AIDS, the study found no evidence that 'HIV widows' faced any more 'stigma' or suspicion than any others.

Much of what the Zomba villagers do can be usefully seen as striving for normality. Rather than denying the abnormal circumstances of the rising toll of HIV-related illness and death, they might better be seen as trying to control those circumstances, making huge efforts to channel them into the normal and normative ways of their society. The ambivalence about naming the disease in relation to relatives, friends or others well-known to the speaker is better seen in terms of normalization than 'denial'. Other efforts to normalize the stressful situation can be seen in the various interpretations given to illnesses and deaths associated with HIV infection. Some who avoid naming AIDS quietly accept the cause of the illness and death of a relative as due to the 'new disease' (*matenda a tsopano*). Other posited causes include the malevolence of others,

glossed as witchcraft, and the identification of a well-known sickness syndrome called *kanyera* that long predates the AIDS crisis. Fundamentally, most of the strain caused by AIDS illness and death, especially in the medium to longer term, is due to the preexisting and continuing levels of need and poverty at household and family levels and of acute shortages at institutional level. This conclusion points to the need to forge a stronger link between HIV/AIDS policy responses and general social and economic policies, particularly to improve people's access to food.

There is also evidence of change: while the level of voluntary testing is still extremely low, there have been increases in the availability of testing in the rural areas; some people are paying more attention to the known behavior of their spouses, friends, and neighbors and making changes in their own practices, such as young people not engaging in sex too early or too often, and adults holding each other to stricter standards than before.

No cases of orphans being put in orphanages arose in the sample and our findings on the importance of the extended family in taking care of orphans raise questions about the emphasis placed on orphanages in national and international efforts to date. The study suggests that a myopic focus on orphans as individuals may displace the efforts needed to provide aid to families who care for orphans. In spite of the vast amounts of funds pouring into Malawi for orphans, there are very few services actually reaching orphans and the families who care for them in the research site. The number of orphan care groups has proliferated over the past five years as a result of the availability of grants, but 'on the ground' delivery of real services to orphans and their families remains tiny. Even less help is received by families caring for AIDS sufferers. There is also an over-reliance by donors and government on setting up community organizations to provide voluntary care and services to those affected by HIV-related illness and death. First, this ignores the fact that virtually all care and cooperative effort in villages are already (and always have been) 'voluntary', even though they have not been labeled such. Second, the large grants given to community groups to set up business enterprises intended to provide a 'sustainable' source of funds for service delivery are inappropriate for most cases.

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I Introduction

Research site and design

The primary purpose of the research conducted from January to December 2006 was to investigate the ways in which the HIV epidemic was playing out in a Zomba District sample of households that had been studied since 1986. The single most important characteristic of this research is that we have information on the same households for twenty years, a span of time for a longitudinal study that we believe to be unique in current research in Malawi. After the initial research in 1986, additional full twelve-month rounds of research were conducted with the same sample in 1990 and 1997, with shorter visits to part of the sample between 1993-6. The data and analysis provided in this report concentrate on the households who were in both the original 1986 study and in the 2006 study; these are referred to as the 'core' households or sample.

The original sample of households was selected in 1986 through a combination of maps, village lists, and visits to villages to select households. The households were purposively sampled to include roughly equal proportions of tobacco growers (growing dark-fired tobacco in 1986 and mostly burley tobacco since 1990), "large" maize growers, and "small" to "medium" maize growers. Since everyone grows maize, these last two categories translated into those with relatively large and those with relatively small land-holdings in the villages.¹ All households selected also had at least one child under six years of age because one of the indicators of welfare was anthropometric measures of young children. The overall outcome of the selection, as expected, was to over-represent the better-off families. Even though the sample includes very land-short and poor households, this point needs to be remembered in reading sample averages.

The resulting six village clusters are situated in an area bounded on the west by the main Zomba-Blantyre tarmac road and, on the east, by the dirt Zomba-Phalombe road, in an area roughly 25 miles by 15 miles (see Figure 1, next page). A graded dirt road (of highly variable quality across the seasons and years) runs through the middle of the research area, linking Thondwe on the tar road with Jali on the Zomba-Phalombe road. Three main market or trading centers (Thondwe, Dzaone and Mayaka) are found along this road where there are clusters of stores and where periodic markets meet twice a week. These and several other smaller village markets were the centers where local farmers buy and sell farm produce as well as other items. Prices for maize and selected crops were collected monthly in the three main market centers.

Most of the research area was once part of the huge Bruce estate that from the 1940s was broken up into smaller estates. From the 1950s and 1960s on, most was converted to 'customary' land, with some areas in the western section converted to small freehold and leasehold estates owned by Malawians. The people now living in the area describe themselves as descendants of Nyanja, Lomwe (who came in from what was Portuguese East Africa from the late nineteenth century), and a few Yao. They follow matrilineal and matrilocal (uxorilocal) patterns of organization; that is, descent and inheritance are traced through the mother's line, and husbands are expected to move to their wives' village. This is also the reality for most so a child grows up surrounded by

¹ The aim of the first study was to compare 'commercial' or 'cash-crop' farmers with others; this was defined as producers of non-food cash crops, particularly tobacco, (all of whom also grew food crops) with producers of food crops only.

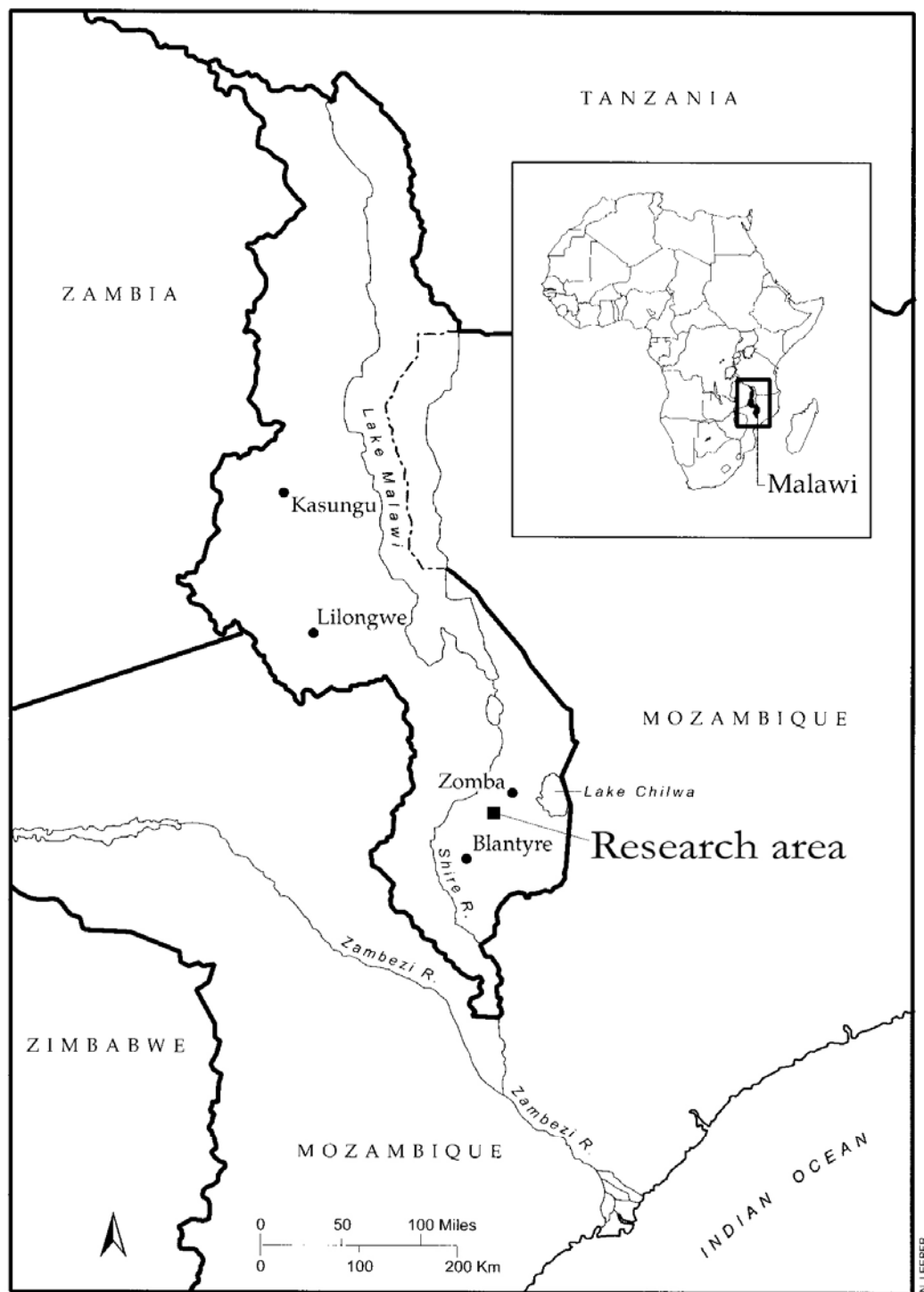


Figure 1: Zomba research area

his/her mother's kin, although, since most marriages are between neighboring families, the father's family may not be far away. As in most matrilineal societies, the conjugal bond is generally frailer than the sibling bond so that many marriages end in divorce and many adults have several partners throughout their lives. There are several implications of these patterns, the most important of which is that most women are living and working on their own land and most men are living and working on their wives' family land. While this does not mean that men have no incentive to invest in farming (contrary to a still current prejudice often aired in the literature but also in Malawi itself) it does mean that women have much greater security over land than in many other areas of Africa. They also wield considerable authority over family matters within their matrilineage and, hence, more broadly in the villages, since the chiefship is also inherited through the matriline.

Methodology

The methods of the study combined ethnography with repeated questionnaire surveys, as in all previous years (1986, 1990, 1997). Research assistants lived full-time in the sample villages and the senior researchers spent part of each week in the villages.² The 2006 surveys included the following: baseline; a repeated (5 times across 12 months) survey on expenditures, income sources, food supply, and morbidity; fields and crops grown; harvest; tobacco club membership and sales; labor/work; and assets. The ethnography was carried out mainly by Peters and Kambewa though the research assistants were also trained in basic qualitative methods, including keeping detailed accounts of observations and conversations in the villages.

The research was designed and conducted on the basis of complementary and integrated methods of data collection in order to facilitate interpretation and analysis of the data. While survey methods produce quantitative data that can be statistically assessed for significance, often the most convincing among competing interpretations of relationships or their absence cannot be determined from those analytical procedures alone. Information gathered through ethnographic methods, based on residence and participation in village life, is essential to guide the appropriate interpretation of quantitative data. Conversely, an understanding of patterns of social relations in work, food consumption or marketing derived from the ethnographic analysis is based on necessarily non-random sets of individuals and families. Therefore, the research was designed to benefit from multiple methods of data collection and of analysis.

While all the earlier years of research among the Zomba sample families has held to the importance of including ethnography as a major form of research, the focus on HIV/AIDS made it even more crucial. Several leading commentators on HIV/AIDS in African countries have stressed the critical role ethnography can play in documenting the shape and effects of the pandemic (see Ashforth, de Waal, Fassin). Some stress that ethnography is especially needed because the bio-medical approach has promoted strictly behaviorist methods with counter-productive results. As Packard and Epstein say, "The medical research community expected the social scientist to adhere to the dominant

² In 1986 and 1990 Peters lived in one of the villages, in 1997 she lived in Thondwe, a few miles from the nearest sample village, while in 2006 she lived in Zomba town, as did Kambewa. In 1990, Walker lived part of the time in a sample village, part in Zomba town, and in 1995-6 did part of his doctoral research in another of the sample villages.

behavioral model. Constructed in this way, the question immediately narrowed the range of sociological data relevant for the discussion. It became not: ‘What is the social context within which HIV transmission occurs in Africa?’ but rather: ‘What are the patterns of behavior which are placing the Africans at risk of infection?’ While the first construction would have allowed for open-ended discussion of a wide range of social, political and economic conditions that might be affecting health levels in Africa, the latter formulation quickly narrowed discussion to an inquiry into the ‘customs of the natives’” (1992: 354).

The main problem with limiting enquiry to the patterns of risky behavior is that very often the conclusion is a version of a frustrated complaint of ‘why don’t people change their behavior?’, so tending to end up, willy-nilly, in ‘blaming the victim’ (Fassin 2006: 25). Some of the most insightful studies of the ways in which people are living and dying in the HIV/AIDS pandemic ask other questions: why are people saying or doing x or y? with what effects for themselves and for others? what do people think about the situation and how do they respond to it? Moreover, detailed and ‘fine-grained’ ethnography is needed to assess the very different situations that are lumped together in most accounts of ‘the HIV/AIDS pandemic’ or, as de Waal says, “if we are to understand the scores of subtly different epidemics across Africa” (2006: 19).

The ‘core’ sample of households

From the original sample of 215 households selected in 1986, 174 (80%) were able to be included in the 2006 research. Of the 41 households no longer in the sample, we have no information for 14 households who were not found again in 1990³; they represent 6.5% of the original 1986 sample of 215. Twelve households (5.6%) moved due to divorce and remarriage, a decision to move to the other spouse’s home, or because of finding work or land elsewhere. Thirteen households completely dissolved, 6 through a non-HIV death, and 7 almost certainly due to the effects of HIV/AIDS. This total of 7 constitutes just over 3% of the original sample. It is important to note that five of these seven were households where the wife lived in her husband’s village, very much a minority pattern in the research area. On the death of the husband, any surviving wife and children returned to the wife’s home where the children belonged. Thus, while the household was recorded as ‘dissolved’ for this study, the surviving members would have formed (or joined) another household in a different area. Two other households (0.9%) refused to be included in the 2006 sample.⁴

Of the 46 households added in 1990 and 1997, ten (22%) were not in the 2006 sample. Three of these had dissolved through death (6.5%), one of them almost certainly of an HIV-related death (representing 2% of the 46). Two of the other households were headed by adult daughters who merged with their elderly mothers, also in our sample (thus they were not ‘lost’ but absorbed into existing households). One family left for the

³ They are evenly distributed across income quartiles and headship types.

⁴ Both refused during the course of a preliminary round of visits in 2005 prior to the beginning of the research in January 2006. In one, the key woman was extremely angry about the fact that a few weeks earlier, her husband of many years had left her, and she said she was ‘tired’ of being questioned (her neighbors told us about her anger and distress over her husband). In the other, the key woman, who had often been rather difficult in previous years, merely said she did not want to participate any more.

spouse's village, one left because of a change in job, one refused to continue as a respondent ⁵, and we had no information on two households (4.3% of the 46).

Of the 174 households who were in the 1986, 1990 and 2006 studies, 8 were not available in the 1997 study: seven due to absence from the villages (usually due to change of marriage or job), while one household on the death of the key woman (mother) merged with another sample household (mother's sister) but then separated again in 2006.

For the purposes of quantitative analysis, these 174 households were reduced to 171 because of insufficient survey data for 3 households, two because of death of the key person during 2006 (one certainly of HIV/AIDS, the other probably so), and one because of repeated absences from the village.

Units of analysis and social dynamics

A key unit of analysis in this research is the household (*banja*). This is for two reasons: the household is a key unit in the social organization of life in Malawian villages, and it is the unit used in all the quantitative data deployed by government, donor, NGO and research centers in the country. The majority of the information, quantitative and qualitative, on which this report is based comes from the sample households.⁶ But it is essential to emphasize that these households are embedded in broader networks. They form part of clusters of households who are connected by relations of kinship, marriage, neighborhood, village, and friendship. The matrilineal-matrilocal pattern dominating in the research area means that the 'key woman' in a household is living near sisters, mother's sisters' daughters, and mother's mother's sisters' daughters (cousins of various degrees according to the European system but referred to as sisters). The clusters are not identical with the matrilineal groups because not every sister or cousin within a group interacts with every other relative. Sister A might interact mostly with sisters B and E and cousins R and S but only periodically or rarely with sisters C and D and cousins T and V. Male siblings and cousins usually leave for their wives' village on marriage though some marry within the village and most retain contact with their sisters. They also return home to live between marriages or, as we shall see, during serious sickness. Throughout life, matrikin provide the surest support and the closest ties to a person, though they are also the main rivals in competition over land, wealth, and status and, therefore, among the suspected purveyors of sorcery and witchcraft.

Children move across households for play and for food as well as to give help (a child may be sent to accompany his/her grandmother to the market or to draw water, for example). There is both a positive value given to having a viable, independent household (visually marked by a separate granary, kitchen, basic tools and utensils, and food supply), and a great deal of cooperation among these independent units. The cooperation

⁵ The husband in 2006 told us half way through the year that he was tired of participating because he was not receiving any benefits. A long conversation with him revealed that he was angry at the fact that several (un-named) organizations had come to their compound, taking the details of the polio-crippled daughter of his wife. Despite our protestations that we had nothing to do with these groups, he was insistent that without specific material benefits from us, he would not participate. His wife remained silent during this conversation.

⁶ The household is based on a 'key woman' since the large majority of women are living on their own matrilineal land; a married key woman and husband = a joint-headed household.

takes place in routine tasks such as women relatives and friends taking turns to brew and sell beer (so as not to compete for the same clientele) or to process crops; and particularly in times of crisis or need, such as births, illness, and death. Individual households are also involved in collective activities such as the yearly grave-yard cleaning, funerals, memorial feasts, projects of road building or boreholes, and in cases in the chief's court. In short, the ability of a household to be 'independent' depends not only on the key members (key woman and husband usually) but also on the supportive relations with other households. While most of these are nearby, some are the households of adult children or siblings who live and work in towns. People, goods and information flow between these connected households and may be seen as the 'lifeblood' of social organization in Malawian villages.

Emphasis is placed on this fact – that households are part of larger networks on which they depend and which they, in turn, sustain – because the effects of HIV/AIDS on individuals and households cannot be understood without recognizing the importance of connections between households. In particular, the research shows the resilience and flexibility of the wider 'extended' family which in this area is a matrilineal family. Without this flexibility and 'absorptive' capacity, there would be far more households that have 'dissolved' or ceased to exist, there would be far more child-headed households, and there would be far more seriously distressed households. While one cannot underestimate the material losses, let alone the grief, of those directly affected by HIV/AIDS, the wider family can be seen as the key provider of care for the sick, the dying and the living survivors, and a bulwark against massive deprivation in this research site. What this specifically means is that the vast majority of care to the sick, bereaved and orphaned is given by the wider family; that existing households within a matrilineal family reorganize themselves in response to the sickness and death of an adult member and to the needs of orphaned children; and that land is not left unused because its 'owner' dies but it is given to another member of the matrilineage, first to the heirs of the deceased but if they are too young then to a close relative to use until the heirs are of an age to need the land.

The way in which this population has responded to and is living with the HIV epidemic has to be understood in the context of a densely populated area, where land is short and in huge demand. Therefore, our finding that the extended matrilineal family is able in most cases, so far, to absorb most of the very high costs, material and otherwise, of the epidemic should not be assumed to be 'the' case for all of Malawi, still less for Africa.

It is also essential that these findings be placed within their real time frame. The phrase 'so far' just used, refers to the fact that many extended matrilineal families are already very stretched, and without improvements in the services to help them increase their income level, their capacity to care for the increasing numbers of sick and of orphans, and to gain more equitable access to medical care, some may find it difficult to maintain their roles as primary caretakers.

First, there is the obvious fact that chronic illness and deaths continue to rise (even if the national HIV infection rate, currently at 14%, were to level off) which means that individuals, households and families are facing a rising burden in terms of costs in resources and time for caring for the sick, preparing for and attending funerals, taking in orphans, and so forth. Second, many of the caretakers are people, especially women, in

their late fifties and older. As these caretakers age, the burdens will also increase for the next age cohort, which has a much higher rate of HIV infection. It is possible, therefore, that the current remarkable ability of matrilineal families to manage much of the impact will be further stretched and undermined.

Moreover, there are cross-household or intra-societal effects at play. As discussed later, the better-off households (those with higher levels of resources and income) have, on average, been more able to absorb the effects of AIDS illness and deaths. But if an increasing proportion of these households lose people, cash and time to HIV/AIDS, then not only are the households themselves affected, and not only are the households related to them through the matrilineage affected. Their losses have broader implications because these better off households play important roles in local relations of production, distribution and consumption. It is precisely the better-off households who are the producers of true 'surplus' maize which they store and sell in much bigger quantities than the majority of sample households; they are also the larger-scale producers of burley tobacco and other cash crops. Declines in their ability to produce large surpluses may reduce local supplies of maize; and will reduce the likelihood of their hiring people for food in the deficit season (which, while not equitable, nevertheless serves as a resource for some of the poorer). Additionally, their reduced overall income level will necessarily cut their expenditures, many of which have been for local products (furniture, beer, mats, baskets, pots, store goods, etc) and services (building, well-digging, tailoring, carpentry, etc). In short, the socio-economic links between the better-off households and others mean that major losses among the better-off minority do not augur well for the poorer.

The obvious conclusion is that the continuing ability of the extended family to take on responsibility for caring for increasing numbers of sick and dying people and for orphaned children is not guaranteed and requires more effective socio-economic development to improve their access to food, income, and public services.

II Striving for Normality in Abnormal Times

The HIV epidemic is unlike other epidemics people have known in Malawi: it affects the people who are normally most healthy and strong – those from the late teens up to fifty; it is a sly, secret disease often not showing itself in serious symptoms till years after initial infection (so people don't know when they get infected); it is primarily transmitted through sexual contact yet, unlike the more common STIs, does not center on the sexual organs; it has no known cure and, in sounding the knell of death, deprives victims and relatives of hope; and it is fast moving once it takes hold in a population, and is producing unprecedented levels of illness and death.

People in the Zomba study feel themselves to be living in abnormal times. Even without the epidemic, people have been struggling to achieve a decent livelihood for their families with many unable to obtain even the basics of sufficient food, shelter or clothing. Their problems are inadequate land in terms of size and fertility, lack of cash or credit to obtain the necessary inputs for permanently used land, too little employment to supplement their earnings from agricultural produce, and many health risks but low levels of health care available to them. Many people suffer acute food shortages and income loss in years of too little or too much rain, when drought or flooding produce little harvest, and in face of frequent shifts in agricultural and development policies that exacerbate rather than relieve farmers' conditions.⁷

How are people in the Zomba study dealing with the unprecedented rise in illness and death among their families, friends, and neighbors? How can they hope to do so in face of the existing low levels of resources, assets and income? The answer is mixed. People as individuals and as households are mobilizing considerable family support in their efforts to care for the sick and orphaned and to deal with loss of income, but at considerable cost to themselves and with little to no help from institutions outside the family.

The study supports those that have found considerable heterogeneity across households in terms of their ability to deal with the HIV epidemic, and a very low rate of household dissolution (Mather et al. 2004). This is partly due to preexisting levels of resources, with the better-off more able to support the increased costs of care and of death, and partly to the fact that households are not solitary units but part of extended matrilineal families that adapt and reshape themselves in relation to loss and crisis. About a quarter of adult deaths reportedly attributable to HIV/AIDS were of the principal couple – the key woman and husband. The immediate impact of such deaths is often acute, with loss of cultivation time and hence of harvests, and loss of other sources of income, and rising costs, financial and other, in caring for seriously sick people and in organizing funerals. However, in the large majority of cases, the households did not dissolve and were taken over either by the surviving spouse who often remarried within a few years, or by adult daughters, sister's daughters and a few sons. Any orphans were shared out among relatives and land was taken over by heirs (usually daughters). There were no cases of 'land-grabbing' but the land of deceased persons followed the customary routes to appropriate heirs. Widows of men known or suspected of dying of AIDS were treated no differently from other widows, the same being true of widowers. There was certainly ambivalence and tension around deaths attributable to AIDS, as discussed fully later, but

⁷ See Peters 2006 for a more detailed analysis of these points.

the study found no evidence that ‘HIV widows’ faced any more ‘stigma’ or suspicion than any others. There is no doubt that the strongly matrilineal and matrilocal practices of the area, whereby women are seen as the ‘builders’ of the lineage and village and husbands are expected to live in their wives’ villages, are the reason for this lack of special suspicion and animus towards widows. In the minority of cases where wives are living in their husbands’ villages, after the death of a husband, the widow returns to her own natal village with her children.

A central conclusion of the Zomba research is that the matrilineal family is doing a remarkable job of providing support to bereaved households. Without the mobilizing power of the matrilineal family in the research villages, there would be far more homeless orphans, and far more acutely distressed individual persons and households than there are now. An index of the central role of the wider family in supporting individual households is that out of fifty seven households who had experienced an HIV-related death over the previous five or six years, only four (7%) could be defined as experiencing acute distress.⁸ Two of these have been poor over most of the twenty year period of research, one has progressively become so, and one has dropped precipitously as the key couple became ill and died. A further 22% of HIV-affected households were seen to suffer severe strain but some of these, and the remainder suffering some to little stress due to HIV illness and death, were able – overwhelmingly with the help of the wider family – to absorb much of the effect.

The ability of the wider family to provide sustaining support to its member households obviously varies. The sheer size of households and wider matrilineal families matters, particularly the number of adult women (daughters) and men (sons), as do preexisting levels of assets and income. It is also important to consider the trajectory of an illness and death, as is seen in the fact that most households in the research suffering acute distress were those most recently hit by illness or death. Similarly, the specific context of an HIV-related illness or death is critical so that, for example, if a woman is not only having to take care of the orphaned children of a daughter dead of AIDS but also has been recently widowed or divorced (with no relation to HIV) then obviously her ability to cope is diminished. As always in research, disentangling the intertwined processes affecting the research subjects is not easy but necessary in seeking to assess the effects of HIV.

The mobilizing of the wider family is proving effective in stemming some of the consequences of HIV illness and death. But this is taking place at often considerable cost to individuals and families. Grandmothers find themselves with fewer adult children to rely on, with some adult children returning home sick and dying, and with the task of becoming mothers to their orphaned grandchildren. Sisters and daughters have to take on extra responsibility in providing care to sick relatives (sisters, brothers, parents, and others), and/or to take in orphaned children of the deceased. In households where the mother, father, or both fall sick, school-going daughters and sons miss days of school, some even being forced to drop out entirely, because they have to provide care to their sick parents and/or their parents are unable to raise the fees and other costs for school. As

⁸ These terms – distress, strain – refer here to economic stress; emotional stress is present in all cases.

discussed at length below, teenage orphans are more likely to drop out of school, even when there is no financial obstacle, and are more likely to marry young.⁹

In all these circumstances, there is an acute shortage of help from outside the family. Given the currently large flows of donor funds coming into Malawi directed towards ameliorating the effects of HIV/AIDS, this is surprising. Even though there is no denying that the overall institutional framework for health and welfare in Malawi is overburdened, one reason for the relative dearth of help to rural families is misdirected policy and program focus. All these summary statements will be elaborated in the body of the report.

How to describe the overall shape of what is being done by the Zomba study families? Recently, Alex de Waal used the concept of ‘normalization’ to refer to the ways in which people “adjust... reality to take account of the miseries of AIDS” (2006:18). He takes the concept from a book titled “States of Denial” written by Stan Cohen (2001), and terms normalization “the most sophisticated form of denial”. Much of what the Zomba villagers do can be usefully seen as striving for normality. However, rather than ignoring or denying the abnormal circumstances of the rising toll of HIV-related illness and death, they might better be seen as trying to control those circumstances, making huge efforts to channel them into the normal and normative ways of their society.

Consider Mai C (609)¹⁰ who responded to a question about how it was decided that she take in the five children of her deceased younger sister by rejecting the implication that there was an unusual choice here and by insisting that it was merely her ‘duty’, as an elder sister to take the children. Or consider Mai Z (323) who, on several different occasions when the question was raised of the four orphaned grandchildren she had taken care of over the past decade (as well as currently taking care of the child of a daughter who had remarried and lived in town with her new husband), ignored any suggestion that this was unusual, and quietly insisted that she had faced ‘no problems’ in taking care of the children.

Enormous efforts are made to recreate a ‘normal’ family. One example is Mai C (household 224): her divorced elder sister, Anna, who was in our sample, died in 2004. Mai C took in four of the children (all teens or older), the two youngest going to a cousin (mother’s sister’s daughter) nearby. In addition, Mai C was looking after two other teenage boys, orphaned by the death of another sister. By 2006, two of Anna’s sons had married, though one lived in Mai C’s compound with his wife. Mai C had only one son of her own who was married and employed some few miles away. During 2006, a younger brother who was very sick came to be looked after by her, a decision taken by two other older brothers along with Mai C. The sick brother had all the symptoms of AIDS though only meningitis was mentioned as one sickness he was suffering with. In no conversation did Mai C suggest that her expanded and changing household was unusual. It should be added that she had the advantage of financial support from one of the older brothers who was a very successful trader and farmer.

The most usual sense in which people are charged with ‘denial’ concerns the dominant tendency in Malawi (as in other places) to refuse to name AIDS. This is

⁹ Despite these tendencies, the sample data showed that 90% of orphans between the ages of 10 and 15 went to school compared with 83% for the whole sample of children in that age group.

¹⁰ Mai=Mrs, Che=Mr, Abiti=Ms in the local language. Numbers refer to sample household IDs so that readers can track references to various households.

discussed in greater detail in a later section but the common instances are failure to attribute illness and death of a relative to AIDS, and failure to refer to AIDS in the homilies delivered at a funeral. The reason for such 'denial' is usually posited as shame or fear of 'stigma'. This is likely so given that the predominant focus among experts and public media on causes of AIDS is promiscuity. But several authors have pointed out that to be satisfied with an explanation of denial as stigma is to reduce the enormity of grief and loss to only one dimension. The HIV epidemic and its unprecedented toll of illness and death have subjected people to 'intolerable' stress (Fassin 2007: 120, de Waal 2006: 18). Failure to name AIDS is not mere denial but an effort to bear the unbearable, to fit the death within the 'normal' round of loss.

Other efforts to normalize the stressful situation can be seen in the various interpretations given to illnesses and deaths associated with HIV infection. Some who avoid naming AIDS quietly accept the cause of the illness and death of a relative as due to the 'new disease' (*matenda a tsopano*). Others, however, posit different causes. These will be discussed at length below but they include a longstanding source of misfortune – the malevolence of others, glossed as witchcraft. Another cause is said to be a well-known sickness syndrome called *kanyera* that long predates the AIDS crisis and is being taken by some people to be either identical, or very similar, to AIDS. Identification of the causes of sickness and death has long drawn on a repertoire of ideas and practices, what Fassin, writing about South Africa, called a "stock of interpretive resources" used "according to certain tactics" (2007: 94). Attributing cause provides the route for actions – choice of remedies, and also for subsequent behavior. As discussed later, serious consequences flow from such decisions.

In making what are often heroic efforts to encompass the losses and the added responsibilities consequent on HIV – to recreate normality in face of intolerable abnormal events – the matrilineal families of Zomba have achieved a great deal. But normalization cannot be fully successful, precisely because things are abnormal, times are out of joint. There are many examples where the rigors of the present situation escape control and cause distress. But they may also be seen to provide potential for changing the sad circumstances of today.

Normalization may fail because of the distress caused by severe illness that is attributed by some to HIV/AIDS. In the face of such illness and subsequent deaths, some people struggle not only with grief but with seeking the cause or who or what to blame. Two cases stood out in the research. One was a woman (217) whose daughter had returned home, extremely sick and recently divorced. The daughter became progressively worse during 2006 and died in July of that year. She appeared to be neglected in the earlier months of her illness; her mother displayed considerable unease about her and was heard to blame the daughter for having brought the illness on herself. But in the final months, the mother was the sole care-giver of the daughter, doing everything for her until her death. Afterwards, neither she nor her husband (the girl's father) spoke of the death or of the dead daughter. In normal circumstances, grief is shown and expected and, without naming the dead, can be referred to. The silence here was palpable.

A similar case was in one of the families in the top twenty-five percent in terms of income. Their eldest daughter had lived away with her husband but had returned to live in her parents' very large compound. Never once in the whole year during the many bouts of severe illness before her death in October 2006 were her parents observed to go to visit

her in her house. She was visited regularly by her sisters and cousins (of which there were many since they were all members of the big chiefly clan in the village). The parents never referred to the daughter or her illness in conversation with the researchers and, like the key woman in household 217, kept a silence around the case that was very unusual. For most people in the sample, even if they did not name AIDS as the cause of the disease afflicting a close relative, they achieved 'normality' in the sense of providing the same level of care given to 'normally' sick people.

The case just mentioned of the mother who was heard to blame her daughter for bringing the (un-named) disease on herself raises a major problem for social incorporation of the effects of HIV. Even prior to the onset of the HIV epidemic, people trying to understand the causes of serious illness and unexpected deaths frequently turned cause into blame. As described below in section V on the local interpretations of illness, malevolence in the form of sorcery or witchcraft becomes one way of attributing blame for the events. The illnesses and deaths now associated with HIV also generate discussions about who is to blame. One of the village headmen, for instance, probed the researchers on whether or not the first one in a married couple to get infected with HIV was somehow more to blame than the other. A case from a village nearer Zomba town concerned a woman whose husband had died of AIDS. Because he was a village chief, the wife lived in his village. After his death, the chief's mother blamed the wife for infecting her son (against all evidence to the contrary) and banished her from the village, preventing her from taking any of the marital property. Although we had no such cases in the sample, blame and recrimination may well be generated by HIV-related deaths.

Seeking normality is difficult, too, for some households with orphans to care for. For all but those in the top income group, taking in one or more orphans obviously adds to the burdens of providing food, and other necessities, as well as a happy, loving environment, to children. But the most striking aspect of non-normal circumstances was the problem many guardians had with disciplining orphans. This is discussed more fully in the section on orphans but the main point is that many orphans, particularly those above about twelve or thirteen years of age, proved rebellious, unwilling to obey their guardians as is the expected norm in the villages, and accusing their guardians of requiring them to do things that 'their real mothers never would have'. The consequence seems to be that some orphans are dropping out of school, even when there is no financial obstacle to their continuing, and some, especially girls, are insisting on marrying early.

Probably the most difficult obstacle in the way of people absorbing the losses and added burdens brought by HIV is existing poverty. One case among many is that of Abiti J (615) who, with only half a hectare of land, has been in the lowest income group since 1986, predating her divorce from her husband in 1993. Having to take on the care of five grandchildren after her daughter's death, she feels extremely pressed, with very little food in store and very few other income sources available to her. She has received no help from a local orphan care group. Her other married daughters living in the same compound have their own children to care for and, although there are clearly exchanges amongst them, Abiti J carries the main load of responsibility for the orphans. Her situation is thus far from 'normal', largely because her income status doesn't allow her to absorb the extra costs.

But one doesn't have to focus on the very poorest to make the larger point that much more has to be done to link efforts to moderate the negative inroads of HIV to

regular and systematic efforts directed at ‘development’ – ways and means to increase the ability of people to produce more crops, to obtain more food, and to earn more on farm and off farm income. At present, huge amounts of funds and other resources (personnel, organizational skills, administration, etc.) are directed towards the HIV epidemic yet are insufficiently tied to the root causes of people’s difficulties in dealing with HIV-related illness and death – namely, low levels of assets, difficulty in obtaining inputs of fertilizers and seeds for production, unstable marketing systems, and insufficient non-farm sources of employment.

The most common call by those anxious to ‘do something’ about the HIV epidemic is for ‘change’ in people’s behavior. One of the most insightful commentators on HIV/AIDS in Africa, Alex de Waal, recently stressed the importance of recognizing that “HIV/AIDS demands some far-reaching changes in individual behavior and social mores” (2006:19). Some of the research done in Malawi, including the present study, has some evidence on such change. But also needed is change in some of the current official approaches to the crisis. As discussed later, the examples of ‘community-based’ care groups and ‘home-based care’ programs in the study area have so far proved completely inadequate. Changes here include a need to disentangle ‘community-based’ organization from the presumption of ‘volunteer-based’ efforts, and a different mode of getting funds to local organizations set up to help HIV-affected families. A different but complementary task is to improve access to health care, including (but not limited to) HIV testing and treatment facilities, for the rural population – the majority of Malawians. Efforts to do so are underway but they need to be intensified, and more attention needs to be given to the quality of care in clinics and hospitals, especially to the need for sanctions against the discriminatory treatment experienced by too many rural people.

The myopic focus on ‘orphans’ in the programs set up to respond to the HIV epidemic in Malawi is a mistake. Certainly, the plight of many orphans requires addressing but the current overwhelming focus on orphans is obscuring and displacing the serious needs of individuals and families affected by HIV/AIDS. Some of the over-concentration on orphans as a separate category of victims is driven by exaggerated accounts of homeless orphans and their representing a likely source of disorder and even violence; some is driven by the representation in foreign media and fund-raising that the main problem of the HIV epidemic is the production of orphans; some is driven by the attractiveness of innocent orphans as draws for raising funds; and some, too, derives from an aversion to dealing with the sexual aspect of the HIV epidemic.

Other authors writing on different countries in Africa have come to similar conclusions. Fassin, for example, notes that, “while the situation of orphans has received huge attention by local authorities, the plight of widows and widowers has not” (2007:245), and de Waal comments that research evidence “for the most part” shows that orphans are not “overwhelming society’s capacity to care for them” (2006: 83). These comments can equally well be made about Malawi. Both authors stress that they do not dismiss the difficulties faced by some orphans, or the need for programs to moderate those difficulties, but that it is unwise to separate the issue of orphans from the wider social context such as pervasive fosterage of children (Fassin) or from recognizing the variability in circumstances (de Waal, referring to studies in Tanzania that found widely different levels of social strain due to orphans).

In the Zomba research, the central role played by families in the care of orphans, the problems of separating orphans as individuals from the situation of other children in an overwhelmingly poor population, and the range of conditions in which orphans are found echo these conclusions. Similarly, our concern that an over-emphasis in funding and programs on orphans in Malawi is displacing the needs of the broader family structure and of individual households suffering the effects of HIV, is felt by Fassin when he expresses doubt about the special treatment of children in AIDS programs in South Africa. He suggests that because “childhood is linked to innocence ...[t]he exceptional compassion for AIDS orphans is thus part of the discomfort that ... surrounds the management of the epidemic” (2007:248). In short, as in Malawi, the focus by government, donors and NGOs on ‘orphans’ as the main problem appears to be more comfortable than addressing the sexual aspects of the epidemic and the socio-economic conditions in which people live that make responding to the rigors of the epidemic so difficult. In so doing, the apparently well-intentioned focus on orphans may inadvertently reinforce and deepen the tendency at multiple levels of society to avoid addressing the uncomfortable questions of sexuality and social context that are at the heart of the epidemic.

The thesis described by Alex de Waal (and Alan Whiteside) of a ‘new variant famine’ posits that the HIV epidemic produces “new categories of poor and vulnerable people”. These include “families directly hit because an adult has fallen sick or died of AIDS”, orphans “who grow up with reduced life chances”, and “older people whose own adult children have died of AIDS and who are thus left with reduced family support systems and perhaps orphaned grandchildren to support as well”. All these three social categories are seen in the Zomba research. De Waal also points out that “the trajectory of destitution when a famine occurs is sharper, and recovery is slower” (2007: 91) for such families. To all these summary statements, the Zomba research would have to add that the vulnerability is increased for households whose livelihood strategies, asset and income levels have deteriorated in the wake of an HIV-related illness or death, and not necessarily for all households who have experienced an HIV-related illness or death or who care for orphans.

While all households suffer negative economic and livelihood consequences immediately with the onset of severe illness and death, the longer term effects depend critically on the preexisting asset and income status of households, and on the ability of the wider family to buttress or replace the affected household. From this perspective, it is absolutely essential to see HIV/AIDS in the context of overall patterns of poverty and inequality. By stressing that, “In important respects, HIV/AIDS can be seen as a chronic, background stress factor”, de Waal (2007: 103), rightly reinserts the overall socio-economic context within which HIV/AIDS must be placed. Everything we have learned from the Zomba research supports such a perspective.¹¹

To the extent that it is essential to include time (and not a ‘one-off event’ as de Waal points out), and to place the HIV epidemic’s effects on households squarely in the socio-economic context, we would stress that at the point of immediate impact, one can speak of specific types of households. But the longer-term effects require one to speak of specific categories of persons rather than households. To explain: de Waal identifies “two

¹¹ Cf. the call for “a broad-based definition of vulnerability, not just AIDS-related” in an insightful study in Zambia by Drinkwater et al. 2006: xvii.

specific subsets of households” with particular vulnerability consequent on HIV infection and death: “those that have been ... recently hit by the illness or death of a prime-age adult”, and “those that were affected at an earlier stage of the household cycle – for example, children orphaned by AIDS who have not inherited sufficient assets from their parents and may have failed to obtain an education” (2007: 102). The Zomba research finds that the relative recency of loss typified most of the households identified as suffering ‘acute’ economic stress resulting from HIV deaths, thus accepting the presence of de Waal’s first ‘specific subset’ of households. On the other hand, it does not support the existence of the second type of household. This is because, while orphans as a category of individual persons do, indeed, face particular risks, the households from which these orphans have been produced – through AIDS deaths – often no longer exist. Orphans are moved to different households, usually those where there has been no AIDS death. Subsequent events – marriage, job, and so on – mean that orphans, as adults, move in and out of yet different households. Hence, while one can certainly seek to track specific orphans over time to investigate the longer term effects of HIV orphan-hood (presumably separately from other types of orphan-hood), it does not make sense to assume one can track specific households with orphans over the long term. The error is to forget that households are not static units but changeable and permeable, able to merge and reshape in the context of the wider family, and that the effects of HIV orphan-hood depend as much on the socio-economic context as on the status of HIV orphan-hood itself.

In short, the emphasis on the ‘new’ in the thesis about a ‘new variant famine’ may be misplaced. What the Zomba research, as well as considerable other research, shows is that the consequences of HIV/AIDS tend to intensify whatever patterns of inequality and livelihood stress are already in place. Thus, the effect of HIV/AIDS on patterns of hunger is to reinforce the problems faced by certain social categories. The effects of the HIV epidemic can not be seen only as a result of HIV/AIDS but must be seen as a result of the interaction of the epidemic with the social, economic and political organization of people’s lives. To repeat, it is best to see “HIV/AIDS ... as a chronic, background stress factor” (de Waal 2007: 103) that affects individuals, households, and families in different ways. Such a view, in turn, emphasizes the need to avoid separating the HIV epidemic from the existing (though intensified) development problems in specific places.

III Assessing the effects of the HIV epidemic

Graphs 1 and 2 (next page) show the age distributions of all sample households in 1986 compared with 2006. They clearly show two categories of loss from the current population: babies and infants, and adults between about 20 and 40. While the sample numbers are too small to be considered reliable demographic data, it would seem that the change in distribution can only be explained by the inroads of HIV, causing the deaths of young adults and, presumably through infection by their mothers, of young babies.

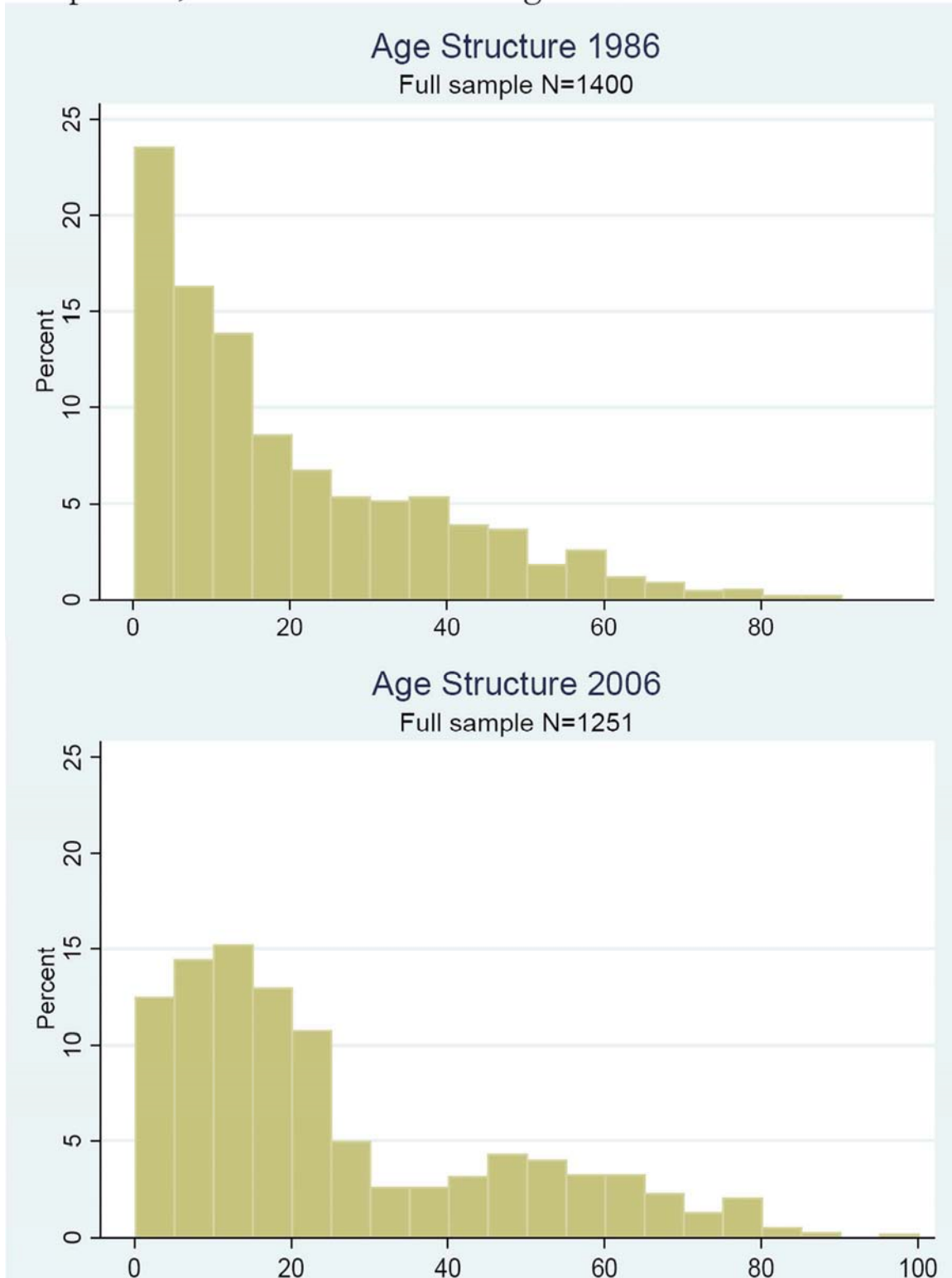
It has been difficult to find a way of assessing whether or not a household has experienced a death attributable to HIV/AIDS. As a practical as well as ethical and cultural matter, testing was out of the question for the research. Thus, we had to rely on reports by sample households on deaths.¹² For reasons explored more fully in section V below, it is still rare for someone to attribute the death of a family member to HIV/AIDS. Since most people do not care to talk of the dead, it is always difficult for outsiders like researchers to pose questions about the number of deaths and the causes of death. It has become even more difficult with the onset of HIV/AIDS. The information we have on deaths and their causes, therefore, has been collected over a period of years and not just in 2006, and comes from a variety of sources.

The main source both in 2006 and in past years has been the ‘updates’ on household membership which elicited information on deaths and, sometimes, about the suspected cause or, more usually, a description of symptoms. Any deaths of sample members occurring during a fieldwork period were recorded at the time with as much detail as possible. In addition, some information on deaths and causes for a particular household comes from other sample members or non-sample villagers (relatives, neighbors, or friends), in the course of conversations held with, or overheard by, the researchers. During the 2006 study, we made special efforts to find out as much as we could about deaths in households, the symptoms and trajectory of the preceding illnesses, and the causes attributed to them. Nevertheless, a large number of the deaths that have occurred over the twenty year period have too little or no information on which to base an assessment of the cause of death. With these caveats in mind, the following summarizes the reported deaths.

Of the 174 households in the core sample, 18% (31) had adult deaths due ‘certainly to almost certainly’ to HIV/AIDS, 21% (36) had deaths ‘very likely’ due to HIV/AIDS, and a further 11% (19) were ‘likely’ due to HIV/AIDS. Evidence for the first category of deaths attributed to HIV/AIDS includes first, actual statements by family or other closely connected families using the various terms for HIV/AIDS; and second, sufficiently detailed descriptions of the typical sequence of symptoms, and types of illness attributable to the disease. Evidence for the second category ‘very likely due to HIV/AIDS’ is based on descriptions of symptoms and length of illness, etc but at a lesser level of detail. And the category ‘likely due to HIV/AIDS’ had an even lesser level of detail. We would put a stronger emphasis on the first two categories. The proportion of households who had a death about which there was no or very little information was 29%. The latter fact, combined with our having to assess the cause of death from highly partial information, means that the assessment of the sample-wide incidence of HIV/AIDS deaths is very tentative. Thus, if one takes the two to three levels of likelihood

¹² This is common; see Drinkwater et al. 2006, note 9.

Graphs 1-2, Zomba research area age structures in 1986 & 2006



of an HIV/AIDS death together, between 40% and 50% of households had had at least one adult die as a result of HIV infection over the previous ten or so years, and about 50-60% had not experienced such a death. In addition, 40% (69) of households had deaths not attributable to HIV/AIDS¹³ and, as noted, 29% (50) had deaths for which we did not have enough information to make an assessment. Another 29% (50) of households had had no adult deaths at all.

We must stress that these figures are extremely tentative and should not be taken as ‘hard facts’ about the population in the Zomba area. They definitely capture some of the deaths but almost certainly not all. Using the categories mentioned as markers for households who had experience a ‘certain to probable’ HIV death, analysis showed some associations that make intuitive sense (see sections on expenditures and harvest etc below in section VII) but cannot be given statistical weight.

While the quantitative results on the sample incidence of HIV deaths are limited by the tentative quality of the ‘HIV death’ variable, the detailed knowledge acquired about sample households and the networks in which they are embedded provides important information about how people respond to increasing illness and deaths attributable to HIV/AIDS.

Ethnographic analysis of HIV-affected households

A close analysis of the households who have experienced at least one death attributable (certainly, very likely or likely) to HIV/AIDS fairly recently (from 1999 to 2006) reveals the following. Four of the fifty-seven (7%) can be described as suffering ‘acute’ distress. Thirteen (23%) can be seen to have serious problems though some are already moving into a third category of an increased burden with some stress (eleven or 19%). The remainder (twenty-nine households or 51%) have had some effect but either that has been relatively short-lived or they are able to absorb the burdens, due to their high income/asset level, to the support from their family, or to the relatively light burden of added responsibility.

Close scrutiny of these households reveals that it is essential to take the time span of HIV/AIDS into account when trying to assess effects. This is the single most important characteristic of this research – that we have information on the same households for twenty years. Examination of the affected households shows that the most acute signs of stress are in the period of severe illness and death, and for many cases, this seems to mean between a few months and a year.¹⁴ The strain, apart from grief, include the time given to caring for the sick at the cost of one’s own activities in the fields and other income-earning activities; money needed to obtain medicines and care, both from ‘traditional’ healers and from clinics or hospitals; provision of appropriate foods to the sick (who often want ‘special’ expensive foods like fish, meat and soft drinks); costs associated with transporting the patients to and from health care centers; and, after death, the costs in resources and time, of funerals.¹⁵ After the death, whether or not the burden

¹³ Many of these were elderly people. Some were small children and the symptoms of malaria were often mentioned; it is possible, of course, that some of these were HIV+ but our information is even more tentative for these than for adults.

¹⁴ Cf. Chimwaza and Watkins 2004:805: “... most of the patients [were] with the caregivers for less than four months. Once they required continual care, the progression to death appeared rapid.”

¹⁵ In the research villages, as elsewhere in Malawi, funerals have increased and people mention the time now demanded for attending funerals. While all villagers especially those surrounding the bereaved

continues to be acute, or reduces to serious or some stress, or seems to be entirely absorbed depends on prior assets and/or a highly supportive family and/or a lesser burden of dependency resulting from the HIV death. A closer look at the households in these different categories of strain will help flesh this out.

Acute economic distress

All four households in the ‘acute’ distress category have either dropped to or remained in the lowest twenty-five percent of households in terms of income. Two have been struggling to achieve a living since 1986, one was doing slightly better, largely because of a son’s tobacco income, in previous years, and the fourth has dropped precipitously down the income ladder, with consequences for the children, from the inroads of HIV. This last case is also the one with the most recent impact.

One of these households had been in the bottom income quartile since 1986,¹⁶ the others dropping to that level since the 1990s. The head of this poor household (615) is Abiti J, born c.1947. She was already divorced in 1986, but later reported that she had had one husband between 1991 and 1993, and the birth of a son in 1987 indicates other partners. During the main study years, 1986, 1990, 1997 and 2006 she was a woman without a husband/partner, and throughout the years she has remained poor. The death that has caused her the current acute distress is that of her eldest daughter who died almost certainly of AIDS in 2003, leaving five children, all of whom have ended up with Abiti J. As described in the Appendix A on orphans, these children were first divided up among the matrilineal family but for various reasons, all came to live with their maternal grandmother. One of the first things she said when we spoke with her at the beginning of the 2006 research was that, “Now I have many orphans to look after”. Her other two adult daughters are married, have children, and live in their own houses within the same large compound, her eldest son is also married with three children and lives not far away in a small market center, the younger son (born 1987) lives with her and is a laborer around the village, and her youngest daughter is still in school. Thus, she has her married daughters and a married son close by, but they are relatively poor with their own children to care for, and even though there are clearly many exchanges among them, Abiti J has primary care for the orphans as well as her two remaining children and is experiencing a very heavy burden of responsibility in providing for their needs. She has only one half a hectare of land and reaped a very small harvest providing a mere 23 kg per capita. She had received no help from one of the orphan care groups that was based in her village, nor from any other group.

Abiti Y is the elderly female head (born c. 1930) of another similar household (203) suffering acute distress in 2006. She has been a widow throughout the years though her mother, Mai C, was the key woman in the household prior to her death in 2004. From the beginning of the study in 1986, the entire localized family of Mai C’s sisters and sisters’ daughters was poor, with small land parcels, and with low levels of assets and income. The HIV death causing Abiti Y particular distress in 2006 was that of one of her daughters (not in the sample but living nearby) who had died in 2005. Abiti Y had cared

compound are expected to donate small amounts of money or goods, the major cost of a funeral is borne by the close matrilineal relatives of the dead person.

¹⁶ As assessed during the 3 main surveys of 1986, 1990, 1997. Income and expenditure data were collected in 1986 and 1990; only expenditure data were collected in 1997 and 2006 and used as a proxy for income.

for her during the last months of her illness, during which she had not been able to cultivate her fields, she also had had to find the wherewithal to buy medicines for her daughter, and, with the help of surrounding relatives, organize the funeral. Abiti Y is now the oldest woman in the local matrilineal group; she lives next to a younger sister who has many children, some of whom lived with their grandmother, Mai C, in this sample household. Now, the small house of Abiti Y is surrounded by the houses of married grand-daughters and cousins. During 1990 and 1997, her household had had her younger son living with her; he grew tobacco and helped to boost their income so that in 1990 she had been in the second income quartile and in 1997 in the third quartile. Since then, the son has married away and she has dropped to the bottom income quartile where they had been in 1986 when her elderly parents headed the household. In addition, during 2006, the young husband of Connie died (both were in their early twenties). Connie was a sister's daughter who had been living in this household since she was a child. All except the immediate relatives said the husband died of *matenda a boma* (AIDS). Connie was herself suffering from various illnesses including sores over her body, and her young child, born earlier in the year, looked severely under-nourished. In short, both looked as though they were HIV+. Abiti Y received some help in the form of food and work from the close relatives around her but she bore the ultimate responsibility and was clearly burdened with it during 2006. The one possible flicker of hope for her is that her eldest son, married in a nearby village, had been selected by the wider family to stand as their chief in their bid to create a new chiefship within the village they lived in. Since this man is reputed to be a 'big tobacco grower' and well connected to village elites, it is possible that if they achieve their aim and are made a separate village, some of the expected benefits might trickle down to Abiti Y.¹⁷

The third of the 'acute' cases is the household 429 headed by a widow, Mai MG. She was in income quartile three in 1986-97 but dropped to the bottom quartile in 2006. She has had three daughters die (1992, c.2000 and 2002) and one son die (2003) of HIV-related disease. In 2006 she had three orphaned grandchildren, aged between 14 and 16, living with her, as well as her deceased sister's son, aged twenty-four (who had lived in this household since the beginning of the study in 1986) and his wife. Both the latter left during 2006 to go to the wife's village. The other grandchildren had all left school and were taking temporary jobs around the village, the girls carrying water, the boy working in a local maize mill. The main strategy followed by Mai MG over the twenty year period has been to sell portions of her land. She was one of the first in 1986 to sell land; her fields were right next to the small trading center that has been expanding over the years. The main purchaser, all the way up to 2006, has been the biggest trader of the area. By 2006, Mai MG had sold off most of her land, remaining with only one field; during the dry season of 2006 we found that she had had a tiny hut built for herself in the middle of the field since the former compound (already moved at least once before) was on the sold land. Also during 2006, she was called to the village chief's court to answer a charge from some of her matrilineage that she had been selling land without discussion with them. Mai MG was about 70 in 2006 and rather frail, though still doing most of the cooking for the family; but the income generated from sale of fields has almost dried up,

¹⁷ Such efforts to create new villages, based on local matrilineal groups with claims to previous chiefly rank, have become common over the past five or so years. They seem driven by people's assumptions that they will benefit from future distributions from government and NGOs, if they control a chiefship.

the income-earning ability of the three teenage orphans is low, so their prospects do not look good.

The final 'acute' case is a family (507) where both husband and wife were HIV+ in 2006, the husband dying in November, 2006 and the wife dying in August of 2007. Abiti N was the only person in the entire sample to be open about her status (see section V below for more on her). The marriage was polygynous, the husband dividing his time between both wives (the other wife lived in a different village some miles away). He gained his income from retailing chickens and vegetables though his increasingly severe illnesses, including TB, greatly decreased his income in the past few years. Abiti N did most of the farming and, despite her own increasing illness, was found struggling with the cultivation and harvest between January and August of 2006. She became progressively more ill and finally died in August, 2007. In terms of income, the household was in the bottom quartile in 1986, in the top quartile in 1990 and 1997, but dropped to the lowest income quartile in 2006. In 1986, Abiti N was divorced with children by at least two different partners, and she was living with her elderly parents. By 1990, she had remarried Mr M, a Muslim man, the man she was still married to in 2006. Her mother died in 1998 and Abiti N became the key woman. Her father died in early 2005. Both she and her husband had been sick for a few years before they were diagnosed with TB first and then HIV in 2005. The slow decline accelerated between 2005 and 2006 with cash income reduced, costs for medicines and travel to health centers increased, and food production cut. In addition, the children (three sons from Mr M) and her youngest daughter from a previous partner, were losing school in having to help their parents. The sons did not seem keen on school but the daughter (born 1986) was in Form 3, a high class in secondary school, and wanted very much to continue. The benefits of earlier, more prosperous years are clear: Abiti N's eldest son had completed secondary school and was married, farming in his wife's village, and her second daughter had also completed secondary school and had a job in a telephone bureau in the capital Lilongwe. Alice, the youngest daughter, wanted to follow in her elder siblings' footsteps, but in 2006 and 2007 not only was her mother struggling to pay the fees but she was also losing school because of having to help her mother with the chores, and then having to run everything as her mother became increasingly incapacitated. After the death of Abiti N in August 2007, her sister who lives nearby will become the guardian of the remaining children (a third sister also died of AIDS in 2005). That household (not in the sample) is not particularly well-off, so the prospects for the orphans' chance for continuing education seem slim at present, unless the elder employed siblings help or another source of aid becomes available.

Serious economic strain

Of the 13 households who can be seen to have serious strain as a result of an HIV death, four (31%) are in the lowest expenditure quartile, two (15%) are in quartile 2, six (46%) in the third quartile, and one in the top, fourth, quartile (8%). Two thirds of the households in the third quartile may be shifting towards the category of 'some' strain. As in the group of acute distress, a majority of this set of households (77%) care for HIV orphans.

Of the four in the lowest quartile, one household (427) has always been in that status. In earlier years, it was headed by a divorced woman with daughters who came and

went from the compound, often leaving some of their children with their grandmother. The old lady died some time after 1997 and one of the daughters is the current key woman. She is divorced and has lost a daughter and a sister to HIV-related illness, and is caring for two teenaged grandchildren who are in school and whose mothers are married elsewhere. She has married sister's children, some of them orphaned, living nearby. She has a tiny amount of land and very low income, but is now the most senior woman of her family living in the village. Her main problem is a very low level of livelihood.

In another household (518), Mai K has been in the lowest income group except for a short time around 1990 when she was married to a successful fisherman and trader. They later divorced and by 2006 she was married to a man who was seriously ill all the year with what everyone except himself said was AIDS. Her daughter had also died, leaving three orphans for whom she cared. Her mother and some cousins lived nearby with whom she interacted regularly. Still vigorous and in her forties, she is currently able to care for the three grandchildren but the extra burden of responsibility for them along with the expenses for her sick husband all through 2006 pressed hard on her. The eldest of the orphans, a girl of 17 seemed to be dropping out of school during the year while her two younger brothers went more often. By mid 2007 we heard that Mai K had remarried and it seems much will depend on the new husband's earning ability as to whether or not she can pull out of the poorest twenty-five percent of households and manage to care for her grandchildren.

The elderly widow in a third household (643) had a daughter die in 2001 leaving four orphans, one of whom is now married nearby, the other three of whom are still in school. This was a large responsibility for her and her income level has dropped since 1997 to the bottom quartile. At present, however, she is supported largely by a divorced daughter with whom she lives. It appears that this daughter has taken on the role of senior woman and guardian of the children. They are also helped to an extent by other married daughters and grand-daughters living around them, and are not short of land.

The fourth household (524) in the lowest quartile is an elderly couple who seem currently to be without any grandchildren able to care for them once they are unable to manage themselves. Their only daughter died in 1991 of TB (possibly HIV-related) and a grandson who had started building a very nice house for them next to their present one died in 2005. Their other grandchildren did not visit nor send anything to them during the time we were in the village in 2006. This is the only sample household where elderly people are without extensive support from children and other family members.

The two households in income quartile 2 (the second from the bottom) are both headed by late middle aged women who are helped a great deal by adult daughters. Mai LS (133) lost her daughter and son in law to HIV-related illness in 2005 and also lost her husband (to a non-HIV death) the same year. She is now caring for the two orphaned children of her daughter. The daughter's husband had a good job in town and they had almost completed a new house in the family compound when they died. Mai LS has another daughter employed in town who took one of the orphans but Mai LS decided she wasn't looking after the child well enough and brought her back to the village. The extra dependency burden and the loss of periodic aid from the dead daughter have been seriously compounded by the death of her husband, leaving her struggling to manage. She has a lot of land which she cultivates with her other resident adult daughter and some older grandchildren, and she also rents out some fields for cash. Like others in the

sample, she had received at least two lots of visitors wanting to record the orphans' names, ages, etc but has never since heard anything more.

The other household (634) in quartile two is headed by Mai LY who has lost two daughters to AIDS (explicitly stated though with 'roundabout' terms described in section V) in 2003 and 1999, and cares for three orphans. She receives periodic help from an employed son and daughter in town, and also has a daughter and a son, both married, living next to her compound. She has ample land but feels pressured by the loss of her children and the extra burden of the orphans. She also reported never receiving help from a local orphan care group.

Of the six households in quartile 3 (next to the top), five lost one to two adult children (mostly daughters, one son, and two sister's daughters), the other household headed by a young married woman lost both her parents. This last household's (526) strain has been on the two remaining daughters – both dropped out of school, the elder took on the burden of caring for her dying mother, and both married extremely young (c.15) bearing children immediately. The elder has a good, hard-working husband and they are starting to do quite well, rising to the third quartile from quartile one in 1997 when the sick mother was still alive. The younger of the daughters married late in 2006 (already pregnant) so it is too early to tell how she will fare. In all the other households, the key woman was being helped by adult daughters and/or sisters and in one case by adult sons. They all had suffered material costs during the illness and death of their relatives and they were dealing with the extra responsibility of orphans, but they were managing largely through the help of adult children, especially daughters, and other relatives.

The only household (517) in the richest twenty-five percent of households in this 'serious stress' category is essentially living off its past. This household was one of the most successful in the sample from 1986 through to the mid 1990s. In 1986, the husband was in South Africa as a foreman, sending money home to his wife who was South African and living in her husband's village. By 1990, the man, like other Malawian migrants to South Africa, had returned and quickly became an active and successful farmer of maize and burley tobacco. He became the chairman of the biggest burley tobacco club in his village and was on many committees where his literacy was useful. He was well connected to the local elite (better off families, local government officers, big traders). In 1997, things were not going as well for him as in the past but still better than the average. In fact, he was already sickening and by 2005-6, he had been ill with various complaints for the previous five or so years. This was told to us with much complaint by his wife who in 2006 told the researchers many times that their standard of living had fallen considerably, that her husband was unable to cultivate much, and that the burden of responsibility for the family fell on her income from her business as a herbalist and seer in local markets. In fact, information collected from others revealed that the husband had taken a large loan on behalf of a committee he'd set up to run certain small businesses, but that he was using the money for his own expenses since he had none from tobacco and had run out of maize. In addition, he was accused by a friend of stealing maize that the friend had temporarily stored in his compound. Thus, although the family remained in the top quartile in 2006, it was built on debt and, in fact, theft. The husband died in December 2006 and though the wife has said for a few years that she wanted to return to her original home in South Africa, she was still present in mid 2007.

Increased burden and some economic stress

In this category, just under two thirds (7) of the households are in the bottom quartile and the rest (4) are in the second (next to bottom) quartile (see Appendix B for detailed descriptions of these households). Four of the seven in the bottom quartile have dropped slightly (from the second quartile) between 1997 and 2006, and two have remained at the bottom. Four of the households are headed by divorced or widowed women who have orphans to care for but who, though in a low income group, receive help from adult children, who live in or near their compounds. Three households are of elderly couples who have a few orphans to care for, others having grown and left in marriage, and who are helped by adult children. Two are middle-aged couples who are not well off but managing, one with orphans, the other with none from the recent death (in 2006) of their eldest daughter. Finally, two are households where a young adult married daughter has taken over the household on the death of her mother (and in one case of both mother and father); both have good marriages and seem likely to improve their income status in the future (all other things being equal including that they do not contract HIV).

Minor economic stress and overcoming stress

The final category of households who have experienced at least one HIV-related death during the previous six or so years are those who have suffered some effect but either that has been relatively short-lived or they are able to absorb the burdens, due to their high income/asset level or to the support from their family. Two characteristics stand out for the group as a whole: First, unlike the households described above in the three other categories, a small minority (14%) has orphans to take care of. Second, most are in the upper income groups (41% in the top, 24% in the third or next to top) with 17% each being in the bottom two quartiles. Some of the HIV deaths were of rather more distant relatives, or else parents where the children are already adult. Overall, reasons for these households seeming to manage the effects of an HIV-related death include: that they have been required to take on a lower level of dependency; that they have an income level that has allowed them to absorb the material costs of illness and death; that, in the cases where households are in the bottom two quartiles, they form part of families where the burden has been shared; that, for both the top quartiles and the lower quartiles, the importance is clear of help coming from family members working in town; and that, in a minority of cases, the deceased person was not a household member but a relative who came for care when s/he was sick and dying (a brother of the wife in one case, and an uncle, mother's brother, in another).

HIV-death of a key woman and/or husband

It is expected that households suffering an HIV-related death of the key adults – in this case, the key woman and husband – are likely to face more serious consequences than where the death is of a less central adult. For this sample, there are twenty-three cases reported of (certain to probable) HIV-related deaths of key adults. A close analysis of these households shows that nine of them are now headed by second generation adults (mostly daughters, a few sons, and two sister's daughters) who have married and who are either over or managing the losses of the deaths. Two other households where the

husband died have dropped in income terms but are helped by surrounding matrilineal kin and are not short of land. Eight households have dissolved, seven of them on the death of the husband. Six of these were households where the wife was living in her husband's village.¹⁸ Thus, the surviving wife and children went home to the wife's natal family after the ritual dissolution of the marriage. Hence, though they constitute 'dissolved' households for the sample, they very likely were reabsorbed by the wife's family. The eighth household was of a divorced woman living alone with a daughter who, on her mother's death, went to live with her mother's sister in the same village. Three of these 23 households were suffering some to considerable stress during 2006. Household 507, described in the above section on 'acute stress', had the husband die in late 2006 and the key woman in mid 2007, both from AIDS. The husband in household 517 died in late 2006, almost certainly of an HIV-related death, and had been living on debt and theft (see above). In the third household, 518, also described above, the husband was seriously ill throughout 2006 and died in early 2007; the wife was raising the three children of her dead daughter (possibly from AIDS) and had remarried by mid 2007.

In sum, of the twenty-three households where a key adult died of HIV/AIDS, just over a third dissolved after the HIV death, though in six (26%) of these households, it is likely that the surviving spouse and/or children were reabsorbed in the wives' village. If these patrilocal households are excluded, only two out of seventeen households (12%) dissolved. Over a half of these households, by 2006, had been taken over by adult daughters or close relatives, all were married couples, and were seemingly over the worst consequences of the deaths. Three (18%) had dropped down in income to a varying degree after the deaths of the husbands, but one key woman had remarried, one was likely to marry, and the third was well ensconced in a large matrilineal group and relatively well off in land. Three households (18%) were suffering considerable stress, all of whom had experienced at least one HIV death in the last year. Of the entire group, the key women in two households (daughters in the second generation category) had ended up with more land than they would normally have had, because of the deaths of parents and siblings. As a result of the dissolution of one of the (matrilocal) households, the remaining sister (not in the sample) and a younger brother had taken over the land of the deceased mother and two sisters, so also ending up with more land than otherwise might have been the case.

¹⁸ In the local language this is referred to as *ulowoka*, and is similar to *chitengwa* in the Central Region.

IV Orphans

The official definition of ‘orphan’ in Malawi follows that of the UN: a child who has lost one or both parents. In the local language, orphans are described as ‘[children] who have been left behind’, ‘[ana] amasiye’. The local understanding places more significance on the loss of a mother than a father in defining a child as orphan, arguing that the mother is the one who has given life to the child and who is the main nurturer. In the study area, this emphasis on the mother is even stronger since people follow a matrilineal kinship system in which a child is automatically a full member of its mother’s matrilineage.

Of the core 174 households, 29% have one or more orphans present in 2006 and 22% had orphans who had left or who had died. All the orphans identified have been incorporated into the extended matrilineal families. In the majority of cases, orphans in the sample families live with their maternal grandmother or mother’s sisters, and occasionally with their mother’s brothers (the all-important uncle to the child).¹⁹ Thus, a few households have an orphan from the wife’s sister as well as an orphan from the husband’s sister. The cases (see Appendix A) also reveal how some orphans move around from relative to relative.²⁰ We found no orphans being placed in orphanages, nor are there any such institutions in the area. We do have one example of a boy being taken by White missionaries (nationality not identified) to be educated and cared for in a different region. This might well be an orphanage but the grandparents who are his guardians did not know the details; he returns home during holidays.

Although, in the sample area, the main responsibility for children, including orphans, lies with their mother’s family, a father is considered an important person to a child, certainly during the course of the marriage to the child’s mother, and in some cases he may play a central role in the care of his children after the death of his wife/their mother. The person beyond the father who sometimes plays a role in orphan care is his mother, the child’s paternal grandmother. We have no cases where an orphan went to his father’s sisters or father’s other matrilineal relatives (apart from his mother). The main onus for care, especially over the longer term, lies preeminently with the orphan’s mother’s family.

The pattern of orphans being taken by their mother’s close female matrilineal relatives is a longstanding one, predating the HIV pandemic. A well-known set of circumstances that lead to an orphan’s facing some difficulty and to their ending up with a grandmother is when a parent remarries after the death of the partner. People in the area well recognize and describe these situations: the stepmother or stepfather either refuses to take care of the children from the former spouse or quarrels erupt, forcing the

¹⁹ Recall this is a matrilineal and matrilocal area – children belong primarily to their mother’s lineage, and most men move to their wives’ villages. Patterns of relations in patrilineal-patrilocal areas will be different.

²⁰ In the local kinship system, the sisters of the mother are addressed as ‘mother’, and usually distinguished by relative age, so that the elder sister of one’s mother is referred to as ‘elder mother’ (*mai akulu*) and the younger sister as ‘younger mother’ (*mai ang’ono*). In normal systems of address and reference, then, there is a plethora of women who stand as ‘mothers’ to a child, even though all are aware of the precise relationship. There are even more that can be addressed as ‘sister’ (*chemwali, anjira, asisi*), including the daughters of their mother’s sisters. A mother’s brother is *malume* or, more often nowadays *ambuye* (*agogo, anganga*, all mean grandfather), and *ankolo* (a transliteration of the English uncle).

stepchildren out of the household. Since the area is matrilineal, most of the cases end with the children living with their mother's mother (their maternal grandmother) or with their mother's sister. In a few sample households, the children live with their father's mother, sometimes because they were used to staying with her on and off, sometimes because she is considered more able to look after them, sometimes because the son has married nearby, or for a variety of reasons, the children's mother's family is unable or unwilling to take in the children.

This situation is also not unique to orphans. In the study area, where divorce and remarriage are common, there is a well established and recognized pattern whereby the children of a woman who remarries after divorce will not necessarily accompany their mother since the new husband may refuse to take them or is expected to refuse. In the fewer cases where a father has children from a former wife (because most often they are living with their mother's family) often the new wife will object to caring for them.

In addition, a common practice among the research families is for (non-orphan) children to go to live with their grandmother or an aunt (sometimes a great aunt) for part or much of their childhood. Sometimes this is due to a woman wishing to have a grandchild to live with her, sometimes a child is 'given' to a sister who is barren, sometimes the child's mother has several small children to care for and one child is sent to live with a relative as 'help' to the mother, sometimes it is the child her/himself who decides s/he wants to live with the relative.

In sum, because of these preexisting practices of children living with a relative, especially but not only, with their maternal grandmother after their parents' divorce or after the death of their father, the current situation of orphans being brought up by relatives is not new. What is new is the scale – the sheer number of orphans needing to be taken in.

Family decisions on the placement of orphans

Major decisions about an individual – concerning marriage, divorce, serious illness or death – are made by a subset of the matrilineage. The main person 'in charge' is referred to as the *mwini mbumba* (guardian of the set of sisters), a man who stands as a mother's brother or, as people age, a brother to the sisters. Sometimes, a woman can take on the role of guardian. The guardian does not make decisions alone but in close consultation with (some of the) other senior sisters and brothers.

After an adult's death, the decisions to be made by this group of relatives along with representatives of the surviving spouse, where applicable, include the care of existing children, and the disposition of property belonging to the deceased. In some cases, this process goes smoothly, with decisions being made about when the family will release (*kusudzula*) any surviving spouse from the marriage bond, and who should look after the children and who receive what property. In other cases there is disagreement and dispute over the property and sometimes over the children, sometimes causing delay in the process and sometimes requiring the involvement of the village headman or a higher level chief.

In some of the sample families, the decision made about who should take in orphans of a deceased daughter was taken by the family as a whole in the meeting usually held on the final day of the funeral.²¹ In some families, however, the decision was made

²¹ This is *tsiku lometa*, literally, the day of cutting hair (of the bereaved).

by one or two close relatives, such as a mother or elder sister. Sometimes, there was no overt decision but the children ended up, in a kind of social default, living with their grandmother, particularly if they were already living in the same village. For example, Amos and Sylvia, a middle-aged couple (household 616), were telling us about how they are raising two orphaned children of their deceased daughter. Asked how the decision was made to place the children, Amos wryly said that ‘everyone was quiet’, that is, no-one offered to take the children, so they ended up with their maternal grandparents. For a few, there was not even a ‘decision’ to be made: as Margaret (609) told us adamantly about the children of her younger sister, it was her duty (*udindo*) to take the children, all the children, since she thought it would be bad for them to be split up. They needed ‘to live as one family’ even though their mother was dead. Margaret had only one daughter of her own and that daughter had only one son, so this relatively light burden of existing responsibility probably influenced her decision.

The problem of ‘discipline’ in caring for orphans

In conversations with sample respondents who were looking after orphans, we were told about their difficulties in finding sufficient food and income to provide the orphans’ needs for clothes, school materials, and so forth. It is clear that having children added to one’s complement of children and other responsibilities is a large burden for many families, and many respondents spoke eloquently about their difficulties in raising the resources to look after the orphans as well as their worries about failing in that task. This is not surprising in a population where most households are food deficit and obtain low cash incomes. Circumstances such as the serious drought and harvest failure in 2001-2 and the poor harvest in 2005-6 intensify the pressure on families.

Nevertheless, the overwhelming problem raised by the sample families when asked about bringing up orphans was that of discipline. In conversation after conversation, when the topic turned to orphans and even in more casual exchanges that happened to touch on orphans, guardians taking care of orphans in their own homes said that some of the orphans are ‘troublesome’ and ‘rude’. Asked to elaborate, they explained that they meant that the orphans do not heed their guardians in the respectful way expected of children and young people. In most cases, the orphans considered troublesome were those in their teens. The common litany of complaints included that many (though by no means all) orphans refuse to help in the gardens or compound as is the norm, or if they do some work they do it poorly, staying a ‘short time’ in the fields and leaving whenever they wanted, so expecting their guardians to complete the work themselves. They do not listen to advice such as the need for regular school attendance or the dangers of ‘running around’ with friends or members of the opposite sex. Many guardians repeated the same refrain that orphans would openly refuse them by saying, ‘no, I’m not going to do x or y since if my mother were alive she wouldn’t be asking me to do this’. Even when the guardians might believe or say that their mothers would certainly have expected the children to help, the children use this rationale for not helping. Moreover, we were told, if the orphan does not like the food or other aspects of living with his/her guardians, s/he will accuse the guardian of neglecting them, and of being ‘cruel’.

One grandfather (616) complained about his deceased daughter’s son, aged eleven in 2006: how he did no work in the fields alongside his grandfather, how he came home

from school, ate and ran off, not coming back till it was late (early evening when it gets dark). He then said he was worried first because he did not want to be forced to be harsh with the boy but that persuasion had not worked so far; and second, because he felt the boy was lacking important aspects of his upbringing. Moreover, the boy's elder sister had refused to continue secondary school, even though her grandparents had advised her to do so. She had subsequently insisted on marrying a young man and had left to live with him (again, an unusual move). They expressed regret at this, saying they were prepared to pay her fees alongside their own youngest daughter (the orphan's aunt). They feared that the boy would make the same mistake.

Other guardians expressed a similar mix of emotions – irritation or anger at the child's behavior but also anxiety that the child was losing out in key things, and fear that they, the guardians, would end up being seen as 'cruel' if they tried to discipline the child, and that they would be blamed by other members of the family or by neighbors.

The question of whether orphans are treated less well than are the biological children of guardians is one that is not new to the society. Orphans have long been known in the society as have stories about the neglect of orphans or of the cruel treatment by stepmothers and stepfathers (here being more even-handed on a gender basis than the otherwise similar stories of 'cruel stepmothers' in European traditions). But the stories may highlight the exception rather than the rule since actual information on the experience of orphans is difficult to come by. One research assistant, describing a family in the sample in 1990, described the death of the key woman of one of our sample households and how her seven children had been taken into the care of the dead woman's sister. The husband of the dead woman moved away but he got a job in town and sent money monthly to help support his children; also the eldest son worked on an estate in the northern region and sent money to help. The research assistant commented (without being asked) that the orphans were not treated any differently by their aunt than her own children. By 2006, this aunt had become the key woman of our sample household and all the children had by then left and married, some nearby, some away.

In 2006, the topic of orphans had become far more frequently aired than ever before. This is due not merely to the increased numbers of orphans, a fact to which the sample families spontaneously refer, but also to the vastly increased public attention paid to orphans by government, the increasing number of NGOs, and various donor organizations in the context of the HIV/AIDS epidemic. Because of the public focus in recent years on orphans and of periodic speeches about the need to 'treat orphans well' by village headmen and other authority figures, it has become more difficult to assess actual treatment of real orphans. Stereotypical opinions tend to be elicited in response to a general question about orphans, namely, that orphans tend to be neglected. When one asks about specific examples of orphans (in neighboring families, for example), then the answers tend to be far more diverse, as the following case indicates.

Robert and Agnes (household 342) have looked after their two grandsons since their mother, their only daughter, died 9 years ago. The two boys were so young that they address their grandparents as mother and father. For Robert and Agnes, apart from the pain of losing their daughter, their life is not very different from what it might otherwise have been. Not rich, they are both strong and hard workers with one of the prettiest, neatest compounds in their village, as well as enough food produced by themselves to last from one harvest to the next. When

asked about orphans, Robert, with his wife nodding, volunteered that for themselves, being healthy and relatively young, they had no difficulties but for older people, perhaps a grandmother, orphans will have to do casual labor to earn money and not go to school and the girls might become prostitutes just to get money to support themselves. He went on to say that if someone has children of their own but then have to take in several orphans, the tendency is for the orphans to get second best in terms of clothes, food, and support for school, and so forth. He painted a sad picture. Then I asked him and his wife to think about families around them who had taken in orphans. They nodded and after a few minutes of quiet discussion between them, they said about 5 or 6 families around had orphans to care for. Then, I said, if you think about those families, do you see whether or not the orphans are being worse cared for than the children of the house. To this, again after a few moments of quiet conversation, they said no – in the cases they knew, the orphans were being treated well, with no obvious difference between them and the other children of the house.

The tensions between guardians and orphans differ by the relationship between them and by the age of the orphans. While the youngest orphans might add to the felt burden of responsibility, they more rarely cause other problems concerning proper behavior or expected discipline. The children aged thirteen or older are more likely to be associated with complaints about ‘rudeness’, refusal to go to school and/or to work, etc. This has to be understood against a cultural background that values independence in people, even young people. There is a delicate balance between the forms of respect paid by younger to elder persons and a sense of individual independence: thus, elders deserve respect but everyone, even a young person, is also expected to be treated with a degree of respect. Hence, it is not unusual for parents to say that a child, who may be as young as nine, decided s/he did not want to attend school, or decided s/he wanted to go to visit a favorite aunt. In many such instances, the parents did not try to stop the child from doing what s/he wanted. Again, this is not true of all parents; many will specifically say they try to pressure their children to attend school or do other things thought to be ‘good for them’. But few will go to the extent of physical or other force. It is against this pre-existing situation that one has to see the apparently intensified tendency for some orphaned children to go against their guardians’ wishes. The impression is that such children are resentful and angry at being without a mother (sometimes a father) and are not willing to concede to a grandmother or aunt or uncle the kind of behavior they might have demonstrated to their own parent.²² Orphans seem to be a particularly fraught example of a situation that many adults complain about, namely, that youngsters nowadays are ruder and less obedient than in the past, a change some adults attribute to the influence of ‘video’ (the English word is used) and radio.

For orphans from the age of 15 or so, evidence of rebellion is more likely to be seen as efforts to be independent of the guardians. Several of the older orphans in the sample married at very young ages (15-17). In addition, orphans this age who are not obedient are more likely to be pressured, whether implicitly or explicitly, to form their own household, that is, by getting married. The value given to independence in the society means that the goal of most people approaching the end of the teen years, with the

²² Observation of a few young children – five to seven – also suggest that they are suffering from grief at the loss of one or both parents. Our research was unable to study this response.

exception of the still small minority able to go to secondary school, is to find a spouse and marry, so forming their own household. While the average age of marriage in the area is fairly low, there appears to be a tendency for orphans to marry at even younger ages. Again, this is not the case for all orphans, but a tendency.

Early marriage takes two main forms – either because the teenagers are left without parents and have to take over the running of the household, fields, and any younger siblings, or because of rebellion against the guardians. In one household, the father died in the mid 1990s; later on the mother became very ill, finally dying in late 2005. The two daughters still at home dropped out of school, the elder of the two married and lived, with her husband and young baby, in the compound where she essentially took over from her mother. After the mother's death, she became the sample 'key woman'. Her sister, the youngest daughter, left home after quarrelling with her elder sister and returned in late 2006 pregnant and married. In a few other cases, the marriages took place against the wishes of the guardians (aunts and grandparents) and seemed to be a way of the orphans gaining independence of what they considered to be unsatisfactory parent replacements. The expectations about independence combined with the tensions generated by the extra burdens placed on a household that takes in one or more orphans, as well as the tensions between orphans and guardians over guidance and advice all lead to this tendency (see Appendix A for cases).

In sum, while some families are so poor that orphans may well suffer a shortage of food and other basic needs, this is usually on a par with the other children of the household. The Zomba research would support the findings of another study in Malawi which concluded, on the basis of data on the health of surviving (HIV negative) orphans of parents who had died of AIDS, that "the extended family ... has not discriminated against surviving children" (Crampin et al. 2003: 389). The anthropometric data were not found to vary significantly between households with orphans and those without, nor between the measured orphans²³ and the rest of the children (see section VII). The Zomba study found no significant differences in school-going between orphans and non-orphans, as did another study in Malawi (Doctor 2004: 31). However, as noted, some orphans rebelled by not going to school, especially to the upper classes, even where the costs for schooling were not a problem. In addition, as noted, orphans in their late teens tend to marry earlier than they normally would.

Problems with the current official definition of orphan

For all of the sample orphans, a child with one parent dead had a number of people able to care for him/her. Most of these are from the mother's family (obviously this will differ across the country according to the kinship, marriage and residence patterns). It cannot be assumed that after the death of one parent, a child is necessarily more vulnerable or at risk than other children in the area. The fairly high rate of divorce and remarriage and the common pattern of children living with grandmothers or mother's sisters for all to part of their lives all indicate the problems of placing too great an emphasis on the death of one parent, especially a father, as constituting the negative state of 'orphan'. Again, we emphasize that this conclusion holds for the area of the study where matrilineal-matrilocal families take on major responsibility for orphans. Even

²³ There were only four orphans among the measured children (under 6 years) so no statistical significance can be claimed.

those children whose parents were living in cities and towns have been taken over in this way by branches of the family in the rural and urban areas. One should not assume this happens everywhere and for everyone; presumably the documented cases of urban 'street children' are a reflection of failure of some families to absorb needy children. However, it is important to point out that far more needs to be known about such children and their origins before concluding that they are in any way typical of how HIV/AIDS affect families. Moreover, as other studies have pointed out, it is difficult in many cases to know with certainty the cause of the orphan-hood and to relate it to HIV/AIDS.

In addition to the fairly high rates of partner change inside and outside marriage, the ambiguity around the status of a marriage can cause difficulties for a definition of a 'deserving' orphan as the case of Catherine and her orphaned children (household 202) indicates.

Catherine died in 2000. According to her mother and sister, she had been 'married' for some years to a local man who lived with his first wife in a household that also happened to be in our sample. The two younger children of the deceased Catherine had been given the name of the 'husband' by their mother, and were so listed in our household list. But the 'husband' had never lived in Catherine's home, nor had he been seen locally as a 'son in law' to her mother. After Catherine's death, he had refused all requests by Catherine's mother to help care for the two children (with food or clothes or school expenses) who bore his name (and, as the researchers could see, his personal facial features). This was particularly bad, in the eyes of their grandmother, because he is one of the richest men in the village. When asked by the researchers why she did not take a complaint to the village headman or a higher level chief, she explained that she could not do so because the marriage was not 'known well'. Here, she was referring to the fact that in the sample villages, it is expected that a person about to marry will go to the chief to announce this and to give him the expected small token payment (of about K100). This constitutes recognition by a key local authority of the said marriage and it has the function of the village headman (and his representatives and advisors) being able to act as witnesses in a dispute, and as arbiters in divorce or conflict. In short, it appears that the man in question treated Catherine as a mistress rather than a wife and in all conversations between him and the researchers, no mention was ever made by him (or his wife) of another wife, as in other recognized polygynous marriages. While Catherine's mother blamed the first wife ('she does not want her husband to be supporting other children'), it appears that the man in question has no interest in recognizing the children openly as his own.

In such a case, the children are considered orphans by the grandmother and, it appears, by neighbors not only because their mother is dead but also because their biological father does not behave like a proper father in cultural terms. The grandmother and the mother's remaining sisters are regarded as having to take on the responsibility for the children. In other cases of a mother's death, where a father is alive and continues to contribute to the upkeep of children even when he does not live with them, there would

also seem to be a problem with defining these as orphans parallel with either the case mentioned or with children who have lost both parents.

In short, the definition of orphan as a child who has lost even one of his/her parents without any consideration of the support available to them ends with a huge inflation in the number of orphans as stated by public authorities and donors; such a definition conflates those who are orphans in a social sense with those so defined in a purely biological sense.

It is against this context of a broad definition of an orphan and of an overall poor, stressed population that one has to place the information on the current services provided for orphans and for HIV-affected persons and families. While the details of particular orphan care groups are presented in section VI on 'Care-Giver Groups', the main conclusion from the research is that, in spite of the vast amounts of funds pouring into Malawi for orphans and in spite of the extensive media focus on orphans, there are very few services actually reaching orphans at least in the research site. The number of orphan care groups has proliferated over the past five years as a result of the availability of grants, but 'on the ground' delivery of real services to orphans and their families remains tiny. Across all the research villages, a very large majority of families caring for orphans reported receiving nothing from any group.

Observations and interviews about the various orphan care groups set up in the research villages are discussed at length in the section on Care Giver Groups but the main conclusions are the following. First, the large grants given to groups to set up business enterprises intended to provide a 'sustainable' source of funds for orphan care are misdirected in most cases. People volunteering for orphan care have neither the tight organization nor the experience to run a business of the scale assumed. In most of the cases studied, the grants and other resources (especially time) were expended on establishing and running the enterprise with very little or no resources actually reaching the orphans supposed to be helped. Second, some to a great deal of the funds obtained by the village groups are appropriated by the lead organizers. Third, such services that are delivered to orphans are highly sporadic, often separated by many months because they are dependent on the organizers raising money and other resources (eg. food).

Nevertheless, there is space for local efforts to provide services for needy orphans. In the Zomba research site and reported on in the larger surrounding area, there are some informally organized groups which successfully, if only periodically, manage to deliver some help in the form of feeding, teaching, blankets, and so on to some orphans. These are small-scale groups who rely more on their own resources, supplemented by small donations from a range of sources, usually individuals. Very few 'village-based' groups will be suitable for the large grants now being mobilized (mainly through NAC, MASAF, and the District Authorities) and more modest grants for a larger number of groups are more likely to enable villagers to help orphans and their families. In addition, some effort at providing modest support for coordination across groups instead of the now stiff competition among them and the related flurry over having to write proposals is likely to produce more help for orphans and their families than at present. Finally, as included in the recommendations at the end of the report, a redirection away from basing all local care groups on 'volunteers' is likely to be more effective in actually delivering some services to those needing them.

The phrase used above – ‘orphans and their families’ – leads us into a final conclusion about orphans in the context of the HIV/AIDS epidemic. The current framework for assessing the needs of orphans and for providing them with support is overly narrow. A focus on individual orphans ignores the current pattern in rural areas whereby orphans are absorbed into the extended family, and in fact mistakenly assumes that the ‘household’ is the only relevant unit for considering orphans. The research found that tension and conflict are often the result of help being given to orphans as individuals rather than considering them in the context of the family. For example, a boy was given soap by a local care group; he refused to share this with his cousins even though his then guardian (his aunt) was providing everything else for him, and, when the soap ran out, he insisted that his guardian should buy soap specifically for him, accusing her of neglecting him when she demurred since she was assessing needs in light of the entire group of children and adults under her care. Programs concerned with the welfare of orphans would be more productive if they focus not only on the orphan child alone but also on the family within which the child lives. Most of these families are already quite poor and ill-served with poor services such as schools, clinics, and so on. Rather than the huge amounts of money pouring into programs for ‘orphans’ as individual children, some at least should be directed to providing the means for families to continue to care for the rising number of parent-less children. As noted above, there is an unfortunate disjuncture between programs directed to ameliorating the effects of HIV/AIDS and broader development programs directed to reducing poverty and ameliorating the ability of people to make a decent living from agriculture and non-farm sources. Improving the livelihoods of people will, in turn, mean that they will be more able to continue to support the increasing number of people suffering from AIDS who are dependent on their family for care and for the increasing number of orphans.

The larger issue, then, is that a myopic focus on ‘orphans’ seems to be displacing the efforts needed to provide aid to families on whom AIDS sufferers depend and where orphans are cared for. If orphans themselves are not currently well-served by orphan care groups among others, the deficit for people living with AIDS is even starker.²⁴ Yet these needs are connected and should be considered as a package in assessing policies and programs. Why is there such a donor and media focus on orphans compared to one on the sufferers of AIDS? One is led to suppose that it has to do with the avoidance and ambivalence associated with addressing the (largely) sexually transmitted disease. Who can not be moved by the images of small children crying over their dead mother or father? Indeed, no-one could deny their need. But one does need to wonder at the disproportionate amount of attention by donors, government, NGOs, and media to the innocent children orphaned by the disease compared with the attention to adults suffering from AIDS and adults widowed by AIDS (cf. Fassin 2007).

²⁴ Cf. Fassin: “...it is remarkable that, contrary to the situation of orphans that has been studied by several surveys and for whom initiatives have been launched all over the African continent, research and actions by the international institutions, NGOs, and local authorities aimed at widows and widowers [of AIDS victims] should be so rare” (2007:245).

V The interpretation of illness in a time of HIV/AIDS

It is now well-known that, in Malawi (as in other countries of southern Africa), the decade after 1986 saw an explosion in the number of cases of HIV infection and of people living with, and dying from, AIDS-related illness. The national statistic now stands at around 14% of the adult population infected by HIV, and the epidemic is responsible for a surge in adult mortality, serious losses in all sectors of society, enormous strain on the medical system, and a growing burden on the majority of families. The research conducted in Zomba district in 2006 looks at how people in the rural areas are experiencing – living – these bare statistics.

Over the twenty years of the research, HIV/AIDS has become both more recognized and more frequently talked about. During 1986/7, HIV/AIDS was not a topic of our research, was not discussed among respondents, and barely heard of more widely in the country. The virus was present in the country²⁵ but it had not overtly entered people's lives in the research villages. By the time of the 1990/1 follow-up research, however, more people were hearing about HIV/AIDS though many did not really understand what it was. Although, in retrospect, we can now see that some people who were ill or who died in the early 1990s were doubtless infected with HIV, it was not until the mid 1990s that the effects in terms of increased illness and deaths were noticeable to the villagers and the researchers alike. Visits to the research villages by Peters between 1993 and 1996 and Walker's research in some of the villages in 1995-6 revealed a growing unease among villagers in view of the rising illness and deaths.

During the full year's research in 1997, many respondents highlighted their concern about the rise in illness and deaths striking their communities when they were asked about changes in their lives, and the twelve months of data collection revealed a clear increase in adult deaths. During 1997, numerous people in the sample explained that when they had first heard about AIDS in previous years, they at first did not believe the stories about an incurable disease that was spreading, and some thought it must be a disease of the whites (*azungu*) that would not affect Africans (black people, *anthu akuda*). Some people said the government was trying to scare people to have fewer children or to stop sleeping around. In 1990, one of our research assistants told us, half-jokingly, that 'AIDS' stood for 'American Idea to Discourage Sex'. As the number of people getting ill and dying increased, people realized that this was, indeed, a new disease and, worse, one that was said to have no cure. Many were aware by 1997 that the disease was passed mainly through sexual contact and spoke of people needing to be 'careful' or to avoid promiscuity. A few said that for those (implicitly men) who could 'not control themselves' it was wise to use condoms. Nevertheless, through the 1990s on, there was a growing moralization of the discourse about AIDS, and opposition by many churches to seeing condoms promoted as a defence. Some people said they believed AIDS was a disease sent by God as a punishment for not following traditional rules or for being promiscuous; others focused on the activities of 'bargirls' or poverty causing some women to sell sex. By the early 2000s, a new source of blame promoted by public media was labelled 'cultural practices', a catch-all phrase that referred to rituals that were said

²⁵ The first cases were officially confirmed in 1986 though the data and discussion did not become public till 1994 with the advent of 'multi-party politics'.

to involve sexual practices in initiation, and post-death ‘cleansing’ rites of widowed spouses.

By 2006, it seemed that virtually all adults in the research villages were now aware of AIDS but the research also showed that there is not a single understanding of the disease. On the contrary, there are different interpretations of what the disease is, its causes, and what may be its relation to other better-known diseases. People vary in their understanding of and their reactions to HIV/AIDS.

People all over Malawi have been subjected to several channels of information about HIV/AIDS – radio, television, written media in newspapers, government and NGO flyers, posters, speeches by secular and religious leaders, and visits to villages by government and NGO groups providing information or education on AIDS. In the villages, the latter and radio are more common sources because the lack of electricity limits television to a minute fraction, and few people read newspapers. Nevertheless, information circulates rather broadly. Despite this blitz of ‘information’ about HIV/AIDS, and despite people making the connection between certain types of behavior (various colloquial euphemisms for multiple sexual encounters²⁶) and exposure to the disease, there is not a universal understanding that there is a virus which, after being contracted, eventually leads to opportunistic diseases, or that AIDS is the outcome of the virus.

People do not distinguish linguistically between HIV and AIDS in their observations of the current situation; the former is hardly referred to at all, while the many indirect ways of referring to *edzi* (AIDS) are references to the illnesses afflicting people (mainly those that result from the breakdown of the immune system). The partial exception is that some people, including some local healers (*asing’anga*), refer to *tizirombo*, ‘little animals’ or organisms in the blood which they see as causing the illness.²⁷ This is a term that is also used to refer in general ways to ‘germs’. People talk about contracting *edzi* rather than HIV. Suspicion about the possible infected state of some people, judged either by their behavior or by being the widows or widowers of spouses known or considered to have died from AIDS, reveals that some people did know that a person can be infected with the HIV virus but appear perfectly well.²⁸ Nevertheless, the vast amount of attention is paid to overt illnesses attributable to AIDS.

While the sexual transmission of HIV/AIDS is well known in the area and, of course, is the overwhelming focus of public discourse and services (clinics, hospitals, etc), it is not the only interpretation given to the rise in illness and deaths. People draw on a range of ideas to account for the unprecedented situation. In fact, there are multiple interpretations given to the rise of illness and death, some coexisting, some competing. People often hold several of these interpretations that are used to attribute a cause to the sickness and to select treatment for it.

The types of interpretations given by the research families to the illness syndromes associated with AIDS resemble those identified by other researchers in

²⁶ *Chiwerewere, chigololo, kuyenda-yenda*, etc.

²⁷ Lwanda (2003:118) quotes a popular song from the early 1990s that included the phrase ‘*tizirombo tikukhala m’magazi*’ (these viruses are living in the blood). The Ministry of Health had translated ‘virus’ into Chichewa as *kachiroombo* (lit. little animal), later amended to the plural as *tizirombo* (Probst 1999:118).

²⁸ One woman commented that a man who often spoke in public about being HIV-positive as part of the information sessions of an NGO was on ARVs and ‘looked fat’ so that someone might think she could marry him even though, she added, ‘he is finished’ (ie. he will die).

Malawi and in neighboring countries. These are: AIDS is transmitted mainly through sexual contact though occasionally through injections or contact by means of infected blood or instruments; AIDS is a more virulent form of a well-known indigenous illness (*kanyera*) caused by infringing certain sexual rules; the illnesses some define as AIDS are illnesses sent by malevolent people through witchcraft; and AIDS is a disease that has been deliberately inflicted on Malawians through infected condoms, family planning pills and injections. The agents assumed to be behind the purposive infliction of AIDS are God (who sent it as a punishment for immoral or sinful behavior), as well as Whites (Europeans or Americans) and the government of Malawi (who distribute infected condoms and other contraceptives in order to reduce the population).²⁹ The agents assumed to be behind the bewitching of people are seen to have a wide range of motives, depending on the relationship between them and their victims, though they generally turn on envy and jealousy.

While the interpretations of origin, cause and agent of the AIDS illnesses may be categorized as above, they are not mutually exclusive. People often hold several different ideas at once or at different times or for different circumstances. It is important to note that well before the era of HIV/AIDS, the interpretation of illness often varied according to circumstances. Depending on the trajectory of the illness, the diagnosis of what is causing the illness may well change over time, particularly if the illness fails to respond to treatment and the patient fails to improve. The effect of AIDS has been to intensify this pattern of multiple interpretations that draw on a repertoire of available and changing ideas. While people in Malawi have long been exposed to serious illnesses from which people have died, the HIV epidemic has produced an unprecedented situation marked by an explosion of serious (chronic) illness in the very segment of population normally most healthy (people from the late teens to around 50), and by the incurable character of AIDS. It is no wonder, then, that people are involved in an agonizing search for explanations.

This research leads us to agree with other researchers about the deeply unsatisfactory use of the term ‘denial’ for the many interpretations of AIDS illnesses that do not – on the face of it – agree with the bio-medical explanation of HIV/AIDS. Fassin, for example, says that ‘denial, in its deepest sense, signifies the intolerable’ (2007: 120). This is a tragic situation of ‘living with death and in death’, when people oscillate between ‘hope and renunciation’: on the one hand, seeking to maintain life for themselves and their families in face of disabling disease and hoping for relief, even cure; on the other hand, fearing death and its aftermath for their loved ones and tiring of the suffering (p.230). In such stressful times, the term ‘denial’ glosses over the ways in which people are torn between acknowledging the way in which the disease has felled them, and refusing to recognize the ‘unbearable’ knowledge (ibid.). Alex de Waal cites an unpublished paper on AIDS orphans in Botswana,³⁰ which said that, “... ‘denial’ is not a passive activity of failing to look, but an active task of struggling to maintain ‘normality’ when it is assaulted at every turn” (2006: 19).

²⁹ Another study in Malawi reports people accusing the whites of doing so either because they, especially Americans, wish to see Black people destroyed or are tired of giving aid funds, and also accuse health workers in Malawi of being in the anti-population growth group and/or wanting to benefit financially from people seeking medical health and needing to buy coffins (Kaler 2004; for suspicions about condoms see Pfeiffer 2004 on Mozambique, Allen and Heald 2004 on Uganda and Botswana, Mufune 2005 on Namibia, Rodlach 2006 on Zimbabwe, Fassin 2007 on South Africa).

³⁰ Margaret Daniel 2005, *Beyond Liminality: Orphanhood and Marginalisation*, University of East Anglia.

A very similar conclusion has been drawn by Chimwaza and Watkins about caregivers to people sick with AIDS in Malawi when they say that the ‘reluctance’ shown by many in speaking openly of AIDS “is not a denial but something more existential... [in that the caregivers] turn away from acknowledging, even to themselves, that their child, their mother, or their aunt will not survive despite their devoted care” (2004: 805). The mother of a young woman who was seriously ill and finally died during 2006 in the Zomba research is an example among others. When her daughter came back to her natal home, having been divorced, very sick and weak, her mother was overheard several times complaining about the daughter who had brought ‘this illness’ on herself, and blaming her for her bad behavior. For several months, the daughter was semi-isolated in the family compound, lying on a threadbare mat rather than one of the nicer ones used by her parents and siblings, struggling to make herself small meals, to manage to wash herself, and so on. Neighbors quietly gossiped about the hard-hearted mother though one woman pointed out that what she was feeling was ‘guilt’ since people assumed that she had not brought up her daughter properly. In short, the mother was interpreted as blaming her daughter for ‘bad’ behavior and yet fearing being blamed herself for not having raised her daughter properly. But in the final months of the daughter’s life as she became weaker and weaker, unable to care for herself, the mother took on the job entirely herself, and was observed carefully tending her dying daughter. While she behaved as a mother is expected to in those difficult final months, she never once referred to AIDS or one of the roundabout terms understood to mean AIDS. After the death, she and her husband remained silent about the illness and death of her daughter, a ‘closure’ that the researchers were unable to open, but that doubtless included grief and ‘unbearable knowledge’.

Naming the disease and avoidance

The first and most obvious point is that the term *edzi* (which, as noted, does not distinguish between HIV and AIDS) is rarely used by villagers to talk about the illnesses and deaths of people related or close to them, which might be attributed to HIV/AIDS. The more common terms are a wide range of highly indirect terms, all of which use the general term for illnesses/diseases (*matenda*)³¹, but which, in practice, are well known as ‘code’ for AIDS. Some of these include: *matenda a boma* (government disease, apparently a label dating from the early years of official government messages about the new disease); *matenda atsopano* (new disease); *matenda a masiku ano* (disease of nowadays³²); *matenda omwewa* (this disease); *matenda obwerawa* (the disease that has come); *mphepo yomweyi* (literally, this wind, a common term used to refer to illness). These were most commonly used during 2006. However, in earlier years and still around, the following terms have been used: *mtengano* (taken together – if one spouse dies, the other soon follows); *kaondetsa* or *kaliwondewonde* (being very thin); *magagawa* (mixing or passing something around); *mliri* (disaster killing many); *kanyera wamkulu* (big *kanyera*).

Thus, many people use what in English would be equivalent to ‘that current illness ... you know...’, or terms that refer to symptoms (being very thin), or to the primary mode of transmission – sexual contact. For those who do not speak the local

³¹ *Matenda* is plural, *nthenda* singular but in speech the plural form is invariably used.

³² This phrase ‘disease of these days’ is also found in Zimbabwe (Rodlach 2006:57).

language, all these ‘roundabout’ ways of referring to the disease and related illnesses are easily missed, but for Malawians, it is fully understood that these terms refer to AIDS. The most usual circumstance when the term *edzi* is used is when a person refers in a very general way to the disease rather than to any specific person affected by it. There were extremely few exceptions to this. Even the local volunteer home-care givers rarely used the term *edzi* in their conversations in the villages. Most of this avoidance is to do with the connotations of sexual impropriety associated with AIDS; some may also be due to the fact that AIDS is associated with death and various euphemisms are also used for death (someone has ‘left us’ or passed away, for example).

A second characteristic is that most people avoided mention of even the indirect terms for AIDS when referring to people close to them who are ill or who have died. Of the few people who did suggest that AIDS was the cause of the deaths of their relatives, most used the indirect terms to do so. Throughout 2006, we had conversations with the key adults in all sample households about the changes in their family, including deaths. When we were told about deaths, we tried, albeit delicately,³³ to find out as much as possible about the symptoms and trajectory of the illness before death occurred. These accounts, in some cases supplemented by information collected in earlier years as well as that garnered more indirectly from neighbors or other relatives, provide the basis on which we made the assessment of HIV-related deaths for each family. In the majority of the cases where the overall circumstances and the accounts indicated that HIV was certainly to probably at issue, the signs and symptoms were described along with the treatments, but rarely were these attributed to AIDS. In the few cases where people referred to AIDS as a cause or suspected cause, the terms used were the roundabout ones listed. Only one or two people said outright that a relative or close friend had suffered and died as a result of *edzi*.

The reason given most often by Malawians in villages or towns, and by the many commentators, whether researchers or practitioners, for the avoidance of reference to AIDS is that this disease is connected fundamentally with sexual activity. It is certainly the case that sexual activity is not a topic for most ‘ordinary’ conversations even though it is a topic that is discussed among peers (gender and age), in cases of sexually transmitted infections, in rituals of initiation, in cases of conflict in marriage, in common gossip, and nowadays in ‘life skills’ classes in primary schools. Thus, to suggest that sex is ‘never’ discussed is an exaggeration. Still less appropriate is any reference to a ‘cultural taboo’. Sexual intercourse between women and men is considered not only normal but necessary, thought to be essential for fully healthy persons as well as for reproduction. Moreover, in many rituals and dances, sexuality is both celebrated (linked especially to fertility) and joked about. Nevertheless, in everyday life, sexual activity is appropriately discussed only within specific circumstances and by specific categories of people. As discussed more fully below, sexual activity is beset with multiple cultural controls, infringement of which brings illness to the perpetrator and/or the innocent members of his/her family.

In addition to the constraints on open public discussion of sexual activities, the greater problem with AIDS is that it is associated with improper sex. The most common stereotypes about AIDS found among villagers are those found elsewhere in the country:

³³ People find it difficult to speak of the dead. They rarely mention the name of the deceased and it is considered inappropriate in most circumstances to refer to them.

people who are most likely to contract AIDS are described as *oyenda-oyenda* or ‘movious’ in Malawian English, what would be ‘sleeping around’ in Anglo-American slang. Some speak of people ‘not being faithful’ to their spouses. These stereotypes are not gender-specific and refer to pre-existing patterns of fairly common love affairs (*chibwenzi*) among villagers outside marriage. Although these affairs have never been condoned as proper and, in certain circumstances as discussed below, can have negative consequences, they were also not considered unusual. The strongly matrilineal and matrilocal character of the research area (and associated with Nyanja, Lomwe, Chewa and Yao groups) may be a factor in that the conjugal bond (‘marriage’) tends to be more fragile than in patrilineal-patrilocal groups. Nevertheless, the pattern of love affairs and sexual encounters outside marriage appears to be common across Malawi.³⁴

Although extra-marital relationships are fairly common, there tends to be a greater social acceptance of such behavior among men (perceived as being ‘in their nature’) than among women. This double standard is revealed, too, in the present context of AIDS where two stereotypes tend to scapegoat women more than men for transmission of the disease. These are, first, bargirls – young women who either work in or frequent the bars and rest-houses found in trading centers throughout rural areas as well as in the towns. While these bargirls have always been looked on as improper, the focus of so much media discussion of HIV/AIDS being on ‘prostitution’ seems definitely to have increased attention to them. Second, people speak of women (of all ages though the focus tends to be on the younger women) being more willing to ‘sell sex’ because of their need or desire for money. There is more specific evidence to support the first – bargirls being more likely to be involved in the transmission of HIV (though it is noteworthy that their male clients are more rarely mentioned), than the second. Even before the emergence of HIV/AIDS, women who were ‘mobile’ in going to markets, especially in towns, to buy and sell vegetables for example, were subject to rumors about their propriety. The slippage between mobility (moving around in pursuit of a job or business) and being ‘movious’ (an implied sexual laxness) is obvious.³⁵

In the context of a general downturn in levels of livelihood for the majority of rural people over the past ten to fifteen years and the repeated years of food shortages due to climatic and political reversals, poverty has pinched more, and women are known to have less ready access to cash sources than men. Nevertheless, it is important to recognize that the view of ‘women selling sex’ out of a desire/need for money or in-kind payment is a commonly repeated stereotype in the context of rising death and illness rather than a proven ‘fact’ about women’s behavior. While such cases certainly exist, they are not as widespread in the research area as common talk would suggest. Researchers and others must be careful to distinguish between popular prejudice and actuality.³⁶ The HIV epidemic uncovers ‘preexisting stigmas’ and prejudices, so revealing as much about the society as about the disease itself (Fassin 2007:32).

³⁴ This appears to be the case in expressed opinions, media, and various documents for all areas of Malawi.

³⁵ The double standard between genders is revealed here: men are assumed to be more mobile than women, a judgment long influenced by male migration for work and trade. Even in the research area where matrilocality greatly moderates ‘male dominance’, women are expected to be less mobile than men.

³⁶ Cf. In four Zambia study sites, people “tended to link high-risk behaviours to women, and disregarded the roles that men play” (ICAD 2006:4). Also see Fassin’s discussion of the repeated rumor in South Africa that ‘cleansing’ through sex with a virgin, including small children, is an antidote to AIDS, despite a dearth of well-documented cases of such acts (2007:95-6).

AIDS as a new, sexually transmitted sickness syndrome

There is a great deal of evidence from the Zomba research that people are well aware of the link between AIDS and sexual intercourse. Already in the mid 1990s, a woman in the sample told us that she had decided to divorce her husband because she had discovered (through gossip) that he was taking girl-friends in town where he had a job, and she explicitly said that she was afraid he would expose her to AIDS. Also in the 1990s, a couple of our research assistants told us that they were fully aware of the dangers and 'were holding their hearts', that is, they were remaining sexually abstinent until they had fixed on a marriage partner. This was by no means the decision of them all so that, sadly, just over one half of all the research assistants we have employed since 1986 are now dead, all from AIDS-related illness. In 2006, a former research assistant was working for one of the NGOs working with youth in the area and he told us that he and his wife are HIV negative and intend to remain that way by being faithful to one another. Also in 2006, one of the village chiefs in our sample area warned the research assistant resident in his village about sleeping around because of the dangers nowadays, referring implicitly but clearly to HIV/AIDS. Such comments were also heard in the many interviews with sample family members, in private comments made about recently deceased people, and in the many general conversations across the villages.

There are many instances of people acting on their knowledge of the link between sexual intercourse and HIV infection. One of the village chiefs (household 501) told us in 2006 that he had had himself and his new wife tested for HIV before they married (his wife had died in the mid 1990s, after which he had had another wife whom he later divorced but we had no information on whether he had insisted on a test with that woman, too). He also explained that he is not alone in paying close attention to whether or not a prospective partner, whether for a love affair or marriage, has had a spouse or partner who died of (suspected or confirmed) AIDS or whose behavior led one to suspect danger of infection. Another man in our sample suspected his wife of having lovers when she went on her frequent visits to the market to sell vegetables. This and some other disagreements led them to separate during 2006. But one decision the man took was to go to have himself tested. On finding he was HIV negative, he went to his wife and asked her to rejoin him in the marriage. He obviously felt that if he was negative, she must be and so must be innocent of sleeping with other men. (The wife, who told us this story, refused to re-enter the marriage not on any HIV-related grounds but because they disagreed on where they should live).

The sexual transmission of HIV is also clear in some of the cases where blame is being assigned for illness and death from AIDS. One mother (household 217) was overheard blaming her daughter for becoming sick through her own fault, an implicit reference to her having being infected by men she had slept with. A middle-aged woman (household 241) had her son die and soon afterwards her only daughter and her son in law, leaving two children. Understandably, she was quite grief-stricken by these losses. With regard to the deaths of her daughter and son in law, she did not refer to AIDS, though all the evidence points to that as the cause. But with reference to her son, she angrily blamed his girl-friend – the woman with whom he was living – saying that she had had a former boy-friend who used to go to Johannesburg (as a migrant worker) and passed on the illness to her son. Even though she did not mention AIDS or one of the

roundabout terms for it, she was clearly referring to the sexual contacts as the route by which her son contracted the disease and died. Further examples came from the meeting with a PLWA (People Living with AIDS) group. The members gave some illustrations of some of their difficulties, including taunts from neighbors that ‘did you get that disease from me?!’, meaning why should you be asking for help, you have only yourself to blame; and overt discrimination by some hospital staff members who similarly blamed them for being ill and dying of AIDS through their own fault. In all these cases, the route was posited as a sexual one and, by further implication, by sexual impropriety. This does not gainsay people acknowledging that some of the victims of AIDS are innocent sufferers, such as the children of some of those dead of AIDS.

Finally, a clear understanding of the sexual transmission of HIV is found in the many messages given by the many churches in the research area. These, as reported in other studies, have privileged messages calling for abstinence outside marriage and avoidance of adultery. A related message from churches, echoed by many ordinary people in the villages, is the danger of drunkenness when people ‘don’t know what they are doing’, whether in the ordinary round of village life (in local beer drinks and bars) or in the festivity associated with weddings and initiation ceremonies.

In sum, the link between sex and HIV/AIDS is well known in the villages, informing people’s statements and actions, and leading some to be more cautious about prospective sexual partners.³⁷ Nevertheless, this does not prevent the acceptance of another link between AIDS and witchcraft, as discussed in the next section.

AIDS and witchcraft

There are two main ways in which the discourse of witchcraft may intersect with interpretations of AIDS-related illness and deaths in Malawi. One is where people attribute a person’s illness and/or death to witchcraft and not to AIDS, and the other, not found in the Zomba sample as of 2006, is where people say that witches ‘hide’ their infliction of illness onto a victim behind AIDS.

The interpretation of illness, death, and a wide range of misfortunes (a smaller maize harvest than neighbors’ harvests, loss of a possession, failure to do well in an important venture, and so on) has long included witchcraft.³⁸ A sudden or unexpected death is frequently attributed to the malevolent intent of others, through witchcraft (*ufiti*) and sorcery (*matsenga*). In speech, there are a number of phrases used in the sample villages to connote the acts of bewitching or being bewitched, in much the way that there are many phrases to indicate AIDS.³⁹ Most cases of suspected witchcraft involve an individual or a small set of individuals, usually related in some way. But sometimes, a collective misfortune is attributed to particular forms of witchcraft. Thus, during several of the severe droughts occurring in Zomba during the 1990s, it was said that someone was ‘tying up the rains’ and the local chiefs met to hold a secret rite that would overcome the malevolent intent of the person. The vast majority of cases talked about in the

³⁷ Cf. Watkins 2004, and Smith and Watkins 2005.

³⁸ This term is used to cover sorcery and witchcraft, a distinction that some writing about Africa find unhelpful (Rodlach 2006: 52), but that in Malawi are distinguished linguistically and according to certain practices. It includes a range of beliefs and actions taken to influence events: use of potions, medicines (*mankhwala*), spells, rituals in order to manipulate powers normally beyond the reach of a person.

³⁹ Such as *kulodza/kulodzedwa* (bewitch, be bewitched), *kupita pansi* (go underneath), *kupondetsa* (to step on), *kukawa* (spiriting away someone’s wealth or maize harvest), etc.

villages, however, concern specific individual persons. A young man who was struck dead by lightning one rainy season when he was walking with other people to a funeral in another village, was said to have been targeted by his uncle. The uncle was said to want the field that the young man's mother (the uncle's sister) had given her son to use and he had used special powers to call down the lightning on the youth. Several of the village chiefs who have died over the past 20 years of research have had their deaths attributed to their being bewitched by close matrilineal relatives who wished to have the chiefship for themselves. Although there have been far more cases of witchcraft talked about rather than any person being overtly accused in the villages, the identity of the person sending the harm is sometimes found out through the victim or a member of his/her family visiting a specialist (*sing'anga*).⁴⁰

Attributing the cause of an illness, death or other misfortune to witchcraft, then, is common, is often said to involve close relatives, and tends to reveal, channel, and reproduce tensions and divisions within a family or lineage group. Thus, such accusations are often associated with splits within lineages and the formation of sub-lineages with their own *mwini mbumba* and their own land markers, and, especially over the past ten years, with efforts to form their own villages. While witchcraft also occurs between unrelated persons, this seems to be more often found in centers such as towns or labor sites where people are interacting most of the time with unrelated others. In the context of HIV infection, with the growing numbers of illnesses and deaths related to AIDS, one can imagine that such stressful conditions are likely to find ways of blaming those with whom one has prior disagreements and grudges. It is unclear, though, that there has been a significant increase in attribution of illness and deaths to witchcraft. On the one hand, this might be expected from the sharp rise in illness and death, on the other hand, as discussed in this section, there are numerous interpretations of the cause of illness and death so that witchcraft does not bear the sole blame.

An example of where illnesses otherwise attributable to AIDS are denied to be so, and are said to be caused by witchcraft is Che K (household 518). He was very sick all through 2006 and his symptoms, both observed and reported, seemed classically due to AIDS: hair thinning and falling out, sores over his body, frequent bouts of diarrhea, wasting, and severe weakness. For most of the year he was found either inside the house or lying or sitting on the small verandah. His wife did all the work of the fields and compounds, with the help of her grandchildren. Although the neighbors of Che K were explicit in their many conversations among themselves over the year that he was suffering from AIDS, Che K insisted that he was bewitched by some of his natal relatives 'back home', and he spent a good deal of the household's money, which was hard earned by his wife by selling a few vegetables from their garden, on going to traditional doctors (*asing'anga*) for medicines. We were also told by the home-based care volunteers in the village that Che K had refused to see them when they had tried to enter the compound to see whether they could help him (and to advise him to go for testing, they added to us). We later heard that he died in early 2007.

Another case where AIDS-related illness was attributed to witchcraft concerned Che C (household 517). He had been a leading tobacco farmer during the 1990s. Before

⁴⁰ Although several instances of witchfinding by experts (always brought in from other areas) have been observed over the years, none has involved the killing of suspected witches as has been described for parts of Zambia by Yamba (1997).

that, he had been a foreman in a mine in South Africa, a job that had allowed him to build capital to invest in tobacco farming when he returned home for good in the late 1980s. Not only was he a successful farmer (with a beautiful brick and tin-roofed house) but he was also a key player on most of the committees in the village as well as being the chairman of one of the burley tobacco clubs. But by 1997, he clearly was doing less well, farming less, with fewer material benefits visible in his compound, and reportedly less healthy. By 2006, we learned that he had been ill on and off over the previous six-plus years, his farming had drastically been reduced to the point that he sold a large field, he had left the burley club because he had defaulted on his loans, and was said by other villagers to be involving himself in various dubious schemes to make money quickly. His wife in a way that was considered unusual and unbecoming, overtly complained about him, indicating that she was finding herself burdened with the need to keep the family going since her husband was able to do so little. She made some money from her own herbalist trade. While neither referred, even implicitly, to AIDS, all the evidence pointed to it as being the cause. In mid-2006, Che C was felled by a severe stroke. We visited him after a few days and found him lying down but able to speak relatively clearly and to move, albeit that he was semi paralysed on the left side. He was being treated by herbs but had not been taken to hospital. A few weeks later, we were told Che C had suffered another stroke but this time had not survived beyond a day. The main story then being repeated was that all this had happened through witchcraft. A friend of his had harvested a lot of maize earlier in 2006 from his fields and asked Che C to look after some of the bags until he found transport to take them to his own compound. When he came to collect them, he found that much of the maize had disappeared, apparently used and/or sold by Che C. He was very angry and reported to have threatened Che C – ‘*uona*’ or ‘you will see’. Thus, people said, his strokes and death were caused by this man sending them through witchcraft as revenge.

It would be wrong to suppose that witchcraft is invoked only in villages. During 2006, three highly educated people in a prestigious institution in the research area died. All of these deaths were described by close friends and colleagues to be due to AIDS. However, in none of the cases was the death attributed to HIV/AIDS by their families but rather, to witchcraft. In two of the three cases, the perpetrators were said to be colleagues of the dead person, jealous of that person’s achievements. In one case, this statement was made publicly by a presiding clergyman at the funeral. In the cases of two of the deceased, their surviving spouses also attributed their deaths to witchcraft and despite efforts by close friends to get them to go for HIV testing, they adamantly refused to consider HIV/AIDS as the cause.

The research in Zomba district shows that chronic illness and death which some might attribute to AIDS may also be attributed to the victim’s being bewitched by some malevolent others. Although the idea that witches were taking advantage of AIDS to hide their nefarious activity by causing illness in someone was heard in the area, it did not feature in any of the specific cases in the sample where people attributed a person’s illness and death to witchcraft. Forster, in his research in Zomba, found that some people claimed that illness and death really caused by witchcraft was mistakenly attributed to AIDS, while others said the reverse – that people blaming witchcraft for illness are really infected with HIV (1998: 542). Probst, in an article discussing Billy Goodson Chisupe, who had claimed to have a cure for AIDS, concluded that “ideas presuming a link

between witchcraft and AIDS are very seldom heard in Malawi” (1999: 118). This statement might be interpreted as people seldom invoking witchcraft in cases of people being ill or dying of symptoms identical with AIDS, or it might be interpreted as people seeing witchcraft as an alternative interpretation to AIDS. It is this latter that we found in Zomba: in the many cases where chronic, serious illness and deaths were attributed to the sufferer being bewitched by malevolent others, AIDS was not seen as the cause. In other words, witchcraft and AIDS (including the elliptical reference to the disease through the roundabout terms discussed earlier) were alternative or competing interpretations for any one incident, even though many people employed both interpretations in their judgments about various people’s sickness and death.

Conspiracy and suspicion: the purposive transmission of HIV through non-witchcraft means

A far less common interpretation given to symptoms and deaths some would attribute to HIV/AIDS than any of the others discussed here (sexual transmission, witchcraft, *kanyera*) is that the disease has been purposely sent to infect Malawians. The most usual form such a ‘conspiracy’ theory takes is that condoms and other contraceptives have been laced with poison or HIV (usually referred to as AIDS). There have long been suspicions held by villagers across Malawi about the various family planning programs to which they have been subjected over the years. A recent paper by Amy Kaler (2004) provides an insightful analysis of past suspicions and of recent ones recorded in journals kept by research assistants in 2003. People suspected that condoms, contraceptive pills and injections were infected with AIDS because the government and their donors want to reduce population, and because the donors were tired of giving aid funds to Malawi.

In the Zomba research, the most commonly expressed fears were that condoms and other contraceptives, including the injections and pills designed specifically for women, caused infertility. A few did raise the suspicion that these methods of preventing the growth of the Malawian population had now turned to the use of HIV/AIDS as a way of stopping people from reproducing. But the most explicit statement to this effect was found among some traditional doctors (*asing’anga*) which is laid out in the following section. It remains to be seen whether the rise in chronic sickness and deaths and the spread of such an interpretation will result in a more widespread embrace of such an interpretation.

The effect of HIV/AIDS on local interpretation of sickness syndromes: the redefinition of *kanyera*

Before discussing how *kanyera*, a local, named disease or sickness syndrome, appears to be becoming aligned with AIDS, we briefly lay out the cultural framework for interpreting sickness and health in the research area (and more widely in central-southern Malawi).

There are a number of well-known, named sicknesses recognized by villagers; some of these may be attributed to ‘natural’ or expected causes, others may be attributed to non-natural causes such as witchcraft or the anger of ancestors. Unexpected or sudden deaths in otherwise apparently healthy people are frequently attributed to witchcraft. Very old people are recognized to have multiple and chronic complaints and their deaths

are usually attributed to those causes, though sometimes other non-natural causes such as bewitchment, sorcery or ancestors' anger might be invoked. A great deal of attention is paid to the signs or symptoms of illness as well as to the context of the sufferer's behavior and that of those around him/her. The two most common terms relating to episodes of ill-health are *matenda*, meaning sickness or diseases with a very broad range from a cold to a fatal complaint, and *mankhwala*, meaning medicine, again with a broad range of reference from herbs, healers' potions and magical remedies to drugs bought in stores or obtained from clinics.

Illnesses considered common and subject to treatment and cure include malaria, often called *malungu akulu* (literally, big or grand fever)⁴¹, *chimfine* (common cold), *nyamakazi* (joint or bone discomfort, arthritis), *phumu* (chest congestion, asthma). Some named illnesses are identified through a cluster of symptoms that might be interpreted in various ways both locally and by health authorities: a common one is *nsungu* (sore throat, chest congestion, skin sores). Much of the time, only symptoms or the locus of the illness are defined: so an eye infection or something wrong with the eyes will be referred to as *maso* (eyes) by the sufferer and other people, including healers, in describing the problem; similarly, *msana* (back) or *mutu* (head); diarrhea, aches and pains, skin rashes, etc will all be identified as such. In many of these cases, an enquiry into the cause of the illness would elicit a range of 'natural' causes, such as pains from having worked long hours in the field, or indeterminate causes, such as *mphepo* (wind) or a particular season and so on. But where a symptom is slow to disappear or where assigned treatments fail to make the sufferer better, then other causes might be invoked.

Another category of illnesses is what we call sickness syndromes⁴² thought to be caused by infringement of rules guiding sexual behavior. These are *tsempho* (or *mdulo*), *kanyera*, and *chitayo* and are attributed to improper behavior –someone not behaving well (*sanayende bwino*) in the context of marital and sexual relations. These syndromes tend to have similar signs – diarrhea, getting thin or swollen, overall pains, cough, and weakness – that occur in combinations. The interpretation of the signs takes account of the known or suspected behavior of the sufferer or those around him/her.

Tsempho (also called *mdulo*) is the result of sexual intercourse at times or places when it is supposed to be prohibited, as well as extra-marital intercourse. The periods when intercourse is prohibited include the mourning period around a funeral (nowadays about three days but this might be more for very close relatives), and during the initiation of one's child. Adultery can bring *tsempho* onto a child if the erring parent does not take the proper medicines to prevent that outcome. A particularly vulnerable period is pregnancy since a man returning home after having sexual intercourse with some other woman can bring *tsempho* on the unborn child and his wife. Terms used to describe what happens include *kulumpha mwana* (jumping the child), or *kusemphana* (crossing/mixing, referring to the mixing of incompatible fluids in sex). The result is miscarriage or swelling (*kutupikana*) in the child who becomes weak, looks malnourished, and may die.

There is a further route of transmission of *tsempho* or *mdulo*: this is when a woman who is menstruating or who has had sexual intercourse during a prohibited time, such as during mourning, or who has had sex with someone outside her marriage adds

⁴¹ This phrase might also refer to meningitis.

⁴² The term syndrome is used because the conditions entail a range of symptoms and outcomes that do not map onto any single bio-medical illness (such as malaria or measles or TB, etc).

salt to the relish (*ndiwo*), the accompaniment to the staple maize porridge, causing illness in the eaters. The vehicle for the transmission of the ritually caused illness here is salt; there are rules about when a woman may and may not add salt to food, though not all younger women appear to follow such rules nowadays.

Underlying all these routes of transmission is a posited incompatibility between ‘cold’ or ‘cool’ states such as pregnancy and mourning and childhood and ‘hot’ states such as menstruation, childbirth, miscarriage, and unregulated sexual intercourse. The latter includes both adultery or extra-marital sex but also sex between a married couple in prohibited periods, such as funerals, or in inappropriate places, such as during the day instead of at night, or outside ‘in the bush’ instead of indoors (cf. Morris 1985, DeGabriele 1997).

While some people see *tsempho* or *mdulo* as the outcome of a man’s having sexual intercourse with a woman (whether a wife or other woman) who is menstruating, who has just miscarried, or who has just had a child, more in our sample say that the result is *kanyera* (also written *kanyela*). Some make a further distinction when they label the state of illness deriving from sex with a woman who has recently miscarried as *chitayo* (a reference to *kutaya*, to throw or, in this case, to abort). In the Zomba sample, it appears that *chitayo* is now seen as a sub-category of *kanyera*. Also, *kanyera* appears to have taken on much of what has been previously (and elsewhere – see Morris 1985) attributed to *tsempho* or *mdulo*.⁴³ As noted above, the signs for these are almost identical.

An example of the importance of the process of interpretation for diagnosis is where a child becomes sick, has severe diarrhea, refuses food, and becomes either very thin or swollen. The child may be identified in the hospital as suffering from kwashiorkor, malnutrition, worms, etc. In the villages, the child may be said to suffer from *tsempho* because, for instance, the father had sexual intercourse with someone while his wife was pregnant. Or it may be described as *utumbidwa* (literally, ‘born over’), a definition that identifies the problem as the child being neglected because a new baby was born ‘too soon’ after the suffering child (a pregnant woman is not supposed to breast-feed the previous child so the latter is abruptly weaned). Or the illness may be attributed to witchcraft; or it may be described as ‘merely’ suffering from a lack of food. The actual interpretation and hence the treatments subsequently used vary and may change over time.

AIDS is [or is like] *kanyera*

While the Zomba research over the past twenty years shows that the interpretation of a sickness suffered by a specific person is subject to change over time, the named syndromes appeared to remain fairly stable. This seems to be changing somewhat with the advent of HIV/AIDS. While death is not new to people in the villages, they have had to face unprecedented levels of chronic illness and death among the very category of people – those between 18 and 50 – who are normally seen to be the most healthy and active segment of a population. For over ten years, now, and for the foreseeable future, people have been forced to come to terms with this unprecedented situation. They appear to be seeking ways of making sense of what is a dreadful situation. Parents watch their adult children, in whom they have put such effort and hope, fall ill and die, often in

⁴³ Lwanda (2003:117) refers to “*kanyela* or *mdulo*” as though these are the same, though he does not discuss these closely.

extreme discomfort and pain. People who expected to enjoy a little rest in their old age when customarily they would be able to do less work in the field and compound as their adult children took over the responsibilities, have now to become parents again to their orphaned grandchildren. When times are so out of joint, is it any wonder that they do not find it helpful to attribute such terrible experiences to a simple word *edzi* and expect that to be sufficient explanation. On the contrary, people feel confused, worried, even angry at the tragedies in their own lives and around them, and one outcome is a reconsideration of well-known sickness syndromes in relation to the new situation of serious, incurable illnesses and resultant deaths.

Unsurprisingly in such an unprecedented situation, people do not agree with one another over what these 'new' illnesses can be attributed to. The medical description of HIV/AIDS and the forms infection takes in sufferers are confusing to villagers in that, first, the disease is said to be incurable while the premise of Malawian interpretive frameworks for sickness and health is that most illnesses do have a cure even though particular individuals may die of a disease. Second, this new, incurable disease presents itself in most sufferers in the forms of well-known diseases such as TB, cancer, sores, mental instability, and so on (cf. Forster 1998: 542). Within these confusing, challenging contexts, one line of argument that emerged more strongly out of the 2006 fieldwork compared with earlier years was a link posited between AIDS and *kanyera*, one of the long-known sickness syndromes known to people. Some respondents remarked on the close similarity of the signs and symptoms of *kanyera* and those described for *edzi*: diarrhea, increasing thinness, pale, thin and straightening hair, and cough. Having noted the similarity, some equate the two diseases; some say that *edzi* is thought to be the cause when it is really *kanyera*; some say that *edzi* is a new type of incurable *kanyera*; and yet others insist that, despite the similarity of signs, these are two distinct diseases. While some claimed that *kanyera* and *edzi* are the same and others denied that proposition, many people shifted among the various positions in the course of a single conversation. The following cases illustrate the range of opinions found in the research villages.

People denying *kanyera* is AIDS

An HIV-positive person: One person who denied that AIDS is *kanyera* is Abiti N (household 507), the only person in the entire research sample who has publicly made known her HIV-positive status.⁴⁴ She and her polygynous husband had been ill for several years with different illnesses, had tried a wide range of treatments, 'traditional' and clinical, but never got better. Eventually, they were diagnosed with TB and started receiving TB treatment. In May 2006, they accepted to be tested for HIV and were found positive. While Abiti N's husband never spoke openly about his HIV status to the researchers, referring only to the various illnesses, including TB, from which he suffered, Abiti N was quite open. This was and is extremely unusual. Over the course of several conversations, she said that when she was told she was HIV positive she was relieved because she finally knew what was wrong with her – she had become very discouraged at having none of the treatments, 'traditional' and clinical, cure her.

Her husband was put on anti-retroviral therapy (ART) as well as the TB drugs but had some difficulty with them. During an episode of serious malaria, he reportedly did

⁴⁴ Although there were a few others in the sample villages who had done so: one, a Mai S, was particularly knowledgeable and vocal about the drug therapy and the diet appropriate for HIV+ people such as herself.

not want to take even more drugs to treat malaria, and he died in November 2006, barely two months after being started on ART. Abiti N spoke quite openly about the increasing difficulties she was facing. Her repeated bouts of illness prevented her from working as hard in the fields, so making it difficult to produce sufficient food for the family, and to find school fees for her youngest daughter who was a good student in secondary school. She accepted, apparently without bitterness or the extreme anxiety not unusual in other people, that she had a fatal condition but she also pointed out that the TB and other medicines given her were helping. In describing her difficulties, she shrugged and said “no-one lives forever!” (literally, you don’t know when you’ll die - *wakufa sadziwika*), “my future is the same as I was before I was HIV-positive – everyone has to die sometime.”

One time she said that she was sorry to see so many people around suffering from the same condition but refusing to get tested and so they were not taking advantage of the chance of being given anti-retroviral drugs which can make them stronger. It was in the course of this conversation that she was asked whether she thought AIDS and *kanyera* were the same. She adamantly denied it. She said that *kanyera* is an illness that has been around for a long time and it is contracted by men who have had sexual intercourse with a woman who has miscarried or who has her monthly period. But AIDS, she continued, is a new disease that attacks both men and women in different ways with different illnesses. She said she didn’t know the origin of the disease but she knew it was transmitted through sex and through injections. (Of course, in the course of her treatment, she had received information from the clinics). In a couple of follow-up visits during 2007, she was found to be very sick, eventually dying in August 2007.

A middle-aged, prosperous couple: A similar response denying that AIDS is the same as *kanyera* came from a middle-aged married couple, healthy and not known or suspected of being infected.⁴⁵ They were first asked a question about the most common illnesses to be found in the area, to which they answered malaria and AIDS (using the term *edzi*). Asked how one recognized AIDS, the husband said “It is easy to see the signs” and listed them as straight and weak hair, being very thin, and diarrhea. His wife added that often such people yearn to eat meat. Asked about *kanyera*, they both agreed that it is a locally known disease but said that it seems to have decreased. The wife explained that it is a disease of men and they contract it after having sex with a woman who has not finished menstruation or who has miscarried. The man becomes thin, his hair comes out, he has diarrhea and vomits, complains about pain in his stomach. Asked how they differentiate *kanyera* from AIDS, they answered that only men get *kanyera* whereas both men and women get AIDS. They also differentiated the signs saying that a man with *kanyera* feels cold so he likes to be in the sun, he passes black stools, he likes to eat salty food; while those with AIDS have sores and wounds on the body, scabies, their lips look red, and they want to eat meat.

Positions equating *kanyera* with AIDS though with occasional ambivalence

A village headman: One of the most detailed accounts came from one of the village headmen (household 137) of the sample villages. This man is a highly articulate

⁴⁵ The man had been married to a younger woman in one of our sample households between 1986 and 1997 but then had divorced, and since then he has lived full time with his first wife whose household is not in our sample. But we had kept in touch with him.

speaker, a well-respected headman, a builder by profession as well as a keen farmer, and an elder in the CCAP church. It was several conversations with this village headman, who is called Sandy here, that first alerted us to the apparent rise in the focus on *kanyera*. During the 1997 fieldwork, we asked Sandy about the new disease AIDS. He explained that at first he had not believed the stories about a new incurable disease, but over time he realized that this was something new and serious. In the 1997 conversation, he mentioned several of the ‘roundabout’ terms being used locally to refer to this new disease, one of which was *kanyera wakulu* (big or serious *kanyera*), but he had not said any more than that at that time.

During 2006, however, he appeared to have become far more definite in linking *kanyera* and AIDS. In a conversation about the rise in deaths and orphans in his area, Sandy stressed that most sickness has come because people no longer observe certain cultural ways (*miyambo*). He said people think there are many orphans because of *matenda obwerawa* (‘sickness that has come’ or AIDS) but in his view, many people are dying because of *kanyera*. He said that he wondered why people just talk about AIDS when they do not know whether a person has really been tested or not, and he argued that the signs people focus on are those for *kanyera*. He said *kanyera* is a serious disease and it needs to be recognized; AIDS is only one of the problems causing people to die. He said that the reason for many of those dying is because they are disobeying the traditional rules about stillbirth or abortion (*mtayo*), menstruation period (*kusamba*) and the rules preventing *tsempho* (see above). When people don’t follow these rules, he stressed, the result is *kanyera*.

Although he maintained that people are too quick to assume certain types of illness are due to AIDS rather than to *kanyera*, he also said that there should be testing (for HIV) centers closer to the villages so that people can more easily get tested. He blamed several aspects of modern life for the rise in both *kanyera* and AIDS though, as noted, he moved between them in ways that did not make clear how one is to distinguish one cause from the other. He blamed the fact that the Church’s modified initiation rites did not teach the young people about the rules of avoiding sex at such times as stillbirth. Only the ‘traditional’ or non-Christian rites still did so.

In a separate conversation a few months later, Sandy complained about the bias of reports on the radio blaming initiation rites (*chinamwali*) for the spread of HIV/AIDS. He pointed out that the real problem is indiscriminate sex (*chigololo cha chipwilikiti*). Elaborating on what he had said about AIDS and *kanyera*, he said that the government talks only of AIDS when they should also be talking about *kanyera*. The government, he said, tells people that AIDS is caused by *tizirombo* (small organisms, the local translation of virus) but they [the people in the village like himself] see that the problem is *kanyera*, caused by the failure to obey traditional rules (*miyambo ya makolo*). He compared the situation to the huge increase in TB. Asked about his son who had recently died, having been diagnosed with TB, he said that it was TB not *kanyera* – he had no signs of *kanyera* like diarrhea, thinning hair, and so on. He had got medicines from the hospital where the TB was diagnosed. The village headman went on to say that he suspects that the reason the son died was that he “did not follow the rules”, that is, he was having sex with his wife when he was taking the medicines, which he wasn’t supposed to be doing, and, he added, that is the reason that the son’s widow continues to be ill with TB.

The accounts provided by Sandy, parts of which have been expressed by others in the sample villages, show him to be linking *kanyera* and AIDS: sometimes he appears to equate them, at other times he distinguishes them, insisting that they are two diseases and need to be treated differently. In pointing to causes, he argues that 'careless sex' is at issue for both *kanyera* and AIDS, though he insists most on the fact that infringing cultural rules (*miyambo*) leads to *kanyera*.

The people who were most likely to equate HIV/AIDS with *kanyera* were 'traditional' doctors or *asing'anga*, though, as with other people, they disagree on some elements of the interpretation. The following is a synopsis of the main points drawn from detailed conversations with four *asing'anga* practising in the research villages.

All had slightly different specialties but all treated the common venereal diseases, severe headache (*mutu*), and other illnesses, as well as bewitchment (*zopondetsa*), and all spontaneously named *kanyera* as a major complaint they treated. They described *kanyera* in the same way as outlined above: an illness resulting from a man having sexual intercourse with a woman who has just miscarried, given birth or who is menstruating, and whose penis 'sucks in' (*amayamwa*) the 'bad things' from the woman (*zoipa zamkazi*), and that the signs are diarrhea, loss of weight, cough, thin hair and paleness. All said that if a man is not treated for *kanyera*, he is likely to die, and a couple said that their medicines were for both treatment and for prevention of *kanyera*. This last point is important because the main fear is that a man will not know that a woman has just miscarried and so may inadvertently expose himself to becoming ill with *kanyera*.

All these local 'doctors' spontaneously pointed out that the signs of *kanyera* and AIDS are the same or very similar – becoming very thin, pale and weak, the hair thinning and straightening, diarrhea and cough. Three of them equated *kanyera* with AIDS while the fourth made ambiguous statements about the relationship.

Sing'anga Byson said *kanyera* is the same as AIDS. However, he also suggested a different cause of HIV infection. He said that people confuse some illnesses they suffer with AIDS. He stated that 'this new disease' (that is, AIDS) does not come from God but from the contraceptives that the government (*boma*) promotes. He stated that the condoms and the drugs given to women for birth control have poison in them, which then attacks the body and makes the person ill. He explained that when men come to him for treatment for sores around their penis and he finds that they have been using condoms, he tells them that the sores are the result of the poison in the condoms and they should stop using them. Similarly, the medicine (birth control pills or injections) that women are given for family planning prevent them from having menstruation so that the 'bad blood' inside them is unable to come out. The buildup of the 'bad things' (*zoipa*) in a woman's body produces all kinds of illness like diarrhea, cough, vomiting, high blood pressure and TB. Asked directly if he has treated people with AIDS, he answered yes and gave the example of a young woman who had come with what he considered signs of AIDS and he had advised her not to use condoms. He did not claim, however, that he had cured her.

Even though in a different conversation he volunteered that one of his adult daughters had died of AIDS (and he used this word), he did not seem to see this as a contradiction to what he does in his normal practice.

Sing'anga Alimu: Unlike the other healers listed here who are Christian, Alimu is Muslim, but his account is very similar. After he described the signs of *kanyera* as being identical with those for AIDS, he was asked if he treats people with AIDS. At first he

said that AIDS has no cure so he cannot claim to have treated someone. But in the very next breath, he said that the signs of AIDS (*maonekedwe a munthu wa edzi*) are the same as those of *kanyera*. In fact, he claimed, people have stopped calling the condition *kanyera* and call it AIDS. The problem with this, he asserted, is that people have been told there is no cure for AIDS but they forget that there is a cure for *kanyera*. He then went on to say that this means that the two conditions (AIDS and *kanyera*) are the same and so those who know the medicine for *kanyera* also have the medicine for AIDS. But, he explained, he cannot state that openly because the government does not want to hear this said. Here, he was implicitly referring to several well publicized cases where a traditional doctor had claimed that he had medicine that could cure AIDS, in response to which government spokesmen had denied that this was possible and made vague threats about preventing such claims being made.

Sing'anga Mapira gave much the same description of *kanyera* but he added a new element saying that the 'bad things' coming from a woman in the states of miscarriage or menstruation contain *tizirombo* (little organisms), that are whitish in color (*totuwa*). These enter into a man's body during sex and they then drain the blood of the man. Moreover, unlike most other respondents, Mapira said that a woman is also infected by *kanyera* because during such sexual encounters the bad blood is pushed back inside her instead of coming out. He claimed to have the medicine that cleaned the body of these *tizirombo*. Asked directly if he treats people with AIDS, he responded by saying that since AIDS is the same as *kanyera*, he does treat it. He repeated that the symptoms (*maonekedwe a munthu*) of both are the same. He said that he does not tell people that he treats AIDS because that is forbidden by the government. He explained how he knows the cause of illnesses: he uses several divining techniques (*kuombeza*) to assess what the patient is suffering from. If it is *kanyera*, then he "sees" the *tizirombo*. After the diagnosis, he gives the patient medicines to drink to cure the *kanyera* and tells him to come back for a check-up. He said that he usually finds that the *tizirombo* have disappeared. He claimed he then tells people to go to get tested (for HIV) though he said he is aware that many do not. But he asserted that some had come back and told him that they had tested negative, which he took as an indication that his medicine had worked.

Sing'anga Francis specifically said he did not treat certain diseases like cancer of the uterus, meningitis, and he included AIDS (*matenda alikowa*), which he said had no cure. He said: "People tell us that there is no cure for *edzi* – even the white people (*azungu*) have failed to find one – yet it is the same as *kanyera*. The signs of both are the same and you get both by sleeping around (*chiwelewele*). In the past, we would give medicine for *kanyera* and the patients would be cured within days. But nowadays, some people get cured from the medicines and others don't. So I think that *kanyera* has become *edzi* because it cannot be cured as was the case before." Asked to elaborate on the difference, Francis said only men get *kanyera* whereas both men and women get *edzi*; there is medicine to cure *kanyera* but not for *edzi*; *edzi* has *tizirombo* (little organisms) whereas *kanyera* is caused by *magazi oipa* (bad blood) and the blood doesn't have *tizirombo* in it.

In summary, during 2006 a number of people in the villages, and perhaps more healers than others, were coming to the conclusion that AIDS and *kanyera* were linked.⁴⁶ Some felt that they were names for the same disease but that people were ignoring the traditional methods of prevention and traditional methods of treatment of *kanyera* and focusing on the new disease of AIDS. Others felt that the old *kanyera* had become more difficult to treat and so now it has been labeled AIDS. Some, noting that the symptoms of both diseases were almost identical, worried about the fact that *kanyera* had been preventable or curable in the past, but now, possibly under the label AIDS, had become incurable. Some of the healers (*asing'anga*) claimed that the treatments for *kanyera* could act as both a preventative and a curative for what is now called AIDS. A few included a new diagnostic – *tizirombo* or small organisms (translating 'virus'), although the interpretation of these in distinguishing an illness as AIDS or *kanyera* varied. Some people, however, insisted that AIDS and *kanyera* are two distinct diseases, even though they share some symptoms, and they tended to point to the facts that *kanyera* is a man's disease whereas AIDS affects men and women, and that *kanyera* cannot be passed from a man to woman, again unlike AIDS (actually HIV infection).

Given the similarity of the symptoms and the fact that most people depend on description of symptoms to come to a conclusion on the cause of an illness, it may not be surprising that *kanyera* is seen as very similar or identical to AIDS. Moreover, a further source of identification is that both diseases are associated with sexual impropriety, even though *kanyera* has been traditionally thought to result from the infringement of specific rules whereas AIDS is linked to a more generalized 'sleeping around'.

The dangers of the close association or identity of AIDS and *kanyera* are clear. Some healers who have long diagnosed and prescribed both preventative and curative medicines/practices for *kanyera*, now claim (albeit indirectly from fear of government censure) that these methods are appropriate for treating AIDS. While it is not unlikely that some of the treatments might help alleviate symptoms of illnesses resulting from HIV infection, they clearly cannot compare with the recommended treatment of HIV+ persons. To the extent that people suffering from illness that might be the result of HIV infection choose to believe healers' claims then they are likely to delay getting tested and treated for the infection.

At present, the role of traditional healers in the fight against HIV/AIDS seems either ignored or seen to be potentially negative by medical and other official authorities. The stories in the press concerning the quashing of claims by some healers of having found a cure for HIV reinforce the negative. The findings from the 2006 study reported here also give cause for worry. But it might be a more productive tack for the government and relevant authorities to seek ways of engaging with rather than distancing themselves from healers. The need for education on the biological pathways of the virus among healers (as of others) is clear. Beyond that, it may be possible to discuss ways of healers being helpful in treatment of some symptoms of HIV-related illness while eschewing any claims of preventative or curative medicines for HIV+ persons.

⁴⁶ For similar syndromes in neighboring countries see Mogensen 1995 on Zambia, and Carla Braga's ongoing research in Mozambique (personal communication).

From interpretation to treatment

It is important to set the question of how people suffering from AIDS are treated in relation to the 'normal' situation of treating sickness. People can be quite cavalier about illness that is not serious – a cold or pain that lasts a short time and/or that responds quickly to easily obtained medicines. But as an illness persists and deepens, then people become anxious and, where the illness does not respond to treatment, they also become suspicious and fearful. In a very large number of cases, serious illness is attributed to witchcraft. Whatever the diagnosis and no matter how often that diagnosis is changed, people expend great effort in obtaining medicines and related treatments to help the sick person get well. The research over the past twenty years show that people search for medicines and treatments of all types up to virtually the last breath of the sick person. There is a deep sense that not to do so is to reveal oneself as implicated in the illness, possibly as a cause of it. A particular pattern found in the sample area is a concomitant of the matrilineal kinship system. When a man becomes very seriously ill, he is usually taken to live with his mother or sister rather than remaining with his wife. This is so for two reasons: first, it is assumed that one's natal family will take better care of one than one's in-laws, and second, spouses and in-laws are often reluctant to see a person approach death since they fear being blamed by his/her natal family for the death.⁴⁷ In cases where a woman is living away with her husband, she will also be taken 'home' to her mother and/or sister in the event of a serious illness. All this remains true with the onset of HIV/AIDS and the rise in chronic illness and death.

In the cases known to the researchers where a person was suffering from (suspected) AIDS-related illness, the reaction and pattern of care varied from long months of careful tending to distant and reluctant care-giving. From our small set of cases, the former type of reaction – attentive care, greatly outnumbers the cases of partial neglect. The situation resembles that described by Chimwaza and Watkins (2004). The family is the main source of care-giving to the sick, including those ill with AIDS-related sickness, and the type of care is essential and 'basic' in terms of feeding, bathing, cleaning sores, washing soiled clothes and blankets, as well as emotional support such as chatting, reassuring, etc. Even though most of the care is claimed not to be a 'problem' by the care-givers, they do face difficulties in obtaining sufficient food, especially the 'treats' usually desired by the sick, such as meat or fish or soft drinks, and money for medicines. Except for the small minority of well-off families, the extra burdens of care brought with the rise in AIDS-related sickness intensify the challenges felt by the majority of families who have little cash and who are food-deficit for part to much of the year. The main care-giver is always a woman even though she may receive periodic help from a male relative, including a husband, and from female relatives and friends. As noted above, a sick person may receive visitors on a regular basis. In most cases, too, the period in which a patient is so ill that he or she requires almost full-time care, tends to be relatively short, on the order of under six months, although there were a few people in our

⁴⁷ This incidentally is the answer to a question posed by Chimwaza and Watkins in a paper about care-givers to AIDS patient where they were "puzzled ... by the absence of wives taking care of husbands" in their cases. They wondered if "our informants considered it normal for wives to care for husbands, and so did not direct us to these situations" (2004: 797). In fact, in their site of Balaka, as in Zomba, the matrilineal kinship norms assume the opposite – that (at least for a seriously ill person) sisters not wives are the best care-givers.

sample who were severely ill for about a year. Finally, as Chimwaza and Watkins stress, the fact that many people do not attribute the sick person's sickness to AIDS appears "to have little consequence for patient care" in the villages (2004: 805). Unlike the former authors, we did find some evidence of "patients [being] stigmatized" or at least of some neglect (see the cases above) but most people suffering from AIDS (however their illness was defined) were being looked after in much the way other sick people normally are.

VI Providing Care in the Context of HIV/AIDS: Care giver groups

In the sample villages, the overwhelming source of care for all those suffering the effects, direct and indirect, of HIV/AIDS is the family. The secondary sources – a very distant second – are the formal health services, and the much newer ‘community’ groups that have proliferated in the wake of the pandemic. The sources of information on which this section of the report is based are conversations with the sample household members, observations by the researchers and their assistants (who were resident in the villages), and more formal interviews with representatives of the various groups discussed.

Earlier sections of this report describe the centrality of the family (extended family or lineage) in the care of the sick, orphans and elderly. Yet the ability of the family to absorb people and traumas does not mean that all families can do everything alone. That has never been the case but is particularly not so in face of the greatly increased burden of care imposed by the rise in sickness, deaths, and orphans due ultimately to HIV/AIDS. The modifier ‘ultimately’ flags the importance of recognizing the severe constraints of income and livelihood experienced by the vast majority of rural Malawians and hence of not separating the traumas caused by the HIV pandemic from pre-existing and continuing socio-economic difficulties. These latter include considerable volatility in economic and climatic conditions, an increase in income inequality over the past twenty years, and a decline, exacerbated by the HIV pandemic, in the quality and availability of health care.

What kind of institutions and organizations might support the efforts of the rural Malawian family? There are the formal institutional structures of the state: probably the most important are those providing health care, education, and agricultural services. Private and semi-private organizations, such as the mission hospitals and private schools, are also involved. Then there are the many types of organizations glossed as ‘informal’ that range from Christian and Islamic groups (in the new jargon ‘faith-based organizations’), community groups, farmers’ clubs, and miscellaneous voluntary groups to international NGOs with a Malawi program. All these have greatly increased over the past decade, mostly in response to the HIV epidemic. The following discussion is based on findings on these latter organizations from the research villages.

Emphasis on “community” care

A presumption of both state and non-state actors at present is that community-based groups should be central to responding to the HIV pandemic and its effects. The National HIV and AIDS Policy states that “Government shall promote the delivery of quality community home-based care (CHBC) as an essential component on the continuum of care” to HIV-infected persons and to their families (GOM 2003a:6). Similarly, the National Policy on Orphan and Vulnerable Children emphasizes “community participation, empowerment and ownership in mitigating the social impact of HIV/AIDS on orphans” (GOM 2003b:4). International donors and NGOs have followed suit.

Following the decentralization policy, community groups are supposed to be set within a district structure: a District AIDS Coordinating Committee (DACC) is a sub-committee of the District Executive Committee and is to coordinate all activities on HIV/AIDS carried out by government or NGOs in the district. The organizational level

below the DACC is that of the Village AIDS Committees, and the community organizations such as Community-Based Organizations, Home-Based Care, People Living with AIDS, Faith-Based Organizations, and Youth Organizations. In practice, as we were told by District authorities and as our field research confirmed, the local (village) organizations seek linkage directly to the DACC or to the latter through the Social Welfare Department that is also situated at District headquarters. The ideal structure, like much of the decentralization structure, remains on paper only. Community groups of all sorts who wish to raise funds from donors such as NAC or MASAF are required to register with the district office of the Social Welfare Department for a fee of K3000 (in 2006).

The emphasis on community groups as key elements in dealing with the HIV/AIDS pandemic is understandable in the context of a health system that is unable to cope with the scale of illness. The statistics and news reports on the Malawi health system are sobering: huge shortages of trained medical staff (one doctor for 135,000 people), equipment and drugs. In recent years, media reports and announcements from the government of Malawi have highlighted the loss of trained doctors and the most skilled nurses who have left to take up opportunities elsewhere (mainly the UK and the USA). A report in the newspapers in 2006, quoting the Ministry of Health, stated that fully 75% of all medicines were stolen from medical establishments.⁴⁸ It is no wonder that people in our research villages complained about the current state of the health facilities, saying that the level of care had declined, including both staff and the availability of drugs. Many rhetorically asked, “what is the point of my spending a whole day to get to the hospital when all they give me is a couple of aspirin?!”, and some added that sometimes they were told that the hospital or clinic did not even have aspirin! For most, a visit to the clinics and certainly to the main hospitals in towns was made only in cases of severe illness. Not only, then, is there no emphasis on preventive medicine but most cases have already progressed to a very serious state by the time a doctor or nurse sees them.

Performance and assessment

This section makes summary statements based on the information from case studies described in an Appendix C, to which readers should refer.

The types of organizations found in the research area range in scale from professional, bureaucratic organizations to loosely structured groups and committees. They also vary in the type of funds they use, ranging from external (international) sources, to national sources and local village sources. Four types of organization can be described: two of them are based in villages, one sort with only self-generated funds, the other with non-local funds; another type of organization is larger in scale, based in market centers or nearer towns, and with non-local funds; the final type is an international NGO based in town, with links, including funding, to the former types, and supported by non-Malawi funds.

Village groups, as noted, may be sub-divided into two types – committees intended to cover several neighboring villages, and groups that have obtained outside funding or that aspire to do so. Both sub-types found operating in the sample villages

⁴⁸ Cf. a figure of 76% for ‘diversion’ or ‘leakage’ of drugs supplied to health units in Uganda (Hardon 2005: 606).

were described by members, in what became a repeated litany, as dedicated to providing support for orphans, sick and elderly. Most described their main activity as being directed towards orphans, followed by that to elderly and infirm people, while only a few specifically included HIV and AIDS in their self-description of care-giving. In practice, observations and conversations with many villagers revealed that the aspirations and self-description of these groups were vastly more ambitious than their actual achievements. Though most overt emphasis was given to orphans, even that was sporadic; the elderly received even less attention, and people infected or affected by HIV received the least.

Conversations with group members and with other villagers, and observations made during the research year revealed the following. Groups set up to provide regular services for orphans – having them meet for lessons, games and feeding once or twice a week, actually did so irregularly whenever they had enough resources (food, help) to do so. Extremely few of the many sample families who were taking care of orphans received any help from these ‘orphan care groups’. In addition, groups that described themselves as providing help to the elderly were found to have helped few such people during the course of the year. Similarly, none of the examples of help directed to families ‘living with HIV/AIDS’ came from the village-based groups. Such help was given by village home-based care-givers linked to the internationally-funded NGOs, which had a professional staff who met regularly with the village workers and provided them with information, contacts (for advice to patients), and basic drugs for their clients. Because of this link, the village care-givers were able to provide a more systematic service that also provided direct material help and not just ‘counseling’. But even they reached a small percentage of people and it is difficult to understand their priorities for help. For example, one HIV-positive woman (Abiti N) was sick on and off all through 2006 when her husband, also HIV-positive and very sick, finally died, and during 2007 we learned that she became progressively worse, finally dying in August of 2007. During all this period she was not visited by the local HBC volunteer who lived not far away in the same village. All help for Abiti N was given by her teenage children and by a sister who lived nearby.

The discrepancy between group statements and their actual performance is due to several factors: the mismatch between a policy dependence on ‘voluntary’ work and the reality of village life and work; serious mismatch between a group’s capacity and the procedure for funding the groups; disruptive competition within and between groups for scarce funds and personal resources; lack of coordination and communication across groups and within the whole sector; and faulty management. Moreover, the overwhelming focus on orphans and, to a far lesser extent, on infirm and elderly serves to neglect the serious needs of HIV-affected individuals and families.

Limits to voluntary effort: The assumption that, apart from the formal institutions of hospitals, clinics, district social welfare services and the like, the organization of care for disadvantaged and vulnerable groups such as those affected by HIV, orphans, elderly, sick, and handicapped can be left to voluntary work is flawed. This research, as do other sources, reveals that there are serious limits to the ability of rural people to provide all the necessary care on a purely voluntary basis. It is essential, first, to emphasize the degree to which virtually all care has been, and continues to be, provided by villagers to each other on a systematic, routine, unpaid basis. But this longstanding tradition of cooperation and

reciprocal help has not been labeled 'voluntary'. Rather, it has been taken absolutely for granted. In recent years, some commentators have pointed to the fact that social relationships in Malawi provide virtually all the 'insurance' and coverage for risk in a situation where there is no public provision for social security, pensions, insurance and so forth, and where private provision is limited to a tiny minority of well-paid professionals. Yet this basic fact seems to have been forgotten in the recent insistence by government and other authorities that care for a wide range of needy people should be 'community-based' and 'voluntary'.

The problem with an over-emphasis on voluntary effort in the provision of basic services was already clear in the mid 1990s when the first influx of NGOs, along with existing government organizations, sought volunteers. Complaints by some of these NGOs that 'Malawians are not willing to volunteer' were completely unfounded since they ignored the fact that each new NGO to enter a village wanted a committee and volunteers, adding to the already growing call for similar committees and volunteers by government institutions. The result was that the same villagers were overwhelmed with waves of similar demands from NGOs and government groups who did not coordinate their efforts.⁴⁹ The escalation of illness and deaths related to the HIV epidemic, the subsequent rising need for care, and the ever increasing numbers of various sorts of NGOs working in rural areas have all exacerbated the pressure on villagers to provide ever more 'voluntary' work. These demands, of course, have then to be set against the equally important facts of very high work-loads in fields and small enterprises that typify rural life, and the low returns in terms of food and cash to those heavy work loads which result in food deficits and shortage of other basic needs.

In sum, Malawian villagers are already over-worked, generally short of basic needs themselves, fully involved in social support networks (for funerals, births, weddings, illness, cleaning graveyards and paths, etc), as well as in existing groups organized by government and others (for management of farming, under-five clinics, school buildings, boreholes, etc), and yet are expected to take on and fully manage the care services for a rising population of HIV-affected individuals and orphans, with the elderly and sick and handicapped often added to the list of needy. It is no wonder, then, that our research finds serious shortcomings in the quantity and quality of the care services provided by the new committees and groups set up in the wake of the HIV/AIDS pandemic. It must be emphasized, however, that these shortcomings in the new groups must be set against the less visible social networks that provide all 'informal' care in the villages, even in the face of the rising demands of increased illness and death. As the cases indicate, even with very low levels of resources, many individuals, families and some committees/groups manage to extend care to needy people.

Overly grandiose projects: There is a mismatch between the capacity of most community groups and the kind of project donors direct to them. Most of the funds in the research villages came from MASAF. The level of funding was very high by village standards, namely, K1.2 million (then worth \$10,000), and the funds were to be directed to starting a 'sustainable enterprise' such as poultry farming or maize milling. The rationale behind this funding procedure was to make the community groups a

⁴⁹ As pointed out in a Memo on the subject of community health volunteers written by Peters in 1993 for the Food Security and Nutrition Unit of the Ministry of Economic Planning and Development.

‘sustainable’ source for providing care to orphans and other vulnerable groups in the villages. The error is to suppose that a loosely structured village group has the capacity, expertise, and resources to run such a profit-making business and, in turn, to use those profits to run a service for disadvantaged groups. A related error is to assume that, even with the requisite capacity, there is a realistic chance of making sufficient profit to establish and maintain such service delivery. In all the groups discovered in the sample villages, the funds failed to generate a profitable enterprise and failed to benefit more than a small handful of people in the village.

The case studies show group members scrambling to cope with the work and management demands of the project, mostly without the requisite technical or managerial expertise to manage a poultry or similar enterprise, and finding difficulty in selling the products or services at a high enough price to even cover costs, let alone to generate a profit for running the care-giving service. Because of such pressures, all groups reported a loss of members over time (most had set up around 2000 or 2001).

The commonly repeated reference to the loss of members being due to their ‘not seeing any benefit to themselves’ has to be carefully interpreted. There certainly were instances of key members skimming off some benefits for themselves (in kind, such as maize or other foodstuffs or poultry feed, concrete, etc., as well as in cash), and in one group there was disagreement among members precisely about the distribution of material benefits to themselves. But the general import of the statement is that people who are already burdened with caring for their own families, as indicated above, find themselves overwhelmed with extra demands on their time. Hence, they will put their own immediate responsibilities first, so appearing to be more interested in their own ‘benefit’ than serving the wider community. The sheer scale of the funded projects greatly exacerbates the pressure on people who are providing voluntary effort. Moreover, there seems to be a contradiction at the heart of the reigning vision between, on one hand, running a business intended to raise profits to provide care and, on the other hand, depending on unpaid, voluntary labor.

Our findings are not unusual. We were told of groups in other villages who had also been given large grants and most of whom experienced the same problems as those discussed above.⁵⁰ A colleague also confirmed this experience for groups living in villages surrounding the town of Zomba.⁵¹ He had known about five small groups of villagers, mostly women, who had decided to help the orphans in their area. They had collected small amounts of money from among villagers as well as other employed or ‘professional’ residents, such as the colleague, which they used to purchase blankets and some food for the orphans. Then, he said, ‘along came MASAF’ and three of these groups were given grants and told to set up a poultry business, a livestock business, and a maize mill in order, as noted above, to provide a sustainable source of funds for their help to orphans. A large brick building, with cement floors, iron roof (as with our sample, often being among the best buildings in the village) was built for the three cows purchased with the grant. But the money earned from the milk goes mostly to the cost of hiring two full-time guards (day and night) against theft and to maintain the animals. This

⁵⁰ A news report in IRIN 14 May 2007 states that NAC has suspended financial aid to community-based organizations because of their failure to account for past funds; apparently “over 30 CBSs have failed to account for” funds received.

⁵¹ Personal communication from Dr Stephen Carr.

echoes the experience of Group ML in our sample (see below). The poultry project was similar. As to the maize mill, it had to be fuelled with diesel oil because it was not near an electricity source, but the higher cost of running it meant that its higher charges led to loss of clientele to another mill within reach and run by electricity. It lost money and was finally closed. He explained that some of the smaller groups who did not get such large outside funds for a business activity continue to provide services to a number of orphans around them, albeit on a small-scale.

Fighting over funds: The proliferation of village groups aspiring to obtain funds is driven by several factors that include: the promotion by government and NGOs of 'community-based' management of care for vulnerable and needy groups; the information through published and 'grapevine' sources on the availability of funds for such community groups; people with a genuine desire to help the needy; people seeing an opportunity for bettering themselves and a step on the way to a 'proper job' (sometimes the last two overlap); and the knowledge about groups already funded. Any visitor to rural areas today is likely to be asked by several individuals and groups to help by giving money to such and such an effort of providing care, and by identifying prospective donors. Aspirants to forming a 'community-based organization' also busily seek help from literate, educated people to write proposals to raise funds.

While some of this energy is well-directed to efforts to form care-giving groups, some is misspent in frenzied competition, with a danger of overlap and replication. For example, villagers have already learned that donors want to see plans for 'sustainability' and for 'learning'. One outcome is that, following the example of some of the well-funded (whether internationally or nationally) NGOs who have started training programs for (older) orphans, many groups in our research area were including such programs in their proposals. The favorites were tin-smithing, building, carpentry, and poultry-keeping (the first three are directed only to boys). None of these groups paid any attention to the question of whether these programs would lead to income-generating employment in their area, again replicating the problem experienced by bigger NGOs with placing trainees after completion of training. A similar inattention to the market conditions for goods and services was seen in the projects set up for orphan care groups (see cases in the Appendix C). In practice, because of the difficulties experienced by these groups, very few people actually received training. And for other groups who had not received funding, the programs remained on paper.

A final point on the problems of too much competition is that, unsurprisingly, local politics become involved in the emergence of community-based organizations. In several of the village groups that had obtained MASAF funding and some of those who aspired to obtaining similar funds, local politics had entered in the form of a local MP pushing people to apply for funds in order 'to bring development to my constituency', and in the rivalry or enmity between a local politician and a group village headman that, according to one group, prevented their being granted funds. Again, in the context of severely constricted resources and of high levels of politicization since the advent of intensely competitive party politics, the promise of more funds attracts existing political actors. The political rationales overwhelm a cool assessment of whether a particular group is able to run a profit-making enterprise and to use those profits to run a reliable service for orphans, and other designated groups.

The drive to professionalization: A distinct tension in many of the efforts to form and/or to maintain community-based organizations is between the aim of providing services to designated needy categories and the search for gainful employment by key members. One of the most frequently expressed critical comments by other villagers about the community-based organizations they observed was that the key members (usually titled director, secretary, and program heads) were more interested in securing a job and income for themselves than in providing services for orphans and other intended beneficiaries. Like the complaint about volunteers falling out of a group because ‘they did not see any benefit for themselves’ (see above), the complaint about key organizers in the CBOs (Community-Based Organizations) has to be interpreted in context.

There were two main categories of group organizers in the CBOs studied in the sample area. In some, and in all the groups who aspired to CBO status and funding, the organizers were drawn from the well-known village ‘elite’. By this term, we refer to those people in the villages who farmed on a larger scale than the average, some with small businesses on the side (selling vegetables, ‘traditional’ medicine, etc), who were involved in local party politics and in local churches/mosques, and who were invariably members of whatever committees were set up for/by government or NGOs. Most of these organizers were men though some women also fitted the elite categorization just made. In the other sub-type of village-based CBO, the managers were fairly young people (in their twenties to thirties), the majority male, and many with Form 2 or 4 education (the high classes in secondary school, after which the next stage – for an even tinier minority – is university). This is a very high standard in the villages, still achieved by only a minority of even the younger cohorts, and historically such education is assumed to lead to a permanent, white-collar job. However, in the past ten to twenty years, the supply of such secondary-school leavers has far outstripped the available jobs, and the cutback in the civil service by structural adjustment programs has further added to the rise in unemployment of such educated youth. Most of these are not interested in seeing agriculture as an option even though most, if living with family in the rural areas, have to engage in farming to a variable extent.⁵² To such young people, the influx of NGOs promises them another option. The model is provided by the large, internationally funded NGOs with office headquarters in towns, with salaried directors and senior staff who drive 4-wheel drive vehicles, and with salaried junior staff who have access to motor-bikes for ‘field’ trips and also to allowances of various sorts.

The bigger of the CBOs observed in the research area followed this model though on a much smaller scale. LASO, for example, was the biggest of those in the research area with a salaried director and several program officers, a rented office on the outskirts of Zomba town, furnished with office furniture, computer, and phone, a smaller office in one of the villages served, and a motorbike for the use of the director, and bicycles for the rest. In contrast, smaller CBOs, such as Dzaone Youth Organization, borrowed a few rooms in an ex-shop in a market center, had no computer or other equipment, and the key managers had no salaries though sometimes managed to get allowances for attending workshops. But the clear aim of these aspirant managers was to use the CBO as a step

⁵² Such young people in the sample families oscillated between town and village home depending on whether they found a job, the vast majority temporary, ill-paid jobs (such as shop assistant, house servant, etc.)

towards acquiring an income and, equally important, the status of being someone ‘with a job’. It is obvious that this drive to professionalization is at odds with the view from donors and government of a ‘community-based’ group and of volunteerism. One result is the tendency for some of the sporadic inflow of funds to be used as pseudo-salaries, allocated in the name of ‘allowances’ for workshops, field visits, and the like, a practice that lends itself to favoritism and embezzlement. While those involved in these practices justify them in the name of their work efforts, others inside the group excluded from such pseudo-payments and outsiders – the observers within the village – see them as evidence of illegitimate use of project resources for private gain (people said “*adyera* – they are feeding themselves”).

Yet most people also recognize that virtually anyone who volunteers to work in these care-giver groups does so at the loss of time, energy and other resources devoted to caring for their own families (immediate and extended). Thus, while some villagers complain about such groups being vehicles for self-promotion, those with relatives or friends involved in the groups justify the practices as their compensation for the work they do. What seems to be ignored in the current emphasis by government and donors on voluntary effort for home-based care for orphans, sick, people affected by HIV, etc., is that there is a huge difference between spending a few hours every few weeks or months to maintain village paths or boreholes and so on, and the regular, consistent effort in providing services for needy groups, let alone for running a business in order to raise funds for the care group.

Conclusion

The overwhelming emphasis among donors and government on basing care and services for individuals and families affected by HIV-related illness and death on ‘volunteers’ in the ‘community’ is misplaced. It ignores the fact that virtually all care and cooperative effort in villages are already and always have been ‘voluntary’, even though they have not been described with that label. The problems are clear.

First, given the scope of existing voluntary work in villages, it is difficult to impossible to add all the new activities and increased efforts related to dealing with the HIV epidemic in the villages as the responsibility of ‘community volunteers’. In short, there are serious limits to which such extra burdens can be carried solely by volunteers.

Second, the way in which the tapping of voluntarism has occurred is flawed. Current funds in NAC and MASAF (and probably others) are allocated, in principle, in response to proposals from voluntary community-based groups. In practice, the funders direct such groups to write proposals for establishing business enterprises intended to provide ‘sustainable’ support for whatever ‘needy groups’ they aim to serve. The most common enterprises encountered in 2006 were raising poultry and cattle for sale, and maize mills. In virtually all the cases found in the sample area, the demands of managing the nascent enterprises overwhelmed the ‘volunteer community’ groups, due to lack of the requisite expertise, time and resources to run such businesses. The outcome was that very few of the allocated funds actually reached the orphans or other categories supposedly being served by the groups. While some of the key organizers in the local groups were definitely diverting some of the finances and in-kind benefits for themselves, the overall policy is unreasonable. There is an inherent contradiction between relying on volunteer effort and running a business for profit (and using those profits for the social

service desired). It is unrealistic to assume that rural residents who are normally fully occupied with farming, temporary laboring jobs, and other small-scale activities can allocate the requisite time and resources to running such businesses as volunteers.

Third, the rationale behind the current mode of reviewing proposals for selection for a grant assumes competition will produce the best projects and hence, the best social service delivery. In practice, the products of the present system are divisive competition over limited resources and time in the villages, and overlapping and redundant efforts rather than coordinated responses to provide help for needy categories. The draw of such high levels of funds is powerful to people who are starved of such grants. It is therefore not surprising that the group efforts get diverted to attempts to turn 'voluntary' work into paid employment via 'allowances', and to aspirations for professionalization of their work.

The overall picture of fragmentary and failed delivery of help to HIV-affected people through the formal grants does not mean that there is no role for voluntary effort. On the contrary, as emphasized before, the vast amount of care being given to HIV-affected people in rural areas is by Malawian rural residents themselves. Thus, what needs to be done is to rethink the mode of getting outside funds to rural people to help them improve what they are already doing. One suggestion is that the currently large amounts (averaging over a million kwacha) are far too large for voluntary groups who are fitting in helping care for needy groups into their already busy lives. These huge funds (by village standards) are also seen as contradictory to local practices of community volunteer effort. More actual help is likely to reach orphans and HIV-affected people if smaller amounts are granted to a larger number of small groups. This would mean dissociating the grants from the implicit requirement that the groups run a business to generate 'sustainable' funds for social services. There may well be a smaller proportion of the total funds available designated for such enterprises but these should be specifically for individuals and groups who can prove a capacity for business management. Moreover, the notion that such businesses be run entirely on a voluntary basis should be recognized as unrealistic and managers should be able to receive compensation that is both clear and related to success.

In addition, groups who receive the smaller grants should also not be assumed to do everything on a voluntary basis. Thus, if a center for needy orphans, for example, is to be set up where children will be fed and taught, then rather than assuming the entire running of the center should be by the volunteers, the groups should be able to select a local, suitably qualified person to run the center. The compensation can be modest, adjusted to local standards, and the monitoring of the quality of care and management by the center leader would be done by the group and, perhaps, by a wider set of local villagers. The volunteers would act as aides and supporters and monitors to the center leader. This model is likely to be viewed as fairer than the current mismatch of voluntarism and business and also is more likely to deliver effective services.

VII Quantitative Analysis of Household livelihoods, 1986-2006

In this section, first are presented findings on key livelihood variables (expenditures, land, crops, harvest, etc) for 2006, and comparisons are made with earlier rounds in 1986, 1990, and 1997. Then we indicate what the quantitative data reveal about the interaction of HIV-related illness and death with these livelihoods.

Expenditures and Income

The quantitative data analysis uses expenditures as a proxy for income. In the 1986 and 1990 rounds, we collected both income and expenditures on a monthly round; we found that they were closely correlated though with the usual pattern of slightly lower income than expenditures for the poorest (reflecting the unreported gifts and loans) and of lower expenditures than income for the richest (reflecting the unreported savings). In 1997 and 2006, only expenditure data were collected and on a less frequent basis – six rounds over the twelve months in 1997 and five rounds in 2006. These then have been annualized for comparative purposes.

The distribution of expenditures in 2006 (see Table 1) shows considerable socio-economic differentiation in the sample: the bottom quartile households, on average, spent a tenth of the top quartile per capita totals, while the bottom decile spent less than a twentieth of the top quartile per capita totals. The trend towards increased inequality in incomes discerned in previous years has been maintained though not intensified: in 1997, the top quartile had an income eleven times as large as the bottom quartile. As to headship, the female de jure households have the lowest per capita expenditure average while the joint-headed and female de facto households have very similar averages. This shows the importance, for most households, of having a husband since men not only contribute considerably to farming but have access to more and better paid wage employment than do women.

One significant association present in earlier studies of this population is the positive correlation between income level and burley tobacco production. This is not found in 2006 and is due first, to the overall decline in growing burley tobacco (from 80% of households in 1997 to 64% in 2006), and second, to a decline in the scale of burley production with large numbers of people growing very tiny amounts, and a small minority specializing in burley as their key cash crop. Significant differences related to burley production in expenditures and other variables, therefore, are seen only for those households earning the highest amounts from burley tobacco.

The comparison of real (deflated) expenditures (see Table 2) reveals complex trends over the twenty year period.⁵³ First, there has been an overall decline in sample expenditures between 1997 and 2006. It is probably caused, in part, by a loss of burley income due to the declining numbers of people growing the crop, the reduced scale of production, the proportion of growers able to sell burley at Auction Floor prices, and the decline of those prices. There may also be an effect, at least for the small number of true surplus producers of maize, of the declining profitability of maize in recent years, with

⁵³ There is a caveat for the deflated figures for 2006 because the calculation for earlier years differs from that for 2006, and the Malawi National Statistics Office re-weighted the CPI in 2000.

dropping output prices and rising costs of production.⁵⁴ Over the twenty year period of 1986-2006, there have been different trends for different sections of the sample population. The top quartile of households made big gains between 1986 and 1990 and again between 1990 and 1997. Those gains were due to the improved ability to sell crops to buyers other than ADMARC, the parastatal, and especially to the sharp increase in growing burley tobacco and its sales on the Auction Floors at world prices. In contrast, the poorest twenty-five percent dropped significantly in terms of expenditure (and income) between 1986 and 1990, and made a slight improvement between 1990 and 1997, while the anthropometric measures of their children were the only ones in the sample to decline over the period 1986-1997. The middle fifty percent moved least, some making some small improvement by 1997, others remaining more or less where they were in 1986. Between 1997 and 2006, the average expenditures for all quartiles declined. As stated above, this seems very likely due to the decline in burley production and in profits from the crop as well as, possibly, losses from maize. But looking back to 1986 from 2006, the top twenty-five percent of households remained considerably above their 1986 level, the next twenty-five percent just above their 1986 level, whereas the remaining fifty percent have declined since 1986, especially the poorest twenty-five percent of households whose average expenditure is only a half of the 1986 level.

Given the possible problems with deflated expenditure figures, we made a brief comparison of movements between expenditure groups and asset groups by using transition matrices for the period 1990-2006. The results basically support the trends discerned above in the expenditure levels. Over this period, just over half (54%) of the top quartile retained their top position in assets compared with 32% of the bottom quartile, suggesting that the top quartile lost more ground relative to the bottom quartile, though at a much higher absolute level of asset-holding.

⁵⁴ Data from Evaluation of the 2006/07 Agricultural Input Supply Programme, MAFS (Ministry of Agriculture & Food Security), Malawi (March 2006), kindly provided to the authors by Dr Stephen Carr.

Table 1

**Expenditures by Household
2006 core Households**

	<u>Variable</u>	<u>N</u>	<u>Hhd Total</u>		<u>Per Cap Expends</u>	
			<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>
Total Sample	2006 core	171	13095.11	13072.88	2678.44	2890.87
Headship	1 - ff	4	13634.40	9594.67	3120.76	2083.11
	2 - fj	67	9514.26	10196.82	2005.84	2355.92
	3 - j	99	15589.72	14411.37	3123.18	3172.62
tobacco	0 - no	59	12384.77	13956.14	2667.22	3336.08
	1 -yes	108	13636.49	12768.78	2680.22	2635.26
HIV5	0 - no	97	13606.51	13532.42	2629.07	2630.04
	1 - yes	74	12424.77	12504.38	2743.17	3218.37
exp pc Q	1 - lowest	42	3977.34	2081.22	618.38	224.10
	2	43	7441.35	2923.38	1381.88	312.75
	3	43	12924.07	5200.72	2465.71	403.05
	4 - highest	43	27745.09	17816.08	6182.13	38.68
Orphans	0 - no	120	13843.96	14142.01	2800.95	2922.01
	1 - yes	51	11333.12	10027.77	2390.18	2823.59

Note: 2006 data were recorded 5 times over 12 months and have been annualized.

Table 2 Sample Per Capita Household Annualized Expenditures: 1986-2006
Nominal and Adjusted for Inflation

	<u>1986-7</u>	<u>1990-1</u>	<u>1997</u>	<u>2006</u>	<u>1990-1</u> <u>Deflated **</u>	<u>1997</u> <u>Deflated **</u>	<u>2006 Deflated</u> <u>to 1997***</u>	<u>2006 Deflated to</u> <u>1986 ^^</u>
Total Sample	62.06	109.89	573.91	2,678.44	57.14	98.48	452.66	77.67
Expenditure Quartile 1 (Lowest)	34.43	32.52	137.07	618.38	16.91	23.52	104.51	17.93
Expenditure Quartile 2	46.11	55.17	271.63	1,381.88	28.69	46.61	233.54	40.07
Expenditure Quartile 3	64.25	78.61	456.37	2,465.71	40.88	78.31	416.70	71.51
Expenditure Quartile 4 (Highest)	105.92	276.37	1,449.29	6,182.14	143.71	248.70	1044.78	179.28
Tobacco Producing	63.86	157.05	621.41	2,680.22	81.67	106.63	452.96	77.73
Non-Tobacco Producing	61.30	78.80	369.70	2,667.22	40.98	63.44	450.76	77.35
Female de Jure Headed	46.46	109.76	474.85	2,005.84	57.08	81.48	338.99	58.17
Female de Facto Headed	65.04	57.13	387.58	3,120.76	29.71	66.51	527.41	90.50
Joint Headed	64.42	117.18	631.49	3,111.40	60.93	108.36	525.83	60.23

Notes: 1986-7 data were recorded monthly for 10 months and have been annualized.

1990-1 data were recorded monthly for twelve months and annualized.

1997 data were recorded six times over 12 months and annualized.

2006 data were recorded five times over 12 months and have been annualized.

** Low Income Zomba Consumer Price Indices were used to derive a Non-Food Index to account for bias from the large percentage of expenditures spent on food.

A deflator of .33 was used to deflate the 1997 data to a 1990 base and then a deflator of .52 was used to deflate to a 1986 base.

*** Deflated to 1997 base using coefficient of 0.169

^^ Deflated to 1986 base using coefficient of 0.029.

Table 3

**Expenditure Shares on Foods and Selected Items
2006 core Households**

	<u>Variable</u>	<u>N</u>	<u>Percent of Budget Spent</u>						
			<u>Maize</u>	<u>Other Foods</u>	<u>Goods & Services</u>	<u>Health</u>	<u>Education</u>	<u>Fertilizer</u>	<u>Labor</u>
Total Sample	2006 core	171	15.1	30.9	33.7	2.4	2.1	10.7	4.44
Headship	1 - ff	4	29.4	24.5	34.0	1.3	0.6	5.4	4.31
	2 - fj	67	16.9	31.4	32.5	3.4	2.0	9.1	5.05
	3 - j	99	13.5	30.8	34.6	1.7	1.9	11.9	4.08
tobacco	0 - no	59	14	34.7	32.4	1.9	1.7	8.2	3.66
	1 -yes	108	15.6	28.7	35.1	2.3	2.4	11.9	4.98
HIV5	0 - no	97	14.2	30.1	35.7	1.9	2.4	10.6	4.66
	1 - yes	74	16.3	31.9	31.2	3.0	1.8	10.7	4.15
exp pc Q	1 - lowest	42	20.3	32.5	29.3	3.3	0.1	12.1	0.13
	2	43	18.6	33.5	33.2	1.8	0.9	7.1	2.40
	3	43	14.1	32.0	30.8	3.0	4.1	10.8	5.12
	4 - highest	43	7.5	25.5	41.6	1.4	3.2	12.6	9.96
Orphans	0 - no	120	14.1	29.9	35.6	2.5	1.8	9.9	4.70
	1 - yes	51	17.4	33.3	28.9	2.2	2.9	12.3	3.84

Table 4

**Expenditure Shares on Foods and Selected Items
1986, 1991, 1997, 2006**

	<u>Year</u>	<u>Maize</u>	<u>Other Foods</u>	<u>Percent of Budget Spent</u>		<u>Education</u>	<u>Fertilizer</u>
				<u>Goods & Services</u>	<u>Health</u>		
Total Sample	1986	20.0	26.0	32.0	2.0	0.4	1.9
	1991	22.0	22.0	31.0	1.1	2.0	3.7
	1997	19.5	19.6	35.1	1.0	0.6	5.6
	2006	15.1	30.9	33.7	2.4	2.1	10.7
Expenditure Quartile 1 [lowest]	1986	25.0	20.0	32.0	2.2	0.2	0.7
	1991	36.0	23.0	29.0	1.3	2.0	1.3
	1997	29.5	22.0	35.3	0.7	0.6	0.2
	2006	20.3	32.5	29.3	3.3	0.1	12.1
Expenditure Quartile 2	1986	23.0	34.0	33.0	2.5	0.6	0.3
	1991	24.0	23.0	31.0	1.2	1.7	3.2
	1997	22.0	22.8	32.5	1.3	0.4	4.6
	2006	18.6	33.5	33.2	1.8	0.9	7.1
Expenditure Quartile 3	1986	19.0	25.0	32.0	1.6	0.5	2.2
	1991	19.0	23.0	30.0	1.1	1.7	4.3
	1997	19.8	19.6	32.5	1.4	0.8	5.2
	2006	14.1	32.0	30.8	3.0	4.1	10.8
Expenditure Quartile 4 [highest]	1986	13.0	25.0	31.0	1.9	0.3	4.4
	1991	9.0	18.0	33.0	0.6	2.7	6.0
	1997	6.6	14.2	37	0.6	0.6	12.6
	2006	7.5	25.5	41.6	1.4	3.2	12.6

The main categories of expenditures in the sample are, in order of importance, food, goods and services, fertilizer, and then health and education far behind (see Table 3). As expected, the share of budget spent in 2006 on maize, the staple food, is negatively correlated with income: the richest quartile spent 7.5% compared with 20.3% by the poorest quartile. Shares on other foods did not differ greatly, except for the richest quartile again spending a smaller share (though of course, because of their much bigger overall expenditure, the absolute quantities were larger). Shares on goods and services followed the opposite curve with the top quartile spending more than the poorer groups. Expenditure shares on fertilizer were little different between richest and poorest quartile suggesting a huge effort on the part of the latter to acquire fertilizer. Finally, the expenditure shares on education were considerably higher for the top fifty percent (3-4%) compared with a tenth of 1% for the poorest. In reverse, the poorest used just over 3% of their budget on health compared with 1.4% by the richest.

A comparison of expenditure shares (see Table 4) reveals changes over the past twenty years, but also shows what appear at first to be paradoxical results until the specific conditions of 2006 are taken into account. The earlier rounds of research showed a steady decline between 1986 and 1997 in the average share spent on staple maize by the richest twenty-five percent of households from 13% to 8.6%, declining further to 7.5% in 2006. This can be explained by the rising average income of households in the top quartile which, as elsewhere, tends to be associated with a declining share of budget spent on staples. In the previous rounds, the middle fifty percent did not follow the pattern of the top quartile, remaining with around 19-22% share spent on staple maize. The bottom quartile experienced a rise in share between 1986 and 1997 that was explained as the 'scissors' effect of rising prices and declining income for the bottom twenty-five percent of households. In view of these findings, the decline in share for the middle fifty percent and even for the bottom quartile in 2006 seems strange. Other conditions – the overall downward pressure on prices received for burley tobacco, a key cash crop, and rising prices for fertilizer, maize and other goods, as well as the newer pressures of illness and death resulting from the HIV epidemic – would argue for either a rise in share on staples or at least a relatively stable share.

The answer to the paradox probably lies partly in the very bad harvest in the previous year 2005, the widespread distribution of relief food by a range of NGOs on behalf of the government (with WFP food) and of some of the NGOs, including churches, themselves, and the very good harvest in 2006. Of the sample households, 45.6% reported receiving relief food. This relief food meant that people spent less on purchased food than they might otherwise have done. The market price of maize in January and February of 2006 was extremely high, many people had no disposable cash to purchase it, and in addition to missing meals and eating local wild foods and mangoes, a large number of people relied heavily on the distribution of relief food. While the relief food was particularly important for the poorer households, it was distributed unevenly. Hence, 26.8% of the bottom expenditure quartile reported receiving relief food compared with 45.5% and 55.8% in the next two quartiles, and 53.5% in the top quartile. A second part of the answer probably is related to the government program of subsidized fertilizer which led many people, including those in the poorest income groups, to put a huge effort

into raising cash to purchase the fertilizer. Thirdly, the conditions of good rain and subsidized fertilizer provided good harvests for many and lower post-harvest maize prices.⁵⁵ All three together may be seen to have shifted the expenditure shares during 2006.

The richest quartile of households increased their average share on fertilizer from 6% in 1991 to 12-13% in both 1997 and 2006. Similar patterns are seen for the middle fifty percent – the next to top quartile increased their share by more than twice between 1990 and 2006, while the second (next to bottom) quartile tripled their share. Most marked was the increase by the bottom quartile from a bare 1.3% in 1990 to 12% of total budget in 2006. This huge rise reflects the enormous – usually unmet – desire for even the poorest farmers in Malawi to get access to inputs. In absolute terms, of course, it means that many of the poorest farmers actually obtained and applied relatively small amounts of fertilizer (most sharing a bag with another family). But the distribution of relief maize also allowed people, including a number of the poorest, to use their limited access to income (and to credit) for fertilizer.

Other noticeable changes over the past one to two decades in expenditure shares include the increase in shares given to health by the lowest quartile, and a less marked increase by the other quartiles; and a decline for the poorest in expenditure share on education whereas the top quartiles increased their share on education.

In terms of sources of cash income for the entire sample, almost one half of the sources reported by respondents were from agricultural production – maize, other food crops and vegetables, fruit, etc., burley tobacco, and a smaller amount from stock, mostly small stock (goats, poultry). The rest came from wage employment, much of it temporary local labor, self employment (miscellaneous retail businesses, services such as bicycle mending, carpentry, brewing, basket making, etc), gifts and remittances almost all of it from adult children, and miscellaneous other sources (relief, rents, pension).

As in past years, almost all households follow highly diversified income strategies. All aim to grow as much of their own food as possible though, due to shortages of land and other inputs, few manage to grow all they need. As noted already, agricultural production provides the bulk of sources of cash income. The sample villages are well placed for markets for vegetables and other foods, being not far from a medium sized urban center, a large one, and many smaller centers, as well as having many markets scattered through the area. The many households with insufficient land and/or insufficient inputs also rely on off-farm earnings; for most, these are from local temporary jobs such as clearing or weeding other people's fields (for men and women), or drawing water (for women), and from a wide range of small businesses and small scale services including retailing. Many families have relatives working in towns or on estates, some locally, some in the Central and Northern districts. Those who go to work as laborers or tenants on estates to the north of the study site are younger people, male and female, and they come disproportionately from the poorer, land-short families.⁵⁶

⁵⁵ The low prices continued into early 2007, a stark contrast to the very high prices in early 2006.

⁵⁶ Estates send trucks to recruit local people, mostly young adults, at the beginning of the cultivation season.

Agricultural Production

Landholding size

The average sample landholding size has remained virtually the same over the period of the twenty years: it was 0.25 hectares per capita in 1986 and 0.26 hectares per capita in 2006. The main patterns of landholding (see Table 5) are also similar in that landholding is positively correlated with overall income and with maize harvest, and that the tobacco growers have, on average, slightly more land than others. These averages mask the fact that a small minority of households have considerably more land than most: thus, the richest decile of households has an average per capita landholding of 0.68 hectares compared with the sample average of 0.26 hectares and with 0.18 hectares for the poorest decile.

**Table 5 Landholding by Household (in hectares)
2006 core Households**

	<u>Variable</u>	<u>N</u>	<u>Total Land Owned</u>		<u>Land per Capita</u>	
			<u>Hhd</u>	<u>SD</u>	<u>Per Cap</u>	<u>SD</u>
Total Sample	2006 core	171	1.21	1.00	0.26	0.29
Headship	1 - ff	4	0.90	0.47	0.22	0.16
	2 - fj	67	1.16	0.75	0.26	0.20
	3 - j	99	1.26	1.15	0.27	0.36
tobacco	0 - no	59	0.92	0.56	0.22	0.16
	1 -yes	108	1.37	1.15	0.28	0.35
HIV5	0 - no	97	1.25	1.21	0.26	0.32
	1 - yes	74	1.15	0.61	0.27	0.28
exp pc Q	1 - lowest	42	0.97	0.48	0.18	0.1
	2	43	0.93	0.49	0.18	0.1
	3	43	1.18	0.82	0.24	0.2
	4 - highest	43	1.75	1.57	0.44	0.51
Orphans	0 - no	120	1.18	1.09	0.26	0.33
	1 - yes	51	1.28	0.74	0.26	0.21

One of the more obvious changes that have taken place over the past ten years is a rise in the number of people renting land (in and out), in the price of rents, as well as an increase in the sales of land. Although land is legally under 'customary tenure' and assumed not to be sold, sales are increasing in the Zomba sample and also reported in

other parts of the country.⁵⁷ Sales of land were relatively few in 1986 and concerned landholdings that abutted the small market centers in the villages. The sale of such land has continued over the years as the centers have gradually expanded; the buyers tend to be the big traders living in the centers. Over the past ten years, other arable land has been sold and the buyers are the better-off and larger scale farmers in the villages; thus, the main buyers of land in our sample are disproportionately drawn from the richest households. The sellers vary; some poor sample members who have inherited more land than they either need or can manage have been selling off fields, other sellers are not necessarily poor but wish to raise cash or plan on leaving the area. However, in a number of documented sales, complaints have been made by members of the matrilineage of the seller and cases have been brought to local chiefs to hear. In two cases, sale of land was related to the pressures of HIV-related illness and death: an elderly woman (Mai MG), described above in section II as a case in the ‘acute economic distress’ category of households, had been selling land since 1986 but the deaths of several of her adult children to AIDS may well have intensified that strategy; and Che C whose chronic illness and death in 2006 caused his household to fall from the prosperous status they had in earlier years had resorted to selling one field and also to underhand dealings. But we found no sample-wide pattern of sales of land being associated with HIV/AIDS.

Cropping pattern

The principal crops grown by sample households (see Table 6) have changed little over the period of twenty years. The changes in the relative amount of particular crops grown at one time or another can be explained. The most frequently grown crops over the entire period are maize, pigeon peas, beans, pumpkin, tobacco, cowpeas, sorghum, groundnuts cassava, sweet potatoes, and miscellaneous fruits and vegetables (tomatoes, okra, numerous green leafy vegetables, cabbage, etc). Maize continues to be grown by everyone, especially local varieties; growing hybrid maize has increased since 1986 though its incidence and scale has fluctuated greatly over twenty years due especially to the availability of fertilizer and seed. 1986 proved to be the absolute bottom for hybrid maize production with less than 2% of households growing it (see Table 7). With special promotional and credit-based programs put in place by the government, this rose to 52% in 1990/1, fluctuated between 42% (in 1993/4) and 75% (in 1994/5) over the next 7 years depending mainly on the presence or absence of free or subsidized distribution of seed and fertilizer (such as the StarterPack program). In 1997, 61% of sample households grew hybrid maize. This, according to respondents’ accounts dropped in the early 2000s but rose to 51% in 2006 due to the subsidized fertilizer and seed program.

Table 6 List of crops most frequently grown by sample households

Maize
Pigeon peas
Pumpkin
Burley tobacco
Cowpeas
Sweet potatoes

⁵⁷ See Peters and Kambewa 2007.

Sorghum
Beans (several varieties)
Cassava
Groundnuts
Vegetables including tomatoes
Rice
Millet
Sunflower
Fruits
Sugar cane

Table 7 Percentage of sample households growing hybrid maize, 1986-2006

1986/7	2%
1990/1	52%
1992/3	68%
1993/4	42%
1994/5	75%
1995/6	47%
1996/7	39%
1997/8	61%
2006	51%

The most noticeable change in cropping patterns over the period has been the rise in burley tobacco production, starting in 1990, when the research area was selected as part of a pilot project for the legalization of burley growing by smallholder farmers (see Table 8). The number of people growing burley tobacco has fluctuated over the period, from 30% in 1990/1 to 60% in 1992/3; this then dropped to 44% in 1993/4, largely because of the drought, and increased to 59% in 1994/5 and 71% in 1995/6. (In these last three years, a partial re-survey of the sample was the basis for the figures). In 1997, an astonishing 80% grew burley tobacco.

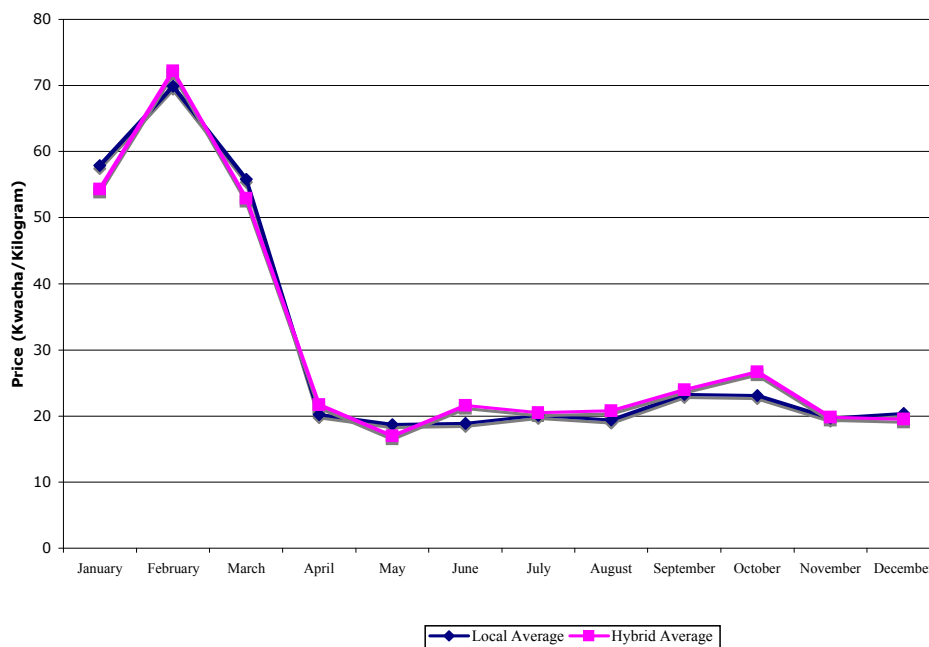
Table 8 Percentage of sample households growing burley tobacco, 1986-2006

1986/7	0% [but one third grew dark-fired tobacco]
1990/1	30%
1992/3	60%
1993/4	44%
1994/5	59%
1995/6	71%
1997/8	80%
2006	64%

By 2006, the proportion of sample households growing burley had dropped to 64%. Respondents explained this as due to disappointment with a continuing relative drop in burley prices on the Auction Floors, and to an inability to raise credit. But it may

also be due in part to the effects of rising illness and death. The number of people in burley clubs has also dropped since so many of the clubs acquired debt they failed to repay. The outcome is a small number of farmers growing fairly large quantities of burley who have doubled their average share of land under burley (from 0.3ha in 1990 to almost 0.8ha in 2006).⁵⁸ Most of these sell through clubs to the Auction Floors. A larger number of households grow small quantities of burley, most of which is sold early in the season to traders or to burley club members, as a strategy to raise cash in the deficit season. Traders were buying tobacco in the research area as early as the beginning of February in 2006. Because the previous year's harvest (2005) had been so poor, most people were very short of food and cash in early 2006 and, as usual in such times, the price of maize in the local markets was very high (see Graph 3).

Graph 3: Maize Prices in Markets, 2006



Overall, the trend seen by the late 1990s of a certain specialization in burley production by a minority and the spread of growing small amounts by a larger number of farmers has been maintained.

Other shifts in cropping over the past twenty years include the rise and fall of certain cash crops such as chili peppers, gram, and sunflower, determined largely by the going price offered. A more distinct upward trend over the past decade has been in the production and sale of pigeon peas, sweet potatoes, and cassava. Pigeon peas have long been second in importance only to maize in the Shire Highlands, being an important food crop and with positive (nitrogen and potassium-fixing) effects in permanently used fields. But over the past ten years, pigeon peas have become a crop in great demand from traders

⁵⁸ An increasing number of burley growers intercrop the tobacco with other plants. They explain this as due to shortage of land and labor, as well as some spreading of the advantages of the fertilizer required by tobacco. But some of the intercrops (such as tomatoes and aubergines) are not appropriate (see Peters 2002).

from the commercial center of Limbe-Blantyre. They are exported in large quantities to the Indian subcontinent as well as being used for processing within Malawi. Over the same period, sweet potatoes and cassava, both long-used crops in the area, have also increased. A now common scene towards the end of the rainy season in April is the widespread planting of sweet potatoes on the edges of fields and roads, and along streams. While some of this increase in sweet potatoes and cassava is due to food strategies by rural households, including those in the sample, it is also driven by a rising demand for these crops, which make perfect 'snack' foods, from the growing urban and peri-urban populations.

More minor changes have been a fluctuation in groundnuts which seems to derive from shifting climatic and disease conditions and thus the availability of seed. Shortages in seed groundnuts are a common complaint in the area. Sorghum continues to be an important secondary crop, for food (mainly supplementing maize flour) and for beer brewing.

The fields continue to be overwhelmingly intercropped; the most common intercropped mixtures are maize plus pigeon peas plus pumpkins plus/minus cowpeas, groundnuts, and several varieties of beans. These are intercropped along ridges. Crops grown along the edges of a field or scattered in a cross-hatched pattern across a field are sorghum and cassava. Crops are also grown in sequence: as maize matures, leaves are stripped off, and pumpkins are harvested, creating space half-way down the ridges for ground peas, and/or for sweet potatoes and gram. The few crops grown single stand are chili peppers, sunflower, (some) cassava, (some) tobacco, and the few plots of maize grown in the 'sasakawa' style currently promoted by the Ministry of Agriculture. All these crops are grown in dryland fields (*mindu*); in addition, about forty percent of the sample families have watered fields (*dimba*) mostly along the streams, where they grow tomatoes, green leafy vegetables, okra, aubergines, cabbage, onions, bananas, etc. Many of the vegetables are sold in local and town markets and are a major source of cash income.

Maize harvests

The factors affecting the size of maize harvests in the research area include preeminently weather (the amount and timing of rainfall), and availability of fertilizer and, to a lesser extent, seed. Land, as noted before, is in permanent cultivation and requires sufficient levels of fertilizer to produce decent harvests. The fluctuation in harvests over the years is due to these factors with the nadir in severe drought years, such as 1991/2. The 2006 cultivation season benefited from ample and well distributed rains with a resulting good harvest (average 184 kg pc – see Table 9) which did not reach the highest recorded for this sample in 1990 (219 kg pc) but which was above that for 1986 (145 kg pc) and of the poor year 1997 (104 kg pc). An additional positive factor in 2006 was the program of subsidized fertilizer put in place by the Malawi government (see Table 10 for fertilizer use 1986-2006). Although there were some problems with distribution,⁵⁹ far more people gained access to fertilizer than would have been the case

⁵⁹ Some of the people authorized to distribute the fertilizer appropriated more than their share of coupons (some of which they kept for themselves, some of which they sold to others for a higher price than the official); some of the distributors, knowing there were more people wanting to purchase than there were coupons, also sold coupons to those prepared to pay extra.

without the program. Half of sample households obtained subsidized fertilizer, and of those using fertilizer, 76% used subsidized fertilizer. 44% of the poorest twenty-five percent of households obtained some subsidized fertilizer compared with 67% in the top quartile, though some of this unequal distribution is due less to patterns of access than to the fact that tobacco growers were specially targeted for particular types of fertilizer. The positive effect of using subsidized fertilizer on per capita harvest is seen in a regression ($p < 0.001$). The overall outcome of the good rains and the increased use of fertilizer, as happened more widely across the country, was a bumper harvest.

As expected, the maize harvest varies positively with the amount of land and expenditure levels, and is higher for tobacco growers. Using fertilizer and obtaining the subsidized fertilizer both had a statistically significant relationship to the maize harvest ($p < 0.001$) and also to stored maize in November/December ($p < 0.001$), the period when many run out of stored food. Of the three main headship types (joint, female de facto, and female de jure), the latter had the lowest per capita maize harvest (145 kg pc), probably due to their overall lower income level, with implications for acquiring inputs. A regression showed that households with a higher dependency ratio (more children than adults) had smaller harvests ($p < 0.001$).

Table 9 **Reported Maize Harvest**
2006 core Households

	<u>Variable</u>	<u>N</u>	<u>Average Maize Harvest (in kg)</u>			
			<u>Hhd</u>	<u>SD</u>	<u>Per Cap</u>	<u>SD</u>
Total Sample	2006 core	171	901.44	830.91	183.36	171.64
Headship	1 - ff	4	787.32	559.2	189.49	140.97
	2 - fj	67	630.74	537.53	144.60	145.11
	3 - j	99	1098.36	944.34	210.47	185.82
tobacco	0 - no	59	570.29	554.76	133.52	143.27
	1 - yes	108	1097.00	900.68	211.52	178.92
HIV5	0 - no	97	916.00	843.68	180.75	167.40
	1 - yes	74	882.56	819.38	186.75	178.09
exp pc Q	1 - lowest	42	668.55	577.42	112.61	121.93
	2	43	630.69	644.37	121.62	121.90
	3	43	902.21	682.05	185.12	146.11
	4 - highest	43	1394.35	1095.89	310.60	206.98
Orphans	0 - no	120	914.45	837.25	188.82	174.93
	1 - yes	51	871.08	814.79	170.62	162.43

Table 10 Percentage of sample households using fertilizer, 1986-2006

1986/7	28%
1990/1	73%
1992/3	66%
1993/4	50%
1994/5	67%
1995/6	64%
1996/7	76%
1997/8	75%
2006	64%

Nb. Numbers based on full samples in 1986/7, 1990/1, 1996/7/8, 2006 and partial samples in remaining years.

Information on the percentage of households selling maize can be seen to be related to that on maize harvests. Of the entire sample, 47% of households sold some maize (most in relatively small amounts, a few in large amounts), which is above the proportion for 1997 (29%) and below that for 1990 (60%) and 1986 (53%). Although the harvest of 2006 (c May) was very good for many households, most were taking account of the severe deficit of the previous year. Thus, many wished to store more and sell less, others planned to use some of the maize for the important rites and ceremonies (initiation, memorials) held in the dry season.

More of the richest twenty-five percent of households sold some maize than others, which reflects their higher landholding and higher maize harvest. The slightly higher percentage of the poorest quartile selling maize (42%) compared with the next quartile (32%) and the fact that the average per capita maize harvest of the poorest quartile was the smallest suggest a U-shaped curve seen in some earlier years (that is, the richest and the poorest selling proportionately more maize relative to their harvest than the middle 50%). This can be interpreted as the poorest people having very few options to earn cash, so selling maize even when their harvests are low. This does not gainsay that for some, selling maize at harvest or converting the maize to flour for sale or to beer for sale, even when they buy later in the year, might be a sensible strategy. The reason here is that conversion to other commodities (flour, beer or a crop bought with the proceeds from maize) can be a step towards an increased return. The difference is that the poorest tend to be involved in 'desperation' sales – selling maize because they have no other way of getting cash, and that the not so poor are able to benefit from a conversion procedure that ends by benefiting them more than if they had kept the maize.

The practice by the most prosperous 15-20% of households continued in 2006 of using some of their stored local maize (which stores better than all hybrid varieties) of hiring local people as temporary laborers in the peak cultivation system. As found before, more poor people do such work in bad years, as was the situation in early 2006, while the good harvests and low maize prices in local markets in late 2006 and early 2007 doubtless helped them to bid up the level of food compensation slightly.

Food Security

In the research area, obtaining sufficient food for the household depends on the amount of land and resources to produce maize and other foods as well as on cash income to purchase food in the deficit season. The rural population of Southern Malawi and the research population described here are food deficit: even though everyone tries to grow as much food as they can, the majority cannot do so because of shortage of land, labor and other inputs. In the sample in previous years, about 85% are unable to produce all the staple food they need, even in a 'good' year. Hence, it is critical that they are able to obtain staples in the deficit period. To do so requires that there is maize available in markets, and that people have the money to buy it. There is a third set of options: obtaining maize on credit from a store (usually at high rates of interest) or a friend (lower rates or none at all), or working for food (the most common strategy for the poor).

In early 2006, maize was very scarce and very expensive because of the poor harvest the previous year. The poorest families were found to be going without meals, making 'stews' out of any green leafy vegetables they could find, or eating boiled mangoes, strategies seen in previous seriously deficit years (1992, 2002). As noted above, a number of NGOs and some churches distributed free food (most from the World Food Program) in the area which provided much needed relief for many. 46% of the sample households listed relief food when they were asked the sources of food for 'meals eaten' the previous day. The rainy season proved hospitable to cultivation, and the wider use of fertilizer because of the subsidized program led to a very good harvest in May-June.

Table 11 **Food Storage by Key Rounds**
2006 core Households

	<u>Variable</u>	<u>N</u>	<u>Round 1 Jan/Feb</u>		<u>Round 3 June/July</u>		<u>Round 5 Nov/Dec</u>	
			<u>%Yes</u>	<u>SD</u>	<u>%Yes</u>	<u>SD</u>	<u>%Yes</u>	<u>SD</u>
Total Sample	2006 core	171	7.78	26.87	95.86	19.89	79.04	40.83
Headship	1 - ff	4	0.00	0.00	100.00	0.00	75.00	50.00
	2 - fj	67	6.25	24.40	95.45	20.99	74.24	44.07
	3 - j	99	9.18	29.03	95.91	19.89	82.29	38.37
tobacco	0 - no	59	8.92	28.77	89.83	30.48	66.67	47.56
	1 -yes	108	7.41	26.31	99.07	9.67	85.05	35.83
HIV5	0 - no	97	5.32	22.56	96.90	17.40	80.00	40.21
	1 - yes	74	10.96	31.45	94.44	23.07	77.78	41.87
exp pc Q	1 - lowest	42	2.63	16.22	97.50	15.81	72.50	45.22
	2	43	0.00	0.00	93.18	25.50	66.67	47.71
	3	43	4.65	21.31	95.23	21.55	81.40	39.37
	4 - highest	43	23.25	42.75	97.67	15.25	95.24	21.55
Orphans	0 - no	120	7.76	26.87	95.79	20.15	78.45	41.30
	1 - yes	51	7.84	27.15	96.00	19.79	80.39	40.10

The effect of the changing harvests over the period are seen graphically when one compares the number of households with maize in store over three periods (see Table 11): the deficit time in January/February of 2006, just after the harvest in June/July, and then late in the year in November/December when people are beginning to run out of stored food. The research found that only 8% had any stored maize in the first period (reflecting the poor harvest from 2005), 96% had some immediately after the 2006 harvest, and the quite high proportion of 79% still had some in store in November/December (reflecting the good harvest of 2006). As expected, only 3% of households in the poorest twenty-five percent had maize in January/February 2006 compared with 23% of the top twenty-percent, and none of the households in the poorest decile had any at that period. The big earners from burley tobacco were much more likely to have stored maize in all periods, including the deficit time of January/February of 2006.

Anthropometry

The nutritional status of children is used as an index of welfare in the sample. Nutritional status is presented in terms of Z-scores, as recommended by WHO. Z-scores for weight-for-height (WHZ), height-for-age (HAZ) and weight-for-age (WAZ) were calculated with the program Anthro 2005, using the NCHS reference that gives a standard distribution for these measures in children by sex and age (Tables 12-14, Graphs 4-6).

Children under six were measured once in 2006 – in August, the dry season. Comparisons with the dry season anthropometric surveys from 1986 to 2006 show a steady improvement in all the standard measurements: height for age z-scores (HAZ) (Table 12), weight for height z-scores (WHZ) (Table 13), and weight for age z-scores (WAZ) (Table 14). The sample average z-score for children for HAZ, that measures the extent of stunting, was -2.42 in 1986, and gradually lessened to -2.23 in 1990, -2.06 in 1997, and -1.40 in 2006. Throughout the years, girls have done slightly better than boys on all scores. Graphs 4-8 also show the improvement since 1990 for the sample as a whole, as well as the much larger gains among households in the upper quartile compared with the poorest quartile households. There are no clear differences between children in female-headed households compared with joint-headed. The failure of the poorest quartile households to improve as much as the others reflects the continuing shortages of food and income available to them.

Table 12

**Height for Age Z Scores for Children Under 6 Years
1990-2006 (2006 Core Hhds only)**

		HAZ								
		<u>1990</u>			<u>1997</u>			<u>2006</u>		
	<u>Variable</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>
Total Sample	2006 core	-2.09	1.38	230	-1.98	na	na			
gender	boys	-2.15	1.42	123	-2.11	1.41	177	-1.37	1.39	51
	girls	-2.02	1.33	107	-1.86	1.48	204	-1.42	1.49	68
Headship	1 - ff	-2.23	1.02	27	-2.24	1.46	82	-1.50	1.34	34
	2 - fj	-1.84	1.51	24	-2.56	1.72	12	-0.72	0.33	2
	3 - j	-2.10	1.41	719	-1.87	1.43	287	-1.40	1.51	84
exp pc Q	1 - lowest	-2.09	1.54	73	-2.39	1.41	104	-1.68	1.45	40
	2	-2.26	1.26	56	-1.69	1.65	108	-1.21	1.76	28
	3	-1.92	1.34	57	-2.03	1.22	85	-1.71	1.06	26
	4 - highest	-2.11	1.32	44	-1.78	1.33	84	-0.99	1.34	26
tobacco	0 - no	-2.04	1.41	147	-1.88	1.68	60			
	1 - yes	-2.14	1.30	74	-1.99	1.41	321			
HIV	0 - no							-1.41	1.39	72
	1 - yes							-1.42	1.55	48
Orphans	orphans							-1.47	1.51	22
	non-orphans							-1.40	1.45	98

Table 13

**Weight for Height Z Scores for Children Under 6 Years
1990-2006 (2006 Core Hhds only)**

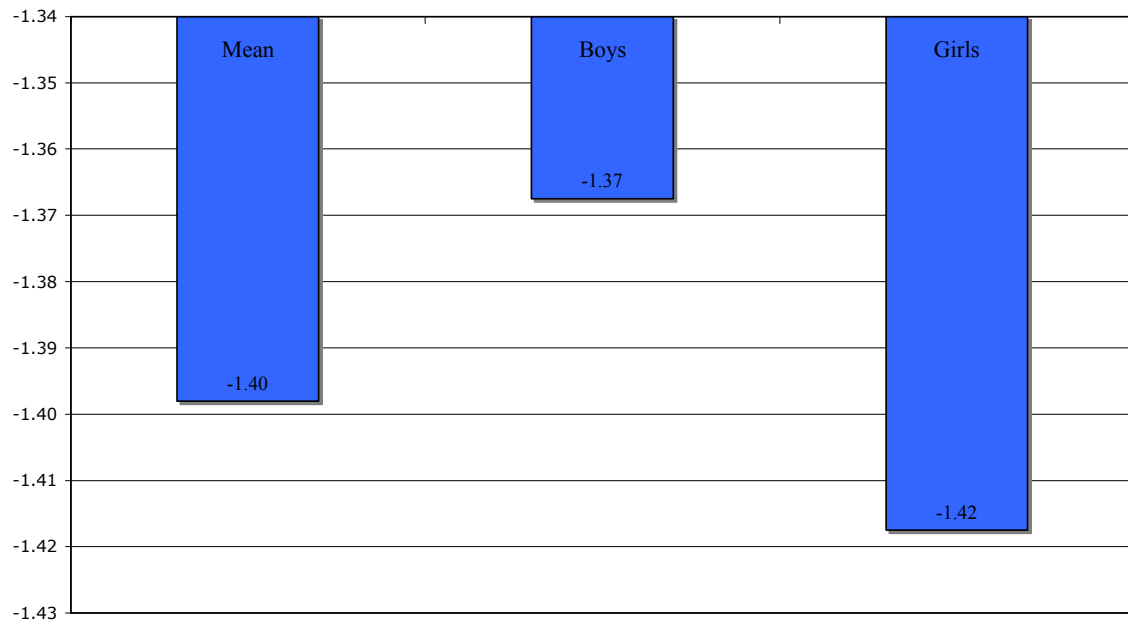
		WH								
		<u>1990</u>			<u>1997</u>			<u>2006</u>		
	<u>Variable</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>
Total Sample	2006 core	-0.11	0.83	232	0.08	na	na			
gender	boys	-0.11	0.84	125	0.10	0.85	177	0.29	1.00	52
	girls	-0.11	0.82	107	0.06	0.87	204	0.38	1.11	68
Headship	1 - ff	-0.03	0.96	28	0.07	0.86	82	0.34	1.19	33
	2 - fj	-0.02	0.83	24	0.03	0.56	12	0.15	0.42	2
	3 - j	-0.10	0.81	180	0.08	0.87	287	0.39	1.08	85
exp pc Q	1 - lowest	-0.16	0.84	74	-0.15	0.89	104	0.16	1.21	39
	2	-0.18	0.88	58	0.17	0.76	108	0.24	0.95	28
	3	-0.02	0.79	44	0.00	0.89	85	0.41	1.07	27
	4 - highest	-0.05	0.81	44	0.31	0.85	84	0.79	1.01	26
tobacco	0 - no	-0.14	0.85	149	0.10	0.78	60			
	1 - yes	-0.03	0.82	74	0.07	0.88	321			
HIV	0 - no							0.44	1.13	72
	1 - yes							0.26	1.04	48
Orphans	orphans							0.41	1.18	21
	non-orphans							0.36	1.08	99

Table 14

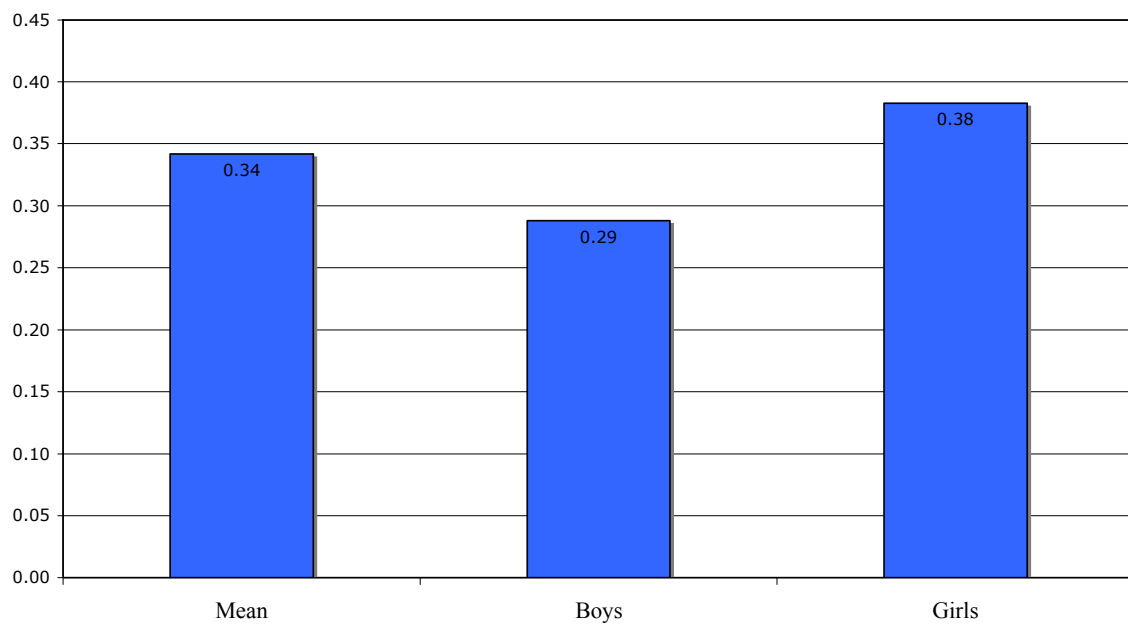
**Weight for Age Z Scores for Children Under 6 Years
1990-2006 (2006 Core Hhds only)**

		WA								
		<u>1990</u>			<u>1997</u>			<u>2006</u>		
	<u>Variable</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	<u>N</u>
Total Sample	2006 core	-1.40	1.08	232	-1.15	na	na			
gender	boys	-1.46	1.16	125	-1.21	0.99	177	-0.61	1.25	54
	girls	-1.32	0.99	107	-1.10	1.10	204	-0.57	1.16	69
Headship	1 - ff	-1.65	1.09	28	-1.32	1.12	82	-0.65	1.16	34
	2 - fj	-1.17	1.12	24	-1.53	0.84	12	-0.31	0.18	2
	3 - j	-1.39	1.07	180	-1.08	1.03	287	-0.55	1.21	84
exp pc Q	1 - lowest	-1.45	1.16	74	-1.56	0.96	104	-0.89	1.18	41
	2	-1.54	1.07	56	-0.93	1.06	108	-0.52	1.41	28
	3	-1.24	0.97	58	-1.23	1.02	85	-0.80	0.77	26
	4 - highest	-1.33	1.10	44	-0.84	1.01	84	0.08	1.06	27
Tobacco	0 - no	-1.40	1.13	149	-1.08	1.11	60			
	1 - yes	-1.34	1.01	74	-1.16	1.04	321			
HIV	0 - no							-0.55	1.03	73
	1 - yes							-0.60	1.39	49
Orphans	orphans							-0.50	1.24	22
	non-orphans							-0.59	1.18	100

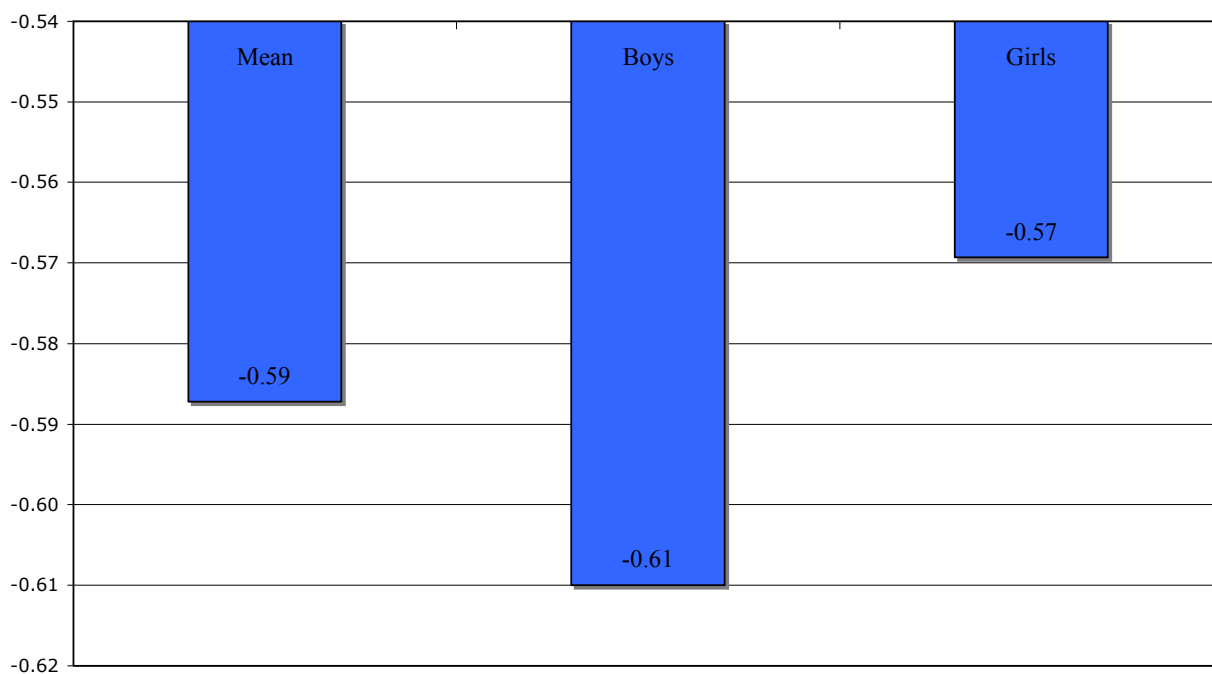
Graph 4: Height for Age Z-Scores for Children Under 6, 2006



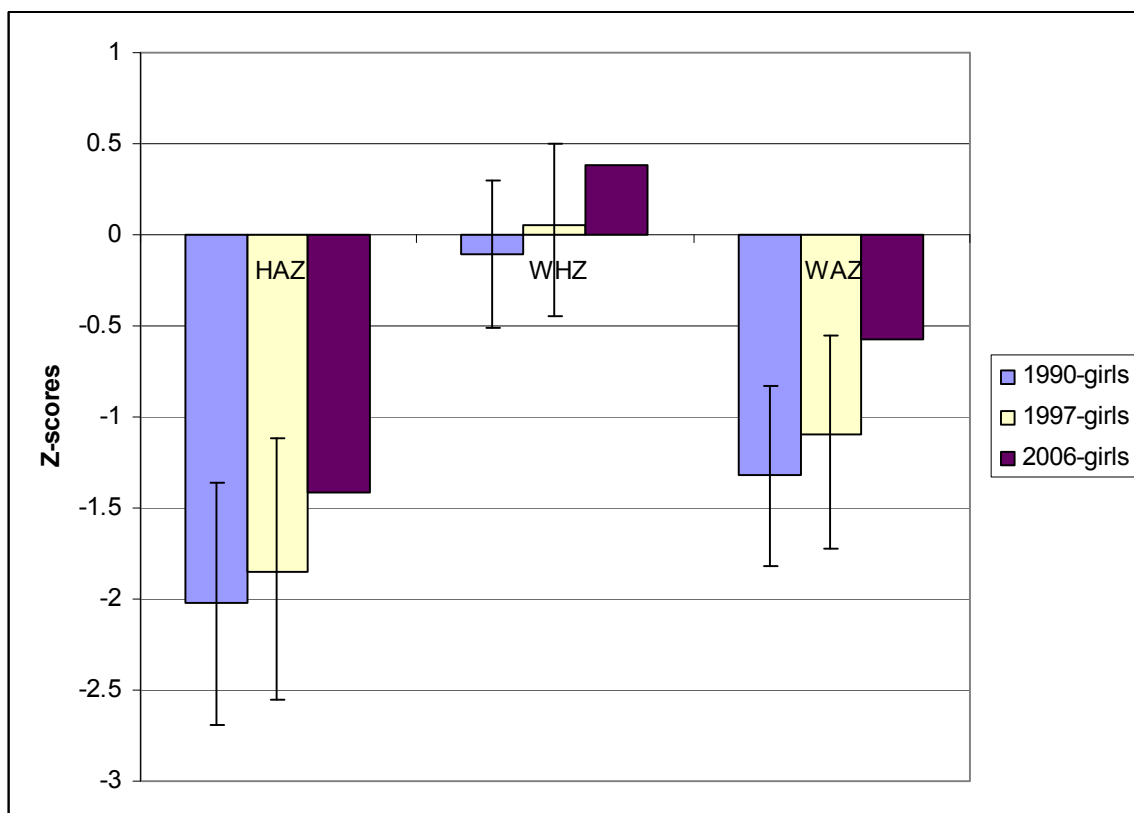
Graph 5: Weight for Height Z-Scores for Children Under Age 6, 2006



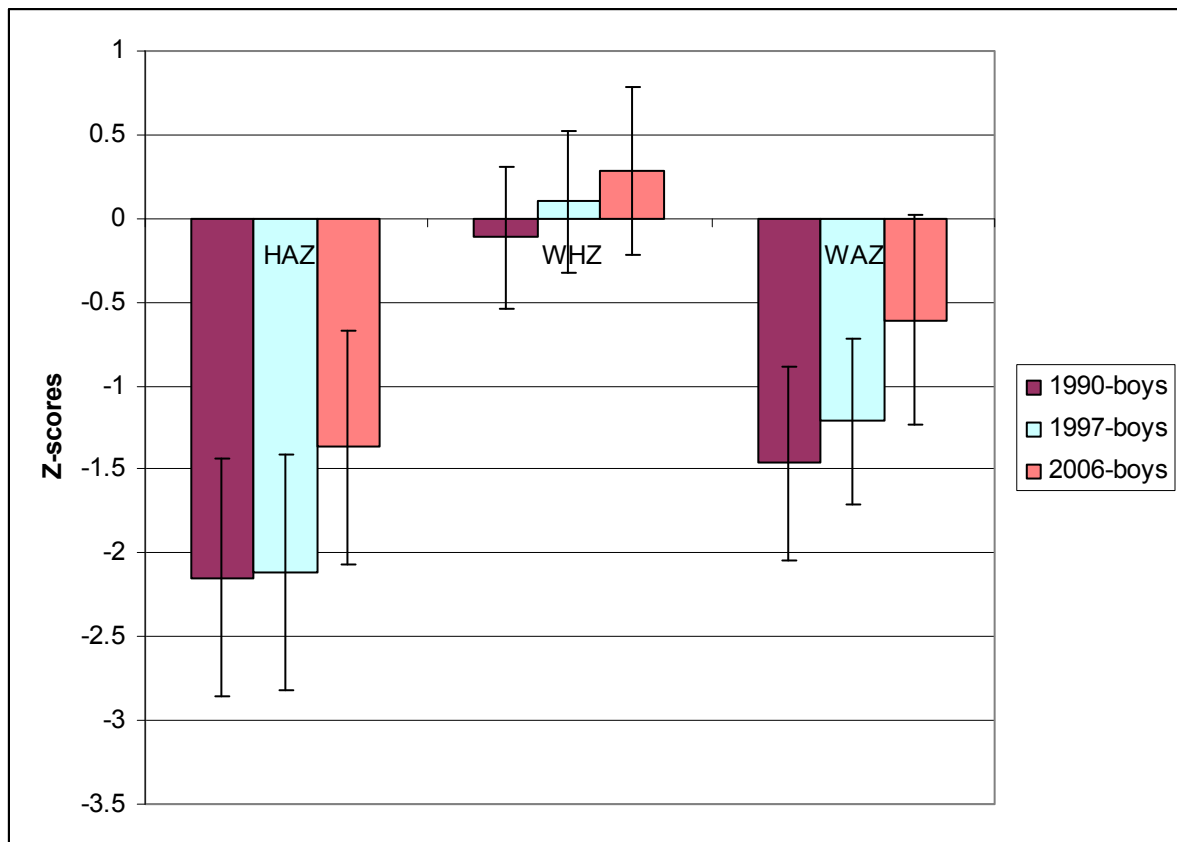
Graph 6: Weight for Age Z-Scores for Children Under 6, 2006



Graph 7: Z-scores for HAZ, WHZ, and WAZ in girls in 1990, 1997 and 2006



Graph 8: Z-scores for HAZ, WHZ, and WAZ in boys in 1990, 1997 and 2006



Evidence for the effects of HIV-related illness and deaths

The two main variables used in the quantitative analysis to get at the effects of the HIV epidemic were households with a reported certain to probable HIV-related death, and households caring for one or more orphans. The former variable is the weaker one in that it is dependent on partial information about deaths of household members but, like other non-medical researchers, we had no other viable option (see discussion in section III).

As discussed in earlier sections, the detailed ethnographic analysis showed that households with a currently very sick AIDS patient and those experiencing a recent death of someone who had been ill with AIDS definitely lost income and sometimes assets. Cultivation was reduced because of sickness and of caring for the sick, so reducing harvests and hence food stores and income from sold crops. Other income strategies (from temporary laboring to small-scale business) had also to be curtailed with consequent losses in income. The higher costs for health care and medicines, for transporting the patient to health providers, and for food (especially where the patient had returned home from living elsewhere) and for 'special' food desired by the sick all added to the economic stress. The sample data on expenditures showed no significant differences between households who had had HIV-related deaths and those who did not. This lack of difference is probably due to the fact that, as discussed at length in earlier

sections, most households adapt to the effects of HIV-related illness and death over time. Those households, so far in the minority, who continue to be severely stressed economically are those who started off very poor in assets and income opportunities and who have high levels of added burdens as a result of HIV.

The same reason – adaptation over time to the losses – likely applies to the lack of significantly lower averages between households who have had an HIV death within the past decade or so and others in terms of landholding, harvest, food stores, or whether or not they had received subsidized fertilizer. In fact, households with an HIV death harvested very slightly more per capita than others (188 kg cf. 181 kg), and sold less (42% cf. 52%). There were some small differences in the expenditure shares – households with HIV-related deaths showing slightly higher shares than others for medical expenses (3% cf. 1.9%), and slightly less on education (1.8% cf. 2.4%), which are intuitively reasonable but not statistically significant. The slightly higher expenditure share on health costs might be driven by those households who had had a severely ill person during the survey year 2006. The slightly lower share spent on education may also be more driven by those whose health costs went up and whose income went down in 2006. But if it typifies more households with an HIV death in the past, then the implications are serious, in that it may portend a vicious cycle in which young people, especially girls, may not only lose education but, in being thrust into early marriage and income-earning, will be at more risk. The ethnographic analysis discussed cases where the teenage daughters of parents who died of AIDS dropped out of school to first help care for their parents (almost always with mother's relatives) and then to run the household themselves. Countering this trend of potential decline is the set of households where the teenaged to adult children inherited more land than normally would have been possible without the deaths of parents and/or older siblings, so obtaining one of the most important assets in the region.

The most significant relationship with the HIV variable was the negative effect on burley growing: households who had had an HIV death were significantly less likely to grow burley tobacco as shown in a regression ($p < 0.01$). Similarly, the earnings from burley tobacco by households who have had an HIV-related death are, on average, less than a third of those of other growers. This suggests the unsurprising explanation that households who have suffered an HIV-related death find the intensive labor and inputs required by burley tobacco to be beyond their capacity. Burley tobacco is such a demanding crop for households, which always also grow maize and other food crops, that it requires both a husband and wife to be full-time farmers if it is to be grown on any scale. The only exceptions are the very tiny number of people, including a few women, who have sufficient assets and income that they are able to employ laborers. In addition to the labor demands, the fact that the price levels for burley tobacco, even on the Auction Floors, have gone down is another disincentive to households who have lost income through HIV-related illness and death.

Insofar as the households who were caring for orphans during 2006 are concerned, they had slightly lower average expenditures than others (K2390 cf. K2800) though the difference is not statistically significant. A comparison of the expenditure shares shows them spending a slightly higher share on maize than those without orphans (17% cf. 14%), a very slightly higher share on education (2.9% cf. 1.8%), and not much difference on health (2.2% cf. 2.5%). These would suggest part of the cost of increased

dependency. Why households with orphans spend a slightly larger share on fertilizer (12.3% cf. 9.9%) is unclear, especially since they are less likely to grow burley tobacco. While these households caring for orphans do not differ significantly from others regarding the size of land, food stores, or receiving subsidized fertilizer, they reaped a smaller harvest (171 kg per capita cf. 189 kg pc), and slightly fewer sold maize (45% cf. 48%). The negative effect of orphans on harvest is slightly less significant than the similar regression, already quoted, showing the negative effect of dependants on harvest, so probably is more a reflection of the effect of dependants on per capita harvest rather than of orphans per se. Nevertheless, these results do suggest the increased pressures, on average, on households caring for orphans.

The anthropometry survey showed no significant differences between children living in households who had experienced an HIV death and others. Only four of the children measured were orphans and their average scores were slightly better than those of the rest of the children though the small number obviously excludes any statistical significance. The improvement in mean anthropometric measures for the sample since 1990 and 1997 is particularly interesting in light of the expected effects of the HIV epidemic. This improvement has also been recorded for national data in Malawi. Presumably, there have been improvements in nutrition and health that offset the effects of the HIV epidemic. More sadly, as other studies note, it is probably the case that the infected children die rather quickly so removing from the children being measured. The age distribution charts described earlier also show the 'disappeared' children. Just as a stunted population, which continues to typify Malawi, is essentially a population of survivors, so it would seem that the improvement in anthropometric scores for children under six years of age obscures the many who have not survived the HIV epidemic.

VIII Conclusions and Recommendations

The Role of the Extended Matrilineal Family

Comparing the sample households over a twenty year period reveals that their ability to deal with the effects of the HIV epidemic – increased incidence of chronic, serious illness, deaths, and orphans – depends on prior levels of resources and income and, critically, on the capacity of the wider matrilineal family to help. The vast majority of care is provided by households and the wider families of which they are part. While a few households dissolved in the wake of HIV-related deaths, the children, assets and land were absorbed into other, related households. No young children (those under fifteen) were living alone and the only household without a senior adult member in charge was that of two young men whose mother and sole adult sister had died – one of these was twenty-one, the other sixteen, and there were two older brothers married and employed in urban centers. The family living next door, one of the most prosperous families in the sample, employed the boys in work after school and on holidays. As described in detail above, some households were suffering acute economic stress after HIV-related deaths but they were in the minority, and most affected households had managed, with the help of matrilineal relatives, to take on extra burdens and responsibilities and to weather the difficulties. The under-researched importance of the extended family has been pointed out by others – by Mtika (2001) for Malawi, and for Zimbabwe by Grant and Palmiere, who conclude that “The extended family as a safety net is still by far the most effective community response to the AIDS crisis” (2003: 233).

However, these findings must not be misunderstood. The ability of most of the sample households and their wider families to avoid disaster does not mean that they are not under strain or that their ability to respond to the need for help is automatic and frictionless. For example, in the Zomba study, while orphans are often divided up amongst relatives, they often all end up with their maternal grandmother, suggesting that some relatives fail their responsibility. Another indication is that the ambivalent, fearful, and negative feelings towards AIDS occasionally lead people to fail to care well for ailing relatives. In addition, many of the current caretakers of sick and dying relatives and of orphans are in their late fifties or older, so that the next cohort of family members, who statistically are more likely to be HIV-positive themselves, will probably be less able to take on extra responsibilities. It is likely, therefore, that the current remarkable ability of matrilineal families to manage much of the impact will be further stretched and undermined.

Moreover, there are cross-household or intra-societal effects at play. The better-off households (those with higher levels of resources and income) have, on average, been more able to absorb the effects of AIDS illness and deaths. But if an increasing proportion of these households lose people, cash and time to HIV/AIDS, then not only are the households themselves affected, and not only are the households related to them through the matrilineage affected. Their losses have broader implications because these better off households play important roles in local relations of production, distribution and consumption. It is precisely the better-off households who are the producers of true ‘surplus’ maize which they store and sell in much bigger quantities than the majority of sample households; they are also the larger-scale producers of burley tobacco and other cash crops. Declines in their ability to produce large surpluses may reduce local supplies

of maize; and will reduce the likelihood of their hiring people for food in the deficit season (which, while not equitable, nevertheless serves as a resource for some of the poorer). Additionally, their reduced overall income level will necessarily cut their expenditures, many of which have been for local products (furniture, beer, mats, baskets, pots, store goods, etc) and services (building, well-digging, tailoring, carpentry, etc). In short, the socio-economic links between the better-off households and others mean that major losses among the better-off minority do not augur well for the poorer.

The Problem of Poverty

Fundamentally, most of the strain caused by AIDS illness and death, especially in the medium to longer term, is due to the preexisting and continuing levels of need and poverty at household and family levels and of acute shortages at institutional level. As discussed below, this points to the need to forge a stronger link between HIV/AIDS policy responses and general social and economic policies. In particular, this means to improve people's access to food: in even 'good' harvest years, like 2006, there are still households with insufficient food a few months after harvesting, and in 'poor' to 'bad' years, the numbers of food-short people quickly escalate. This has long been a problem in Malawi but the HIV epidemic brings it even more to light: poorly nourished people are more vulnerable to sickness, and sick people without access to sufficient nutrition are less likely to improve. The people in the sample who were known to be HIV-positive and the two who were on anti-retroviral therapy all spoke of their problems in getting 'good' food and of the interactions between powerful drugs and the levels of food intake.⁶⁰ Providing access to sufficient food should be more incorporated into health treatment, including that for HIV positive people, as well as into the activities of NGO and 'community' groups. In addition, most of the time, the failure to obtain enough food is not a problem of food supply but of insufficient income to purchase it. Again, the issue is widespread poverty, and the danger of policy priorities being focused too narrowly on the HIV epidemic at the cost of finding ways of raising incomes, improving food security, and providing more effective health care and education.

Normalization and Change

It is important to point out that the Zomba study supports other researchers who have rejected images of a static, conservative and fatalistic population beset by the HIV epidemic. The overwhelming view that emerges from the research is people's valiant efforts at 'normalization'. This term has been adopted from other research on HIV/AIDS to capture the efforts made to incorporate the effects of rising illness and death into the normal round of life, in short, to try to make the abnormal as normal as possible. Thus, the single notion of 'denial' fails to capture the complexity of response by Malawians such as the rural residents described herein. The general avoidance of the term *edzi* (AIDS) in favor of a whole range of 'roundabout' labels that, nevertheless, are perfectly understood to refer to the new disease complex, and the avoidance of attributing a person's death to HIV/AIDS in public homilies at funerals are attempts to hold at bay the hopelessness that a disease 'without a cure' might inspire, and to give everyone a proper

⁶⁰ Stephen Lewis stressed the importance of food and nutrition when ARVs are introduced, pointing out that "treating malnourished people with ARVs can be deadly ... they are six times more likely to die than those who are well-nourished" (ICAD 2006:9).

farewell at the final obsequies. As with the contributions of the extended family, such efforts at normalization are not all successful or without costs. But they should be recognized as active, constructive attempts to deal with the inroads of HIV/AIDS.

There is also evidence of change: while the level of voluntary testing is still extremely low, there have been increases in the availability of testing in the rural areas; some people are definitely paying more attention to the known behavior of their spouses, friends, and neighbors and making changes in their own practices, such as some youngsters ‘holding their hearts’ (that is, not engaging in sex too early or too often), and some adults holding each other to stricter standards than before (a woman sending off her husband because she learned he was taking lovers in his trips to town). These echo the detailed information made available from the University of Pennsylvania study from the late 1990s to the present (for example, Watkins 2004, Smith and Watkins 2005). Again, this is not to say that there is profound transformation in the sexual and related practices of Malawian villagers in Zomba. To expect such would be to misrepresent the capacity of people living in severely stressed situations to ‘choose’ to completely change well-established practices. For example, as we have found before, a woman with a decent amount of land can attract a husband more easily than others, and everyone knows that two adults can produce more crops and more income from such land than can one; so it is not surprising that widows, especially those under about fifty, tend to remarry quickly. Many people continue to have multiple partners, some sequentially (as in remarrying after death of a spouse or after divorce), some simultaneously. As pointed out earlier, multiple partnering is not confined to the rural areas and may even be more common in towns and among those with higher incomes.⁶¹ But the responses of the Zomba villagers echo those reported elsewhere in the country, showing the concerted efforts of generally poor people to strive to absorb the high toll of loss brought on by HIV/AIDS. This is not denial and it is not fatalism. Neither is it easy. It requires more support from routine social and economic policies.

Tighten the Link of HIV/AIDS to Socio-Economic Policy and Programs

The Zomba study strongly supports the growing number of researchers and commentators who plead for a much stronger linkage between responses to the HIV/AIDS epidemic and social and economic policy designed to increase household income and food security, and improve access to basic services of education and health. One cannot deny the tragedy of the HIV/AIDS epidemic in Malawi, as across much of Africa, but many authors point to the danger of attributing all problems currently faced by people to the epidemic and of ignoring the ongoing socio-economic causes of insecurity and poverty. In a recent synthesis of research on “the impact of AIDS on food and livelihood insecurity”, one conclusion was that, “Many changes occur that are not related to AIDS: farmers switch to labor-saving crops more suitable to current market conditions, and youth leave homes to make their own way in the world ... reflecting a general decline in interest among rural African youth to work in agriculture” (Murphy et al 2005: 271). There have also been exaggerated reports of ‘child-headed households’ without careful analysis of exactly where these occur and why.

Similarly, care is needed in assessing the effects of HIV/AIDS on agricultural production. Insecurity over land access and land ‘grabbing’ are often wrongly attributed

⁶¹ National data show that HIV prevalence is actually higher among high income groups.

to AIDS rather than to a set of other socio-economic circumstances (Aliber et al 2004), with which, obviously, AIDS interacts. In Malawi, references to land-grabbing, especially to the disadvantage of widows, are assumed to apply to the whole country rather than the specific site of the research. But, in the Zomba research, there are no cases of land grabbing or special disadvantage of AIDS widows compared with other widows. The critical distinctions between areas where patrilineal-patrilocal patterns hold and those, as in the Zomba research site, where matrilineal-matrilocal patterns hold must be stressed. In the latter, women as 'daughters' are the heirs of land and sons are expected to marry out and use their wives' land; where men use land belonging to their own matrilineage, the reasons are that it is a temporary use until the female heirs claim the land, or the family has so much land that even sons can use it (again, viewed as a temporary use), or the man is a chief and hence must live in his own matrilineal area. Other research notes the important difference between patrilineal-patrilocal areas and matrilineal-matrilocal areas in terms of the greater independence of women in the latter to form social networks without interference from a husband's family (Helleringer and Kohler 2005). Hence, incidents of increased insecurity of land access or other disadvantage are currently too easily attributed to the AIDS crisis rather than being carefully situated socio-economically to identify the causes.

Again, commentaries on the impact of HIV/AIDS assume that AIDS illness and death necessarily create major labor shortages. Research in several countries shows this not to be a necessary outcome (Tibaijuka 1997, Yamano and Jayne 2004). The Zomba research also found that land was seldom left unused due to HIV-related labor shortages for more than a season, and often less, because either other family (not just household) members took it over temporarily or as heirs, or it was rented out. In the two cases where AIDS appeared to be related to the sale of a field, there was clearly stress, but in one case the woman seller had been selling off land since 1986 to buttress her poor income level; and in the other case the household had a lot of land and the sick husband sold one field; it was also a very unusual household in that the wife was a foreigner and thus lived in her Malawian husband's village.

Yet another assumption has been that HIV/AIDS would lead to significant changes in cropping patterns, especially in driving a shift from labor-intensive crops to others less so. The Zomba study found that there were no sample-wide changes in cropping patterns attributable to AIDS even though individual households affected by AIDS reduced or dropped the labor- and input-intensive burley tobacco, at least for a while. Most crop changes over the past two decades have been due to shifts in prices or other market conditions, or to the availability and price of needed inputs of seed and fertilizer (cf. Murphy et al 2005). Nevertheless, as pointed out earlier, HIV-related illness and death are definitely added interruptions to the 'normal' cultivation patterns of households. So far, many of the heirs of the fields and assets of those dead from AIDS are managing to bring back the production to earlier levels. But since the cohort of young adults now taking over the fields are statistically more likely to suffer from HIV-related illness and death, it is possible that there will be reduced production levels, which will have negative effects not only on the affected households but, as indicated earlier, on a broader set of households linked not just by kinship but by exchanges, labor and service relationships. On the other hand is the evidence of appreciation of the dangers of

HIV/AIDS and of some change among some people which might be able to avert major negative shifts in cultivation.

A final point on the importance of situating sample households within the wider socio-economic context supports the conclusion from a recent longitudinal study in Zambia: "... it is not possible to understand the social nature of vulnerability and resilience without an analysis that goes beyond the household level" (Drinkwater et al. 2006: xii). Comparison between the Zomba and Zambia studies, both of which do not consider 'households' as the sole unit of analysis, can go even deeper. The research by Drinkwater et al. took place in an area of Zambia where matrilineal groups lived. The Zomba research would support their conclusion that matrilineal kinship and residence systems appear to provide the necessary 'flexibility' and 'resilience' to deal with the effects of HIV/AIDS. On the other hand, the people in Zomba district (as in the rest of the Shire Highlands and north through Balaka) follow very different inheritance and residence patterns than those in the Zambian case described by Drinkwater et al. Thus, it is impossible for sons to 'take over land and assets from their fathers' in the Zomba area: they are members of different lineages so sons are not considered possible heirs. As described above, land is inherited by daughters and sons are expected to obtain land for use from their wives' families. In the few cases where a son uses land belonging to a parent, it is considered a temporary use, requiring special dispensation by the elders of the respective families, and is rarely kept beyond his own generation. More details are not appropriate here but the point is that such comparisons are necessary if one is to understand how different households and differently organized family systems are responding to the inroads of HIV across Africa. In both the Zambian cases and the Zomba case, the family system is matrilineal but they are different types of matrilineal systems with differing rules and practices about inheritance and residence. If studies continue to focus only on households rather than on the kinship, residential and other social systems of which they form part, understanding will continue to be highly partial.

Health Care

What might be done to help support the major efforts being made by rural families? First, as emphasized by others, both treatment and prevention programs are needed, and they should be better integrated, rather than one or the other taking precedence (Hardon 2005). Earlier doubts about the viability of providing the currently most effective treatment (ARV therapy) to rural Africans seem to have abated and closely studied places like Masaka in Uganda show the feasibility of such programs. However, the requirements for skilled and experienced health personnel and the administrative logistics are high, and some point out that so far, the effective treatment programs are in high-resource pilot projects like Masaka (Hardon 2005: 606), or in wealthy countries like Botswana. The serious shortages in Malawi's burdened health system are likely to make the spread of appropriate treatment slower than in other places with more resources. In addition, the Zomba research, like other studies, shows that even for the very few who gained access to ARV therapy, there remained the large obstacles of obtaining sufficient food, and of managing the severe transport problems in getting to the treatment centers (cf. Hardon 2005).

Most care currently given to sick people, including the increasing number with AIDS-related sickness, is provided by the family. In light of the enormous strain on a

severely undermanned and provisioned health system in Malawi, this seems likely to continue for some time. However, it may be possible for the Ministry of Health and NGOs to do more to provide some basic training for the many caregivers across Malawi with reference to the basic hygiene and biology of AIDS (cf. Chimwaza and Watkins 2004: 806), as well as to provide some simple equipment like rubber gloves, soap, and basic medicines. While better knowledge about the biology of HIV/AIDS is insufficient in itself to achieve change in sexual practices, it can help. The Zomba research points out that people virtually never distinguish HIV from AIDS and that HIV is essentially linguistically ‘silent’. Very few refer to a virus, talked about in the same terms as germs (literally small animals or *tizirombo*), and even those display highly partial and incorrect information about the process of infection and path to illness. Similarly, the precise role of anti-retroviral therapy is not well-known by most.

There are programs underway to identify and provide basic training to volunteers for the Home-Based Care programs set up both by the Ministry and a number of NGOs. Extending this training to villagers, especially if associated with basic equipment, would be of great use to the many village-based caregivers trying to manage added burdens in an already difficult situation. Some form of assisted networking among the family caregivers themselves might also be able to provide periodic assistance by others to give them some brief respite from the constant burden of care.

Efforts to improve health care for HIV-related illness and non-HIV-related illness are desperately needed. As discussed earlier, respondents complain about the decline in levels of health care with reference to personnel, medicines, and the quality of care; these comments are more than supported by the government’s own reports on the loss of doctors and skilled nursing staff and a very high rate of drug theft from clinics and hospitals. The degree of untreated and acute suffering in the villages is extremely high: a woman suffering vaginal hemorrhaging and abdominal pain for over a year before she died; a woman who is HIV positive with persistent diarrhea, severe stomach pains, headache, bodily aches; neither of these received pain-killers beyond a few aspirin equivalents before their deaths. There are also widespread problems with sexually-transmitted infections, many of which do not get treated or treated early enough; yet a high level of such STIs is now well-known to increase the risk of HIV infection for women.⁶² Thus, even before the onset of HIV and the subsequent rise in people with chronic and severe illness, there were – and are – serious gaps in the current health care system.

The efforts to increase the number of centers for HIV testing need redoubling. Even more necessary is to find ways of providing more care for those ill with AIDS-related ailments. Only two people in our research sample were receiving ARV therapy (both of whom died during 2006) and a handful of non-sample individuals within the villages were also on ARVs. The obstacles are the distance to the very few hospitals that provide ARV therapy and related treatment and, hence, the cost in time and money for people to reach these centers. Despite the difficulties, the need to extend this therapy to more people is not only to extend those individuals’ lives but also to provide more evidence about the possibility of a longer life to the many people who equate diagnosis of HIV infection with a death sentence.

⁶² Local practices of cutting genital sores and medicated incisions may also increase risk of HIV infection.

Engaging with Local Interpretations and with Traditional Healers and Risk

The discussion in section V on the multiple interpretations given to AIDS concluded by urging, in agreement with authors like Ashforth, Heald, Mogensen, and Rodlach, that the indigenous or non-biomedical interpretations be engaged with rather than dismissed or ignored. People's own interpretations about the origin and cause of an illness will influence and help determine the action they take to treat and to prevent illness. Thus, there must be a proper engagement with other points of view than the bio-medical. Simply condemning 'traditional' medicine may not diminish the influence of these beliefs or practices but only make them illicit, and therefore more difficult to observe and productively engage.

At the same time, there are serious implications of the findings from the study in Zomba. Research in the Zomba villages over the past twenty years found that, while the interpretation of a sickness suffered by a specific person is subject to change, the named illness syndromes appeared to remain fairly stable. This seems to be changing now with the advent of HIV/AIDS. During 2006, a number of people in the villages, and a possibly larger proportion of local healers (*sing'anga*) were coming to the conclusion that AIDS and an indigenous illness, *kanyera*, were linked. Some people equate AIDS and *kanyera*, others see a close similarity between them. Both are thought to be caused by sexual infringements and both share similar symptoms. It is important for such local understandings to be considered seriously. In this particular case, the serious implications are that if someone who is HIV positive and who is beginning to suffer the effects of AIDS is convinced that he is suffering from *kanyera* and should seek medicine from traditional healers, he will miss out on bio-medical treatment, including ARV therapy. Of even more concern are the claims by some healers that they have preventive medicine for *kanyera*: if people interpret this to mean they do not need to consider the now well publicized risks of 'unprotected' sex with multiple partners, they will be exposed to infection. In both instances, then, the notion that *kanyera* is or is very close to AIDS provides serious risks. More productive engagement with traditional healers rather than ignoring or threatening them is needed to allow them to provide herbal remedies for symptoms, perhaps especially for dealing with pain, but to get them to see that AIDS is not *kanyera*, and cures and preventives for *kanyera* should not be assumed to be treating AIDS.

As well as engaging with local healers and their practices, more attention should also be paid to the many rumors found in Malawi, including the research site, connect to AIDS and related health programs. Earlier we spoke of some of the rumors that condoms are laced with poisons designed to reduce fertility, and referred to papers detailing the pervasiveness of such beliefs among Malawians. It is a mistake to treat such rumors and widespread opinions as deriving merely from incorrect knowledge. A well-known historian has pointed out the dangers of treating rumors merely as things that are 'not true' (White 2000). Such rumors are prevalent accounts or discourses with real effect for people's interpretation of illness and for their actions. The increased rates of illness and death, and the suspicions and fear that they inspire are the context in which to consider the widespread discussion – in media and among people in villages and towns – about 'vampires' and other illicit blood-suckers, the collection and sale of body parts, and the growth of cults of Satanists, believed to be behind many road accidents among other

tragedies. The Zomba research did not elicit any specific connection between HIV/AIDS and this widespread discourse about perceived risk, but the context within which the treatment of HIV-infected people and HIV-affected households and families should be taken more seriously.

The Risks of Injectors

Another risk that needs more attention is the pervasive and popular use of injections for a multitude of ailments in the villages. The injections are given by people, all men in our area, called *amajekisoni* (those who inject). Their popularity has been documented in our research since 1986, and it has not waned despite periodic government statements about the dangers of injections, warnings that have increased over the past ten or so years. These seem to have had little to no effect on villagers' beliefs in the power of injections. In fact, the increase in illness and the concomitant disappointment among villagers with the lack of medicines and appropriate levels of care in local clinics and hospitals appear to have increased the use of injections (and at least one 'injector' in our sample villages set up a 'clinic' at his home).

In earlier years, we talked to a number of *amajekisoni* about their practices. Most of the medicines they use are obtained through the illegal but pervasive market for medicines that originate from clinics and hospitals. Official statements in 2006 that 75% of all drugs are stolen from clinics and hospitals reveal that the situation is the same or worse. These medicines are mixed indiscriminately and diluted with water (usually not boiled) in the syringes. In the past, these syringes were not sterilized in any way and were re-used. Since the onset of HIV/AIDS and the increase in government and other messages about the dangers of transmitting HIV through blood transfusions and untreated needles, some of these *amajekisoni* claim to use separate needles for each patient and to sterilize the needles. Research observations during 2006 suggest this is not the case for some to many. Assistants living in the villages were able to observe the actual practices and to be told by our sample respondents in the normal course of conversation about their treatment by *amajekisoni*. First, many of the families turned to these practitioners at many instances of illness. Second, while the practitioners, if asked, left the needles with the patients – an indication that the needles were not to be used again - they gave their patients the option of paying a lesser charge if they did not insist on a separate needle (the average was K200 a shot, circa \$1.60 at the time). Hence, they were using the same needle for several patients.

The danger of infection with the HIV virus as well as many other infections (such as hepatitis) through shared needles has been identified before, though tends to have been greatly downplayed in most discussion about HIV/AIDS (Gisselquist et al. 2003, Allen 2005). In Malawi, there has been virtually no discussion of local 'injectors' though there has been some over-dramatic media attention to shared razor blades (during circumcision rites and when healers make cuts on patients' bodies into which they rub medicines). For many years, the *amajekisoni* were tolerated by authorities. Even now that the government and other agencies have warned the public against such practices, the widespread popularity and use of these injections have not diminished. It should be noted that the warnings, in the context of the HIV/AIDS pandemic, focus on the transmission of the virus through reused needles. Less discussed is the fact that the injected liquids are also

unlikely to be beneficial and may even be detrimental, both in the short term but also the long term (with reference to the buildup of resistance to antibiotics).

Over Emphasis on Orphans

Results from the study suggest that, first, a myopic focus on orphans as individuals seems to be displacing the efforts needed to provide aid to families on whom AIDS sufferers depend and where orphans are cared for. If orphans themselves are not currently well-served by orphan care groups among others, the deficit for people living with AIDS is even starker. Yet these needs are connected and should be considered as a package in assessing policies and programs.

A second reason to be concerned that attention to orphans too often becomes the sole or major response to ameliorating the effects of AIDS is that it obscures the avoidance and ambivalence associated with addressing the (largely) sexually transmitted disease. Images of small children crying over their dead mother or father are moving and hence effective vehicles for fund-raising. Who can not be moved by such images? No-one could deny their need. But one can question the disproportionate amount of attention given by donors, government, NGOs, and media to the innocent children orphaned by the disease compared with that to adults suffering from AIDS and adults widowed by AIDS.

Despite the emphasis in donor programs and the media on orphans, the main conclusion from the research is that, in spite of the vast amounts of funds pouring into Malawi for orphans, there are very few services actually reaching orphans and the families who care for them, at least in the research site. The number of orphan care groups has proliferated over the past five years as a result of the availability of grants, but ‘on the ground’ delivery of real services to orphans and their families remains tiny. Across all the research villages, a very large majority of families caring for orphans reported receiving nothing from any group (see section IV and Appendix A). Changes in the ways in which funds are directed to orphans and the families that care for them are needed, as discussed next.

Community-Based Caregiver Groups and Voluntarism

There is an over-reliance on ‘community volunteers’ by donors and government for providing care and services to those affected by HIV-related illness and death. First, it ignores the fact that virtually all care and cooperative effort in villages are already (and always have been) ‘voluntary’, even though they have not been labeled such. Second, the large grants given to groups to set up business enterprises intended to provide a ‘sustainable’ source of funds for service delivery are inappropriate for most cases. People volunteering for orphan care rarely have the tight organization or the experience to run a business of the scale assumed. In most of the cases studied, the grants and other resources (especially time) were expended on establishing and running the enterprise with very little or no resources actually reaching the people supposed to be helped (see section VI and Appendix C).

While there is definitely a role for ‘volunteers’ in programs designed to help HIV-affected people, other models can be more effective in delivering services. First, the very large grants now being made are appropriate for very few groups that need to be well-organized and skilled. More useful for the majority of village-based volunteer groups would be much smaller grants given to a much larger number of small local groups

(without the need for written proposals, committee formalities, complex accounting and reporting). Second, rather than assuming a 'committee' of villagers can run centers (say, for orphans) in their very limited 'spare time', local groups should be encouraged to hire a suitable local person who can receive a locally appropriate level of compensation, while the volunteers act as helpers and monitors of the center activities. This is a recognized model and would require far less administrative overseeing by district and other authorities than the current proposal-based grants do. Similar conclusions emerged from a study in Zimbabwe, with authors describing the reliance on 'volunteerism' as "highly problematic" in face of lack of resources, lack of requisite skills, and already large burdens of responsibility among people (Grant and Palmiere 2003: 238). They argue for proper professional training for local people providing social services, and for monitoring and support by "a consortium of involved organizations". Organizers and educators in local centers for 'youth' or orphans or people living with HIV/AIDS need to receive a "living wage" and to be trained and supported in the same way as other service providers (ibid). In short, voluntary effort is alive and well in Malawi but it is totally unrealistic (and unethical) to assume social service delivery for the HIV epidemic should be based on volunteers alone.

IX Appendices

Appendix A: Cases re: Orphans

A. Mobility

Case A1. When Dorothy died in 1991, her elder sisters, Felesi and Callista along with Esther, the adult married daughter of Felesi, took responsibility for the remaining orphaned children (their father also died). Two older girls went to Felesi but later moved to Callista, who has no children of her own, before marrying and leaving. A boy who is mentally impaired also went to live with Callista, where he remained in 2006. Later, in 1997, a boy Love came to live with Felesi, his maternal grandmother, after his mother died. Then in 2004, two more children, a girl of 14 and a young girl of 2 came to live with Felesi. These were the daughters of her younger sister Nelly. Their father had also died; the younger of the girls died soon after; Felesi said that the cause was *matenda a tsopano* (AIDS), the same as her parents. Love has proved 'troublesome' according to Felesi and Esther. He has moved several times across the households of his grandmother, Felesi, his aunt Esther, his uncle (Esther's brother), and his cousin (daughter to Dorothy, who has been married for some years), always due to arguments and his accusations that he is not being looked after well. During the latter part of 2006, he was living with his grandmother; he was almost 15 and still in Primary school.

Case A2. During July 2006, a young man came to live in Anne's compound. He is Ephraim, the son of her younger sister who died a year or so ago. At first he and his sister continued to live with their father, who after a while, remarried into a family a short distance away in the same village. Then, Ephraim and the step-mother quarreled and he decided (or was told) to go to live with Anne, his mother's elder sister, whom he addresses, following local custom, as 'mother'. His sister remained with their father.

Case A3. The mother of 4 boys and 1 girl died in 1988; by 1990, the widowed husband, Sam, was remarried. After a while, the boys, now in their mid to late teens, quarreled with their stepmother, accusing her of failing to feed them as well as her own daughters. She, in her turn, claimed that they were rude to her, and pressured her husband to send them away. They moved out to live with an elder sister of theirs who had married some time before and who lived in the same village. They then moved out for their own marriages and jobs so that by 2006 none was present but the household had been taken over by their niece, their sister's daughter, who was now married herself. During 2006, this young woman (early twenties) and her husband had taken in her youngest brother (age 19) as well as the orphaned son (also 19) of her husband's deceased sister: this boy's siblings had been taken by the other sisters of the deceased woman.

B. Role of father's family

Case B1. After the death of Elube, and then her husband, their younger son went to stay with his mother's sister. The elder son stayed in the Blantyre house of his parents, looked after by his mother's brother. But the main upkeep for the boy came from the rent of several houses built by his father. Some of his father's matrilineal relatives had claimed these houses as theirs, following custom, but some said that the dead man had wished the

houses to be for his children. Following a decision by an unspecified authority in Blantyre, this is what happened.

Case B2. The four orphans Athaonse has still with her are her deceased daughter's. While the children from her dead son's two wives are looked after by the families of their respective mothers, she told us that they often come to her (their paternal grandmother) asking for advice or help, which she gives them whenever she can.

C. Making decisions about who should take care of orphans

Case C1. Egilie explained that her sister Lidia left 5 children and because none of her sisters could manage to take them all, they divided the children between two of them. Anne who has 3 daughters of her own aged 20 (in the top form of secondary school), 14 and 11, both in primary school, took 2 orphans, a girl aged 8 and a boy aged 11, both in primary school. Egilie herself took three: a boy aged 19, and two girls, one aged 16, and one, the last born, only 5 who is chronically ill (probably HIV positive). Although Egilie did not say so, it also seems that the two sisters who took in the orphans were slightly better off in the sense of available resources relative to existing responsibilities than the other sisters.

Case C2. Elube was living in Blantyre with her husband and two children; the husband was employed in town and they were doing quite well, since he had invested some of his pay in building several small houses which he rented out. Elube was ill for some time and died in April 2005. Her mother Edda went to look after her, and after her death continued to spend time there to help care for the children because their father, her son in law, was also ill. The husband died in December 2005. The elder boy, aged 17 in 2006, stayed in the Blantyre house, being looked after by his mother's brother. The husband had specifically asked that the houses be left for his own children. Elube told us that a claim over the property made by his own matrilineal relatives was rejected by some authorities in Blantyre (she was unable to explain who these were). The younger boy, aged 7 in 2005, should have come to live with her, said Edda, but because she had not been able to harvest much food due to her having looked after her daughter and then the children for months, she felt she could not feed him. So he lives with his mother's sister who also lives in Blantyre.

Case C3. Janet died in 2005, her husband already having died in 1997 (both probably due to HIV). Emily is the elder sister of Janet, living next door (and another of our sample). She is a widow, her husband having died in 2002. She has no children of her own but had two of her sisters' children living with her, both of whom died as adults in the late 1990s and early 2000. Another sister's son lives with her. When Janet died, the eldest son who lived nearby with his wife took over his parents' compound. Two of the sons had already married and left and a daughter had married but lived nearby. The orphans remaining were 4 boys, two in their early twenties, one late teens, and one 13, and two girls, one 15 and one 11. The two elder boys and the elder girl came to live with Emily; the third boy stayed with his eldest brother next door, the youngest boy went to live with his elder brother living in town, and the youngest girl went to live with her elder sister married nearby. During 2006, the third boy quarreled with his elder brother and came to live with

Emily, by which time the two other brothers had married away. On several visits, we found the youngest girl also in the compound with her aunt, whom she addressed, as did the others, as '*mai*' or mother. Since these compounds are part of a larger complex of kin – the sisters and mother's sisters of Emily and Janet and their daughters living nearby – there is a considerable amount of interaction across the households all the time.

Case C4. Rita's daughter Grena died after a long illness (TB and signs of HIV). Grena had been living in Blantyre where her husband worked but was building a house in her mother's compound before she became seriously ill. After her death, the husband went to Lilongwe, apparently for a job, and the two children (boy and girl, aged 9 and 7) were taken by Grena's matrilineal family. At first, the girl went to stay with her mother's sister in Lilongwe while her brother came to live with his grandmother Rita. But by 2006, the girl was also living with Rita, who explained the decision as 'things are expensive in town' so it was better for the child to come to stay in the village with her grandmother. The implication was that the girl was not getting the level of care her grandmother thought appropriate. She added that it was better that the two siblings be together since they missed each other. In late 2006, the husband was reported to have returned to his own matrilineal home since he was ill; he had not contributed to the care of his children.

Case C5. Anna, a healthy woman in her early sixties in 2006, is the daughter of a now deceased village headman who was the single richest man in the entire sample between 1986 and the mid 1990s. After his death, much of the land he farmed was taken by his matrilineal relatives, though a not inconsiderable number of fields remained with Anna and her remaining adult children, all of whom live in town. The widow was very frail by 2006, blind and fairly immobile so she was being looked after by Anna. In addition, two school-going grandchildren lived with Anna. These are the children of her son who, with his wife, died of AIDS. She also had had another grand-daughter living with her, the child of her daughter who had also, with her husband, died of AIDS, but this girl had failed her secondary school final exams and had been taken by Anna's eldest son who lived in town so that she could resit the exams. Anna explained, when asked, that she was looking after the two younger children of her dead son because their mother (his wife) had come from a poor family so the decision had been for them to live with Anna. The eldest boy had been taken by Anna's eldest son in town.

D. Problems in caring for orphans

Case D1. Eliza has 5 orphans, the children of her deceased daughter (who had been divorced; the ex-husband, the father of 4 of the children, had also subsequently died). Before her death, the daughter had first farmed along with her mother and then had a paid job as a housemaid in town from which she was able to send money to her mother. After the daughter's death, the relatives met, as usual, to discuss the children and other matters. The children were first divided: Eliza took the eldest boy and the youngest; the next to eldest boy went to his father's brother, and the remaining two boys who are twins went to two different sisters of their grandmother. However, all have ended up coming back to live with her. In the case of the father's brother, he remarried and the new wife did not like having the orphan boy and had quarreled with him. The other two boys were 'sent back' although Eliza said she did not know the reasons. In early 2006, she was able to

provide only one meal a day for herself and the children since the previous year had been a poor harvest. While she has three other daughters living around her, they have their own children and, in some cases, husbands to care for so they are unable to help much with their late sister's children. She also has one of her own sons still living with her who helps by doing casual laboring jobs. She was quite open about the stress she felt in trying to provide for the children.

It is clear that caring for the 5 orphan boys, children of her dead daughter, in addition to her own son and her youngest, school-going daughter is a considerable added burden for Eliza. But beyond the difficulties with food, clothes and so on, Eliza also spoke openly of her difficulties with some of the boys being 'rude', failing to work or just doing very little in the fields – the primary source of food and cash to the household, or in the compound, such as helping with the cooking and cleaning. She attributed the rudeness to their father's family, implying it was an inherited trait. One of the married daughters sitting nearby commented that not all of the boys are rude but some are difficult. Eliza sighed and said, loud enough for all the children to hear, that they would learn how lucky they were to live with her when she dies – then they will realize how much she has done for them.

Case D2. Athaonse is a vigorous woman in her late 60s who has a healthy and responsible husband, both of them are active farmers, and she is also a local herbalist able to obtain some money from selling her services. During 2006, she had four orphan grandchildren between 13 and 18 living with her, and another two boys, aged 20 and 22, had left to marry. She described how she does her best to assure that her orphaned grandchildren learn the things they would have learned from their parents, such as farming. But she went on to explain that some orphans are troublesome and rude; they object to being told what to do, and reject advice. Giving the example of her telling a grandchild to weed a field, collect firewood or sweep the compound, she said that a common response from a rude child was "Why should I do [x or y]? If my mother were alive, she wouldn't ask me to do that. Why should I do it for you?" Athaonse, like other villagers, is well aware that a mother would, in fact, ask or tell her children to do such tasks. What is at issue here is that an orphan uses the loss of a mother to justify a refusal to his/her grandmother. Such resistance goes beyond the doing of jobs, Athaonse said. These rude grandchildren will refuse to go to school for no good reason except they don't want to. She, being a rather formidable woman, was not willing to accept such rebellion and used various sanctions such as withholding food if they refused. She stated strongly that it was important for them to attend school since their future was at stake. She did not want them to lose out on education, a situation she implied was often the case for orphans in other families. She gave the example of one of her granddaughters who was a diligent student and had been chosen by a village committee for the single village scholarship to enable an orphan girl to continue to standard 8 (the final year of primary school). This entailed receiving a grant of K1000, clothes, school materials, mosquito net, and other things. The scholarship was allocated by the committee out of the pool of orphans who had done very well in school, hence rewarding merit as well as being dependent on orphan status. Unfortunately, this grand-daughter, despite having won the scholarship, insisted on spending a lot of time with a boyfriend rather than concentrate on her schooling. Athaonse feared the girl would become pregnant and sent her to a local clinic

to be tested for pregnancy (negative). In 2007, Athaonse was afraid the girl was planning on leaving school and she told us that the girl “is a problem ... she does not listen to me, saying I should not interfere... It is not easy keeping a child who has lost her mother”.

Case D3. Egilie took in 3 of her deceased sister’s 5 children. During the year’s research, she had often complained to the locally resident research assistant that her nephew, aged 19, was ‘troublesome’. He did not listen to her, often refused to work in the fields or the compound, was reported to her for causing problems in school, and so forth. In October we were talking with Egilie in her compound, surrounded by other members of the family, including the nephew. While we had been waiting for Egilie to join us, we had chatted with Thoko, the nephew. We asked about a job he had had for a few months (April to August) as a ‘stock-boy’ in a store near town. He said he left because if anything was missing, the store owner automatically deducted the cost from his wages. Asked if he missed his mother, he said ‘very much’, explaining that she was the one who was paying his school fees (when they were living in Lilongwe), but now he has no-one who could do so. After Egilie came, we chatted and she told us that Doreen, one of the orphans and the sister of Thoko, had left a few days ago to go to live in her husband’s village (an unusual move). I commented that she seemed to be very young – barely 16 – to marry, and Egilie, grimacing slightly, agreed. She went on to explain that Doreen had refused to continue in school and had taken up a boyfriend and now has married him. She implied that all this was done against her will. She commented that Doreen is younger than her own daughter who goes to secondary school (in Lilongwe where she lives with Egilie’s other sister’s daughter). Later in the conversation, we asked her to comment on her experience with orphans. She said that she had had problems with Thoko, the boy who was sitting nearby, repeating a few of the things that she had told the research assistant before. After a few minutes, we looked at Thoko, making a slight joke, and he shamefacedly said he had changed now. Taken all together, the situation seems to be that the two elder children resented having to live with their mother’s sister and rebelled. One factor might well have been school fees since it appears that Egilie’s own daughter who is in school depends a great deal on her cousin in Lilongwe. The third orphan, a small girl who is frequently ill, gives no disciplinary problems to Egilie who spends considerable time and resources taking the child to clinics and local healers.

Case D4. Amos echoes Eliza about their difficulties with two of the 3 orphaned children of their daughter. The eldest girl refused to stay in secondary school even though the grandparents were able to pay for her, along with their own youngest daughter (aunt to the orphan girl). She left and took a boyfriend and then married even though they tried to dissuade her. The boy, aged 11, still lives here but he is a problem ‘he is lazy, he doesn’t work in the fields with me, he just comes home from school, eats and off he goes without a word, disappearing all day and coming back late’. He is rude and won’t listen to his grandparents. Amos said he will realize what he’s doing if his grandmother dies or leaves! He denied that the main problem with orphans was ‘poverty’ or the inability to look after them, the problem is their rudeness – one is lucky if an orphan is like a sheep (obedient, following others). The youngest of the orphans, a girl, has gone to live with her mother’s younger sister who is married to a man with a white-collar job with a large NGO.

Case D5. Annie has had two of her adult daughters die, leaving 5 orphans altogether, 3 of whom live with her (one died, one boy married away). After noting that there are difficulties in maintaining extra children without their mothers alive to help, she echoed what so many others had said in referring to some of the orphans being ‘rude’. “If I ask them to do something, they cry, saying they wouldn’t have to do that if my mother was alive”. She shrugged and asked rhetorically, “What has happened to respect [for elders] these days?” She answered herself in suggesting that part of the reason may be the influence of the wireless and videos – children see and hear things they never did before so they become rude.

Case D6. Afasileni and Thomas are young parents of two small children. In addition, they have taken in during the past year, two young men, both 19 years old; one is the younger brother of Afasileni and the other is the sister’s son of Thomas. The mother of Afasileni and her brother died in 1988 and their father has remarried some miles away. At first, Afasileni went to live with her mother’s sister who lived in a different district but, after her marriage, she had returned and has taken over (not without some tension with her mother’s relatives) the site of the mother’s compound and her fields. Since she, as the only remaining daughter, is considered a replacement for her mother, she is the proper guardian of her brother. He had lived here before but he ‘behaved badly’, apparently not working and stealing things, so they sent him away. But during 2006 they allowed him to return. He is an orphan according to the local and national criterion that the mother is dead. Thomas’ sister’s son is an orphan, having no parent alive. Thomas explained that he came to live with him because there were 4 children and Thomas’ sisters, who lived in their natal village some miles away, had taken the others.

E. Tendency for orphans to drop out of school and to marry early.

Case E1. Mr JP died in 1995. Two young daughters died early – one in 1996 aged 3, described as swollen and coughing, one in 1990 aged 1. The wife, Mrs JP became ill in the early 2000s and it appears that Enelesi dropped out of school to help at home. She married around 2001 at the age of 15, and her young husband came to live in her mother’s compound. She had her first child at 17 and the second at 19. By 2004-5, her mother was seriously ill, visiting clinics periodically; she finally died in October 2005. At that point, Alindine, the youngest living daughter of the dead woman and the younger sister of Enelesi, lived at home. By early 2006, however, the two sisters had quarreled and Alindine had left home without saying where she was going. Later, one of the research assistants saw her at one of the local trading centers where she had found a part-time job in the market and she told him that she had left because her sister wasn’t giving her enough food to eat. It was a difficult time since the year’s previous harvests had been poor and with the illness and then death of her mother, there had been expenses, even though the dead mother’s brother living next door had helped. By October of 2006, Alindine, who would be 15 in November, reappeared pregnant and with a young husband. She started to build a small house in the family compound though she spent a good bit of time at her husband’s home, while he commuted back and forth. When we left the field, Alindine was at her husband’s home where he was cultivating fields, though she was reported to be planning on returning with him to her family compound and taking up

one of her late mother's fields. Given the lack of cordial relations between her elder sister and herself, it is not clear how this will pan out. The overall outcome of parental deaths (which are highly likely to have been due to AIDS) for this family appears to be that both girls left school earlier than they might have, married early and are having children early. Their only advantage is that they have more land to use than if their mother and two other deceased sisters had lived; there is also an elder sister who has long married and lived out of the village who is not claiming land (yet). Also see Cases D3 and D4 above.

Appendix B: Households with increased burden and some economic stress (see section III)

Household 309 is headed by a long divorced woman; two daughters have died, leaving two orphans. She is helped by two married daughters and a married granddaughter who live nearby. During 2006, they cared for the orphans while she had gone to help her other daughter, married away, in childbirth. Low income and very little land are the main problems. Some income during 2006 came from a lover of the key woman though this relationship broke off in late 2006 and she seemed increasingly to depend on her married daughters for cash income.

Household 314 is headed by a divorced woman whose sister and brother in law died, leaving orphans who were divided among the sisters, with 314 taking three. The youngest child is chronically sick, presumably HIV+. The elder orphan married against her aunt's wishes and left the compound in 2006 while her brother remained, working in laboring jobs on and off and being 'troublesome' to his aunt. This is a big compound with other adult children and a man who is a mother's sister's son to the key woman but who used to live with her mother when he was young and who has returned now that he is aging. There are also other matrilineal relatives all around who share some resources. Although in the bottom expenditure quartile, the household has over two hectares of land.

Household 323 is headed by an elderly couple who still cultivate their fields but who are in the lowest expenditure quartile. Two daughters died and at first the grandparents had four orphans to care for but now three are married (two of whom are nearby) and a fourth has been taken by some missionaries to be educated in a different district. The elderly couple say that they do not have any problems now and they also receive some help from sons who are married away and from their nearby granddaughters.

Household 409 is headed by an elderly couple whose income status has dropped over the past fifteen years. They have had three daughters die, and the orphans have been divided amongst themselves, other daughters (aunts to the children) and their successful son who runs a small shop and tailoring business in the market center a mile away. They also live near and interact with the adult daughters of the wife's sisters. The elderly couple, though remaining fairly active, appear to be in transition to a more dependent relationship on their surrounding adult children.

Household 431 is headed by a divorced late middle aged woman who had no daughters but four sons; one of these died in 2002 after 'a long illness', leaving a daughter who now lives with 431 (an unusual but not unique example of a child living with its paternal grandmother). Her income status has dropped steadily since 1986 but she also appears to be well integrated with her other matrilineal relatives living around her as well as receiving help from her married sons.

Household 508 is headed by an elderly couple in a compound that has expanded and contracted over the years as daughters and grandchildren have come and gone. Two daughters had died of HIV related illness and another of unknown cause. In 2006, three orphans lived here, one in her teens in school, two boys of 18 and 20 who 'helped' in farming. There had been four other orphans who had married and left. The household had fewer dependants and more income-earners in 1986 when it was in the third (next to top) income quartile, but it dropped to the second in 1990 and 1997 and further to the bottom

by 2006. By the latter part of 2006, it appeared that an adult daughter had returned home to live and was taking an active role in the family, though the elderly couple remains fairly active.

Household 635 is headed by a young woman, aged 26, married with a couple of young children. Her mother who had been the key woman died in early 1997 and the role was taken over by the eldest daughter who then died of AIDS in 2003. The current key woman is her younger sister. The youngest sister, aged 17, is also married with one small baby, living next door in the same compound. Both couples seem to be rebuilding the family and are doing well enough that they may well be able to raise their income level above the bottom rung where they are at present. This household, then, has suffered stress in the past but now, along with the new household formed by the youngest sister, they both seem to be moving out of that phase now.

Of the four households in this 'increased burden and some stress' category who were in the second expenditure quartile in 2006, two have dropped to that level and two have remained the same. Household 609 is headed by a widow who lives with her only daughter, currently divorced and with only one son of her own. Her younger sister died leaving six orphans whom she took in. One of these died, three married (one, a young woman, is living next door), and the remaining two live here and go to school. In early 2006, she also took on the task of caring for a (different) sister's daughter who came, seriously ill and subsequently died, very likely due to AIDS. During that time, she lost time cultivating her fields. The compound is large, with several good houses, a new one being built in 2006. Despite having dropped down the income ladder since 1986 when her husband was still alive, the widow, with the help of her own daughter, and now the married sister's children, has survived the increased burdens of care and dependency she has incurred from her sisters' children.

Household 217 has dropped down the income ladder because the husband gave up his job as a temporary teacher and now they are dependent on farming their very small landholding and on local temporary laboring jobs. In 2006, their eldest daughter was seriously sick (almost certainly of AIDS) and finally died in July, 2006. The toll on the family in emotional terms was grievous and the mother certainly lost time in caring for her daughter. But the daughter left no children so this family has taken in no orphans.

Household 520 is headed by a woman who is a vigorous farmer and a herbalist, and her husband (not the father of the deceased children mentioned) is an equally hard-working farmer. The eldest son and a daughter have died of HIV-related illness. The daughter left six children who were taken in by 520. Two married, leaving four still being cared for. One of these is clever in school and she won a scholarship though by the end of 2006, her grandmother complained that she was taking up with a boyfriend and feared she would drop out. The family has a large increase in dependency, including periodic visits from the children of her deceased son, who live with their mother in another village, but seems so far to be managing. They have been in income quartile two for most of the survey years.

Household 428 is headed by a young woman and her husband; she is the daughter of the former key woman who died in 1999. The daughter has married well and seems to be doing reasonably well, though being only in quartile two where her mother was for most of the survey years. She is caring for her youngest sister, aged 12 in 2006 and in school; she has five brothers, two of whom are married away, and two do small scale

business in the nearby market center. The youngest brother lives with one of his elder married brothers.

Appendix C: Cases of Care-Giver Groups

Village-based Groups

Orphan Care Group ML: We were made aware of this group when Mr WK, a man in one of our sample households (and a Village Headman), mentioned it in the course of a conversation about his fields and cultivation in April 2006. He was the founder of the group, had originally recruited ten members to a committee, and, after a few years raising small amounts among themselves, he had successfully obtained a grant of K1.2million from MASAF. He said the grant was given to them to build a chicken house and chickens which they were supposed to raise to earn money for running the Orphan Care services. Asked, at this first conversation, how the group managed the work, he said there were 300 children served by the group but that he did most of the work himself since ‘people are not interested to help if they cannot benefit themselves’. Asked how many of the children had lost both parents as compared with losing one, he seemed at a loss but then seemed to guess ‘about 20’ had lost both parents. He described the children meeting twice a month when they received a meal, did physical exercises (he explained these as good for the body and for discipline, referring to his having been once in the army), and received teaching from the bible.

Subsequent observations by the research assistant resident in that village showed that the children met more rarely and in smaller numbers. Comments made by other sample household members in the same village area also revealed that very little was being done for children by Group ML. These findings were confirmed by the founder himself later in the year. In June, one of the researchers (Kambewa) made a visit to the group: he found that the chicken house had been finished and he met two women, who described themselves as members of the Group committee, tending to the chickens. The women had set up paraffin stoves in the house for the 300 chicks which had arrived two days earlier, and were setting up small charcoal stoves to keep the house warm (June is a cold month). They seemed to be unsure of how to manage the heat and Kambewa (who has training in agriculture and livestock management) helped them to set up the stoves, advised them on how to protect the chicks from the stoves and how to judge whether it was warm enough for the chicks, and then helped them figure out what to do with the 24 bags of different kinds of chicken feed that had also been brought. Asked what was to be done with the chicks, the women said they were not sure but they were expected to raise money to help orphans in their own and four other surrounding villages. They explained that the committee used to have 27 members when it first was formed some years back but some had resigned, saying they saw no benefit to themselves, and so there were about 15 members left. These have their own children coming to the group’s activities.

In another visit made in November 2006, the founder, Mr WK was tending the chickens alone. Mr WK explained that the chickens from the June batch had been sold for K95000 but the money had been used to buy the second batch of chicks, the feed and vaccines, and other costs for looking after them, and some money had been used to open an account as required by MASAF. He said that some of the first batch of chickens had died because they had not been vaccinated – according to his figures, just over a tenth had died. Then they had difficulty selling the chickens locally, most to local priests and villagers, taking up to the end of September to sell them. He commented that this project ‘was given to them by MASAF’ and they were finding the experience difficult since it

was time-consuming and difficult to rear the chickens well. He added that numerous people had dropped from the committee because of this and because they didn't feel they were benefiting. When the group was originally formed in 2000, there were 27 members, these had reduced to about 20 by 2006 and had dropped further to 15 by mid 2006. He said in 2005 he had cultivated a field alone without help to raise some money for the project. He felt that people would volunteer to work on such groups only if they have incentives like making a business themselves; he had asked the Social Welfare department in Zomba to give his members loans but was told that members were supposed to be volunteers and not get anything in return for the work with orphans. He commented that people were not willing to volunteer because they would rather work for their own families. That day, two women members were supposed to be there according to the schedule the group had set up but they had not come so that is why he was there alone looking after the chickens.

Asked what the proceeds from the first batch of chickens had done for the children, Mr WK said 'nothing' and repeated that the money was used for the care of the chickens and for opening an account. In fact, he said, the children need food, clothes and blankets and have been asking the project to give them these things. So he had decided he must write more proposals to get more money, and he asked the researchers to help him identify potential donors.

In sum, during that entire year of 2006, the vast majority of time, effort and funds had been directed to managing the chickens and very little had been available for the children the project was supposed to be serving.

Orphan Care Group SS in another village had a very similar experience to that of group ML though we have more scattered information on it. We first heard about the group from the resident research assistant who had been told by a couple of families that there was such a group. However, he had also been told by several families looking after orphans (ranging from two to five orphans) that they had received nothing from the group. In a subsequent series of conversations held by the senior researchers with the families with orphans, we did not find any family who had received assistance from the group. The villagers were very skeptical of the group's activities. This skepticism was extended to all such groups: several families told us that they had had 'their names written down' by representatives of outside (and unnamed) organizations but then had 'never seen them again!' The shrug of the shoulders and the hollow laugh accompanying such statements revealed a long-established experience of failed promises by many unknown organizations.

In an interview with the local village headman about this group, he appeared knowledgeable about the group, mentioning the names of two to three of the main actors. He took the researcher to the house of the secretary, Mai RM. She explained that the group had started around 2000 at the suggestion of the then MP (Member of Parliament) who said he wanted people in his constituency to 'take part in development' just like other areas of the country. Mai RM understood their subsequent grant of K1.2million from MASAF through the District Assembly to have been facilitated by the MP. Like others, the grant was to be used for a poultry business even though, she said, the group had really wanted to have a maize mill. The poultry house looks like one of the new school buildings in the village, being built of brick, with iron roof, good windows,

cement floor, and plastered walls. Asked about the chickens, she said she did not have any idea how the chickens would be sold (implicitly suggesting one of the other members would make the decision), and was not clear on how the sales money would be used. She described the group as being made up of 10 members of whom 6 were women. They were supposed to contribute K20 each time they met to buy things like soap for the children and they also had a garden where maize was supposed to be grown for the children's food. However, later in the conversation she said many members of the group had left because the work did not benefit their own families so they felt they were wasting their time. She said that there were 375 children from four villages who were in care of the group, but not all were orphans, and they were supposed to meet twice a week and be fed. Prompted on when the children were last brought together to be fed, she replied that they had not managed to do so since March 18 (it was then May 25). She said the group also helped the aged and sick and so far (implicitly since 2000) they had repaired three houses for elderly people and during the rainy season they had weeded gardens for the elderly and sick (unspecified number). Later in the year, several families caring for orphans in the very same village told the researchers that they knew the chickens had been sold but they had not seen any of the money, and believed that the group organizers used it for their own needs.

Orphan Care Group KL: This group emerged out of an initial effort by a local Baptist church to bring together some of the local orphans for food and activities at its small compound in one of the sample villages. The effort was generated by observations by members that there were increasing numbers of orphans in the villages who were found 'wandering about' and who lacked proper care. The church members used some of their Sunday offerings to buy food, starting, apparently, in 2002. Between then and 2005 they were also helped financially by an expatriate missionary until his departure from the country. They also received in May, 2006 two bags of maize, 10kg of beans, and K2700 donated by one of the NASFAM (National Smallholder Farmers' Association of Malawi) groups in the area that had been organized to help orphans and other disadvantaged groups. During 2006, our various conversations with members of the group and others in the village indicated that the main organizers, a chairlady and about four allies, were trying to raise money from other sources, including any visitors to the villages, and wanted to become a registered group with the Social Welfare Department in Zomba in order to gain access to funders such as MASAF.

The chairlady in 2006 was also a home-based care volunteer starting in 2004 though we did not learn anything more about this part of her role. She was described by several respondents as someone who dominated the committee and who was unwilling to allow others to make decisions about the group's activities. Over the months, we were told of dissension within the committee that led by mid year to a movement of the group out of the church building to some newly constructed sheds on a piece of land nearby allocated to them by the Village Headman (also a member of our sample, who confirmed this in a separate conversation). Some sample respondents in surrounding villages benefited from having an orphan in their families being allowed to attend the periodic activities for children, while others complained that there were far more needy orphans around than the group accepted and that the main beneficiaries were the members of the group and their close kin and friends. Hints were made about some of the donated funds

and maize being siphoned off as a benefit to the committee members. On the other hand, another informant (not a sample member) said that one conflict had arisen when the local pastor had suggested to the committee that they use some of the donated money to 'buy soap' for themselves (often a euphemism for buying anything of need). Some agreed but others did not, including the chairlady; the upshot was the departure of those who had wanted to gain some benefit from the donations.

The chairlady's account was that when the group was first formed (through the church) in 2002, they were feeding 25 children; these had increased to 63 from four villages by 2006 (another member of the committee in a different conversation said there were 48 children), and they met every Monday and Friday. In fact, observations by the resident research assistants and by the senior researchers' time in the village showed that the children were called for food and for lessons (given by a couple of young secondary school leavers) and games irregularly, determined by when the group had access to enough food. Although the church and its associated missionaries were no longer the main source of income, there remained a link so that during the dry season of 2006, three young Canadian students spent a few weeks helping the group, largely by playing various games with the children (since they did not speak the local language). The group, under the firm leadership of the chairlady, also organized special dances and presentations for any visitors to the village such as a journalist and a researcher in mid 2006, from whom she solicited funds.

A lack of communication or agreement within the group was shown when the chairlady and one other member said they had registered as a group in 2002 but now were soliciting funds from well-wishers to get help to write the constitution, whereas another member, called the secretary, said that the group had not yet been registered. The aim of becoming a fully registered group, with constitution, by the Social Welfare Department was, as in other groups, to be able to apply for larger grants. Members of the group explained their failure to raise the sort of grants Groups ML and SS have (in neighboring villages) as due to politics: they believed that the then MP was on bad terms with the headman of the village where they were based so blocked them. They were not sure why the new MP hadn't been of more help.

In sum, this group was also unable to provide consistent help to orphans (unlike some of the other groups, they did not claim to be dedicated also to helping other disadvantaged people) because their funds came overwhelmingly from outside the village and were sporadic in nature. While the core group of volunteers did dedicate time and energy to the project, they also limited the benefits to a smaller number of potential beneficiaries, including their own children or relatives' children, irrespective of whether or not they were 'orphans'. They had experienced a loss of volunteers for a variety of reasons, some explained as leaving because they found 'that they did not gain any benefit from being involved', others due to clashes over decision-making authority within the group. Like other groups, they looked to winning large outside funds to provide the wherewithal to continue. But, also like the other groups described, they are not set up to manage a business activity designed to make sufficient profits to sustainably run a service for orphans or other needy people. Information obtained in June 2007 reported that the group had split. One version was that the chairlady was accused by the local pastor of misappropriating some of the funds and donated food, and he had sent her off and told people to stop supporting the group. The chairlady herself said that the pastor was angry

that the group had moved their activities away from the church compound, and that he also objected to the chairlady having ‘sacked’ the treasurer for rarely attending the group’s meetings. She said that he had told local people not to help the group, and also told an expatriate missionary in Zomba who had been occasionally helping the group that she had misappropriated things so now they were without supporters. She nevertheless said that the group was continuing though were able to do little for the children at present because they had no funds. Hence, as of mid 2007, there were competing versions of events and of the status of the group but what was clear was that it was not fulfilling its role of providing regular services for orphans in the village.

Village Committee SD: In addition to village groups such as those described above which, despite their shortcomings, either have received a grant and/or have some rudiments of an ongoing organization, in some villages there are committees that have been formed to provide services to needy groups but that have an indeterminate membership and highly sporadic set of activities. An example is the committee in Village SD. The village headman, in answer to a question on the existence of such groups, said that there were none specifically dedicated to care of aged, orphans or handicapped but that there was a health committee set up to cover four villages, including his own. The chairlady was Mai JU, who also was in our research sample. The Village Headman said that the committee had received help from LASO, an organization with headquarters near Zomba town, in the shape of a wheeled stretcher for transporting the sick to clinics.

When Mai JU was asked about the committee, she said it was not a health committee as had been described by the village headman but a Village AIDS Committee covering her own and three neighboring villages. It had been started around 2000 with 12 members though three had left because they didn’t feel they were benefiting from the work so now nine remained (seven women and two men). She explained that the founder of the group was a young man who encouraged the villagers to form the committee in order to obtain support from LASO. He invited the latter to come to register the committee and to provide training to members in the work of HIV/AIDS. The young man subsequently left after getting a job as a primary school teacher in one of the three villages. Mai JU explained that she and some members received the training, that they sometimes went to the LASO office to present reports on their work, and that they had received a wheeled stretcher (also mentioned by the village head). She gave the numbers of 54 orphans and 8 elderly people, describing the committee’s work as providing counseling to the orphans, sometimes buying medicines for the sick, cleaning and repairing houses of the elderly, washing clothes for orphans and elderly, and helping with work in the gardens of the elderly. As she continued, however, it became clear that these things were done very sporadically, and that the figures for people helped remained more on paper than a reality on the ground. She herself described the work done by the committee as ‘not demanding’ and gave as one reason that the members decided they could not manage to feed the orphans, recognizing that members were not willing/able to spend much time on such work.

Conversations with research families, and overheard spontaneous remarks made in the course of the fieldwork by other families in the village where Mai JU and some of her co-members lived, as well as observations by the researchers revealed a very low level of activity by the committee. We heard about only two cases of help received from

the committee, both of which emerged spontaneously during the research. One was an elderly couple who told us that they had had their compound swept and tidied up by some people but they had no idea why they had come. The other was a family who had been looking after an orphan boy, the son of the key woman's mother's deceased sister. He had once received some soap from the committee.

Other remarks were quite skeptical about the committee: as in other villages, we were told by several families that their names had been written down as caring for orphans, leading them to believe that they were going to receive some assistance, but that was then the last they ever heard. (It should be added that other non-village based organizations are included in these cases but neither the families nor the village headman were able to give any names of the various people coming to 'take names' in the village). Some respondents expressed more serious reservations, complaining that the members of the local village committee (which, we discovered, included several of the richest people in the village) went off to workshops where they got allowances, while village families with orphans or elderly benefited little if at all; one woman who lives near Mai JU and another of the committee members added that the committee did nothing for families affected by AIDS even though they had received some training.

Even allowing for exaggeration by the critics and the possibility of examples of help not heard of by researchers during 2006, the low level of care and benefits actually reaching the designated categories of people is obvious. In addition to the constraints under which the majority of villagers live mentioned above, the tendency for the better-off to be committee members (often because the village head or other authority is asked to select candidates) who then benefit from the small benefits of allowances and a certain status further undermines the principle and practice of 'voluntary' work by the 'community'.

Larger-scale organizations

The organizations working in the research area include local CBOs who work on a larger-scale than the village groups described above, and who obtain funds from national or international donors. There is an overlap, however, since some of these groups stop providing services when their funds run out. Four organizations operating at a range of effectiveness are described below.

Lambulira Aids Support Organization (LASO)

LASO operates in two Traditional Authority (TA) areas (Chikowi and Mulumbe). According to the current director, the original founder was Isaac Jambo who was one of the first people to make his HIV status publicly known in Malawi. He joined the Southern Region Aids Network in the early 1990s and through this network he was helped to provide awareness about HIV/AIDS in the Lambulira area. In addition to Isaac, his wife and daughter were HIV positive and made their status publicly known. In 1994 Isaac formed what was called Lambulira Aids and Orphan Care (LAOC). He died that same year so his wife, Grace, took over the leadership of LAOC, registering it with the Social Welfare Department in Zomba District. At that time LAOC was working in eleven villages in TA Chikowi. In 1995 the name LAOC was changed to LASO to indicate its including other activities as well as orphan care. In the same year LASO was registered

with the Social Welfare Department and it applied for funding from Action Aid. Their realm of action expanded beyond TA Chikowi to TA Mulumbe.

The current officers explained that LASO's 'mission statement is "to mobilize the community towards the elimination of HIV and AIDS in communities wherever we will be working by providing; treatment, prevention, care and support for people living with and affected by HIV and AIDS, and promote gender, human rights, livelihood programs in order to improve quality of life for the people of Malawi". The LASO 'goals' are "preventing the spread of HIV and AIDS", and "mitigating the impact of the HIV and AIDS epidemic in the said area". The LASO 'vision' is "to promote quality of life" and their declared 'values' are "being exemplary in our conduct", "being transparent and accountable to beneficiaries, donors and other stakeholders".

The organization has become professionalized, with a well-equipped office near Zomba, which has been rented in order for them to have electricity, and the older village office which they own. They also have a motor-bike for the use of the Director in his village visits, and bicycles for the other staff. The funds as of 2006 came from the NAC (National Aids Commission) and the Southern African AIDS Trust that has an office in Lilongwe though its headquarters are in Zimbabwe.

The method followed by LASO was described to us as their establishing village AIDS committees (VACs), each of which is to cover three or four villages. In 2006, we were told that there were 17 VACs, comprised of 145 members. Apart from the village AIDS committees, LASO managers said they also reached potential beneficiaries, especially orphans, through the community-based child care centers. They described both the village AIDS committees and the community-based child centers as voluntary groups established as community institutions to look after orphans and vulnerable children, as well as the sick. In light of the information on Village Committee SD and the orphan care groups described above, there is a real likelihood that these figures of groups and members may be more paper figures than an index of actual provision of services.

LASO has recruited officers (mostly young people with secondary education) to run the three main programs: Voluntary Counseling and Testing and Positive Living, Home-based Care, Orphans and Vulnerable Children, and Information, Education, Communication and Youth. The Voluntary Counseling and Testing and Positive Living Program runs the counseling and testing, and organizes meetings for people living with AIDS (PLWA). Since 2005 the organization has registered 122 people living with HIV and AIDS; these have formed four committees specific to people living with AIDS. The officers described that the members meet to share experiences, to encourage one another, to prepare home remedies such as traditional medicine and food preparation, as well as speaking up publicly to spread the message about HIV/AIDS and to encourage people to go for HIV testing. Of these HIV positive people, 32 had been linked to the District Health Office and Zomba Hospital, and they have been receiving ARVs. However, the officers pointed out (and this was confirmed in a later meeting with a PLWA group), most people, including HIV positive people, face problems in getting to Zomba Hospital because of the cost of transport and the time taken to get there and back. LASO does not have the ability to provide HIV testing services, but is reliant on other organizations such as Inter-Aide (see below). Thus, LASO has to pay Inter-Aide (in the form of allowances) to bring its mobile testing service to the LASO areas. This apparently is an obstacle and

often prevents the provision of this service. At times, LASO has also paid for transport costs for the PLWA members.

The Home-based Care and Orphans and Vulnerable Children Program was described by the female officer (who was also the secretary of the organization) as providing care to the named categories, sometimes distributing food, clothes or drugs to the sick. The program was in charge of five community based child centers (CBCCs), and had provided training in child-care and teaching of under-five children. The officers said that children met at the centers to play and to be taught basic reading, numbers and singing. However, in follow-up meetings to some centers, it was found that there is a large gap between the ideal picture painted by project staff and what actually happens at the centers. This program was also described as assisting villagers by providing bicycles and stretchers for carrying the sick to hospital. In fact, as indicated elsewhere, one of the sample villages had received a wheeled stretcher from LASO.

The third main program on Information, Education, Communication and Youth helps to set up youth clubs in the villages. By mid 2006, there were 18 youth clubs; ten of these were composed of school-leavers, while the rest are for school-going youths. In total, 554 youths participate in the clubs. These youth members carry out awareness campaigns on HIV and AIDS through drama, poems and singing. This program also provides free condoms: like Inter-Aide offices, a box of condoms sat in the main office with a paper on which the office staff members were supposed to record the demographic details – sex and age of the recipient and number of condoms taken by date. The records we saw and oral evidence showed that the recipients were mostly young men with a much smaller proportion of young women but we were unable to find out if the recipients were the same people coming regularly over time.

The newest program is the Primary Justice Program run by the LASO director and the man who runs the VCT and Positive Living Program. This is a pilot program started in 2005, supported by MASAF and implemented in Zomba, Chikwawa, Rumphu and Lilongwe districts. The aim is to provide justice at village level by increasing access to the judicial process through existing systems, and it also hears cases themselves with the involvement of the village head. These cases, according to the director, include gender-based violence, theft and witchcraft. So far LASO has handled 46 cases in the first three months of 2006. LASO collaborates with the Victim Support Unit of the Police, Community Police Forum, the District Commissioner and the Court Users Committee. We came across none of the outreach of this new program in our sample villages.

The program officers were asked whether there is any competition over members and funds among the different youth organizations that they have established in the area. The head of the VCT and Positive Living Program said that they had seen such a competition, and commented that now there are a lot of youth organizations formed. Both he and the (female) head of HBC, Orphans & Vulnerable Children said that the problem is that it has become a fashion to form youth organizations, and young people see that as a way to gain training or a job, and to earn some allowances.

MK Safe Partners Organization (MSPO)

This organization had its headquarters in one of the trading centers in the villages (that is, away from the tarmac road). It was visited only once though some information about it came from the resident research assistants. MSPO was described as being

founded some six or more years ago by four people, including a local village headman. It was registered with the District welfare office in 2000 and some time before 2006 had had its proposal accepted by NAC to the tune of K970,000. However by 2006, the organization's officers said they had received only K200,000. The Director commented that he was not sure they would get all the remaining money from NAC because they had not yet accounted for the first tranche. He added that they had also submitted proposals to MASAF for a building where they proposed to teach income-earning skills (the examples were building or tin-smithing) to older orphans, and to ASUPO (AIDS Support Organization) for funds, but they had received no reply (as of early June 2006).

The documents shown by the officers reported that the organization had listed 190 orphans, and it had registered 31 people living with HIV and AIDS. The director said that there were over 10 orphans in each village they covered (around their headquarters). However, one of the research assistants reported that in one of these villages, he had been told that only five of the village orphans had been listed. Moreover, the listed persons seem to have been helped only once or twice. The organization's officers said that at one time each orphan and each person living with HIV received a 25 kilo bag of maize, one packet of salt, and one packet of sugar. However, a villager told the research assistant that the recipients actually received 10 kilos of maize. More generally, various comments made to or overheard by the research assistant indicated that some villagers were not happy with the work of MSAPO, several making the usual comment that the people running the CBO are doing so in order to get money for themselves (*adyera* or they feed themselves).

Community Alliance Youth Organization

This is one of the two youth organizations based in one of the main trading centers in the research area. After hearing about the group, we were directed to two young men who were Charles, the director of CAYO, and Lawrence, the secretary. Both are from neighboring villages. Charles finished Form 4 (final secondary school class) in 1999 while Lawrence finished in 1998. Charles worked as a guard for the company Securicor from 2000 to 2004 while Lawrence has never worked elsewhere. Both are married with two children each. Charles explained that the organization started in 1999 with an aim to address the problem of rape among young people. They ran a number of campaigns in the form of drama to educate the public about the dangers of rape. Later on, the group diversified its activities to include food security, HIV, orphan care, home-based care and human rights.

Although the group claims to have diversified its focus, its main activities concern orphans. They have recently received funds from MASAF to start a nursery school. They showed us the site where they are constructing a childcare center. The building is big, composed of a classroom, a kitchen, and offices, and it is well-made of burnt bricks, with plastered walls, and tin roof. They explained that they had been granted K2.4 million for the building, and for training volunteers in the work of HIV/AIDS. The surrounding communities have helped to mould bricks and collect sand for constructing the building.

They described that they have 200 children in their care who come every day for nursery school, with lessons from 7.30am to 12.00 noon. Since no children were visible the day of the interview, we commented on that and were told by Charles that the children could not come while they were building the classroom.

The group works in nine surrounding villages, and their main activities apart from the child care center being built is to perform dramas to provide education and awareness about HIV/AIDS. The group members also (seemingly from time to time) provide soap to orphans, clean and repair houses for the sick and for the aged. Sometimes they buy medicine for the sick in the villages. To raise funds, the group conducts drama and disco shows and also collects K20 monthly contributions from its members.

However, they faced a shortage of funds and a drop-off in members. Charles could not recall how many members they had been at the beginning but said it was a larger figure than the current number of 40 members, 25 of whom are men, 15 women. He attributed the drop out to some leaving the area, while others feel that they are not benefiting personally. Both were concerned that their organization was growing but they did not have reliable support to continue with their activities, especially caring for the orphans. They therefore wanted to approach organizations that could help them with funds to continue the work. The Director had written proposals to NAC and OXFAM but none had yet replied. Finally, they mentioned that there were several other youth organizations in the area, mentioning five others (interestingly, they did not mention the other one in the same market center described next) but, they pointed out, only they (CAYO) had received funds from MASAF.

DE Youth Organization (DYO)

A meeting with the DYO took place in the store-front which they used as an office. Present were the director, Charles, Patrick, the education officer, and Martha, the research and training officer. All three had finished primary school though only Charles had passed the Junior Certificate of Education. Charles explained that DYO started in 1997 and it has 32 members (11 girls and 21 boys). However, this number is a drop from 46 in 2004. Patrick and Charles said many members have been dropping out because they feel they are not personally benefiting from the organization. Charles explained this as some youths thinking that the organization would provide them with jobs so that they dropped out when they learned that the work was voluntary.

DYO was established to fight HIV/AIDS in the area, to promote education for girls in the area, and also to promote human rights. It covers 47 villages in the areas of three Group Village Heads. Asked whether the organization does anything for the aged and orphans, Charles and Patrick explained that they did not provide for old people but only for orphans. They used to run two child-care centers, starting in 2002, one in the market center, the other in a neighboring village, and they taught the preschoolers how to read and write, and gave them food in the morning and afternoon. But they had to close them down when they ran out of funds. In addition, they used to cultivate gardens to grow maize to feed the children and members were supposed to contribute K20 per month, which was used to buy sugar, salt and soap for the children. However, these means of raising money fell away so they had to close the nursery centers. Thus, their only activities were awareness campaigns on HIV/AIDS. They said that sometimes they helped the sick by cleaning their houses, and that in early 2006 they were assisting seven sick people in the area, but two had since died, two had recovered, and three were still sick. They also distributed condoms to youths. Asked if DYO collaborates with other youth organization, especially Community Alliance whose office is a few hundred meters

away, Charles said there was no close collaboration apart from the fact that they knew each other, and they shared catchment areas.

At another time, one of the senior researchers (Kambewa) was introduced to two women who were members of the Board of Directors for DYO. Asked how the organization started, the women were unable to answer except by referring him to a man who had been a member longest (but who was never met with). The two women explained that the purpose of the board of directors was to settle disputes among youths in the organization. Asked to describe the effect the youth organization was making in the area, one of the women, Mai KS, said that the youth share knowledge; for example, some of them had stopped smoking chamba (marijuana) because the organization discourages them from doing so, she added that some young people, such as her younger brother, learned new skills in carpentry so were able to make furniture.

Asked if the board has any 'vision statement' (as do many of the local organizations), Mai KS said that they would like to build their own offices since the one they were using right now belongs to Inter-Aide. They wanted to have their own office so that their director could spend most of his time in the office. In fact, she went on, they would like the director to work full-time, and said that the donor who gave them money would provide funds for paying allowances. The other woman interrupted her and said that paying the director is not an unusual idea because the same thing happened with LASO – now their director has a full-time salaried job. Here, we heard an explicit statement of what many others in the new care-giver groups aspire to.

International organizations

The most formal and well-funded organizations operating in the research area were international NGOs, including the Inter-Aide Youth Project, a national program funded from mainly European sources and with international headquarters in France, and Dignitas, an organization established by the ex-Director of Médecins sans Frontières, with head offices in Canada and the US, and funded by a range of mainly North American sources.

Inter-Aide Youth Health Project

Inter-Aide is an international NGO with headquarters in France. It operates in several areas of Malawi mainly through the youth project though it also has programs providing supplementary foods for children and concrete platforms for latrines. In the research area, Inter-Aide Youth Project ran three centers at Chimwalira, Thondwe and Jali, three of the marketing centers in the area; each was headed by a small salaried Malawian staff, most of whom appeared to be secondary school leavers. The managers in the headquarters described each center as having 12 youth clubs under its auspices, operating within a 10 km radius; each club covers 3 to 4 villages. In Thondwe, the center manager said that there had originally been 30 clubs but they had to cut them to 12 because they could not manage to supervise them. The centers have small libraries of books for youths to read, video films and games, and the staff members provide testing and counseling to young people who attend. The centers also provide condoms free of charge; examples of their distribution were: during 2005 Thondwe Center distributed 3018 condoms to 564 girls and 2454 boys, and Jali Center distributed 4240 condoms to

404 males and 27 females. In addition, the club members periodically perform dramas in surrounding villages about HIV/AIDS.

The most important service the centers provide is the mobile HIV testing facilities. The only other place for testing is in Zomba town and in Chiradzulu, both 15 plus miles away for people in the area. In 2005 Chimwalira Center, which is attached to a government clinic, tested 3893 people for HIV, of those, 65 percent were female, mostly aged between 20 to 26 years old. Tests revealed that 14% were HIV positive, and 60 percent of those testing positive were females. The number of women is understood to be higher because most of the mobile visits took place in the under-5 clinics where the mothers of children gather. Of the people who tested HIV positive, the Inter-Aide managers said only 27 were on ARVs. Lower numbers were tested in the other two centers Jali and Thondwe, and a total of 26 persons from the two centers were on ARV therapy.

In addition to the HIV testing, Inter-Aide mobile services provide tests for pregnancy and sexually transmitted infections (STI), and offer counseling on all these infections. The managers of the local centers each have a motor-bicycle which is used for their visits to the head office in Zomba town as well as for other official business, and also have access to a computer for recording the numbers of clients. In Chimwalira, where the project is attached to and works closely with a government health clinic, one of the female counselors is 'on loan' from Dignitas (see below).

Some of the centers have groups of HIV-positive people of PLWA– those 'living with AIDS', who periodically meet. On a visit to a group's meeting, we were told that they meet for the purpose of sharing ideas and encouraging each other. The group was formed in January 2006 by six members but has expanded to 46 members, 20 male and 26 female. On the day of the visit, there were six men and twelve women present; some had come from as far as 10 miles. Of the 46 members, we were told that 18 are receiving ARVs. However, the members present explained that many had difficulty in obtaining ARVs because they have to travel to Zomba Hospital (15-20 miles away), and sometimes they had gaps in their drug therapy because they did not manage to get to the hospital. Asked whether the Youth Center was able to help them, one of the members said that the Center used to provide transport costs to the members but it had since stopped due to lack of funds. The members explained that when they met, they sang songs and recited poems, and sometimes they helped with the outreach of education about HIV/AIDS in the villages. Some said that they sometimes helped one another financially. However, most complained about the lack of material help and said that they heard through the radio about a lot of money coming to Malawi to help people with HIV/AIDS yet they did not see any of it. They said, '*ndife makasu ogaulira, okolola ndi ena*', literally meaning that 'we are just hoes used to till the land, but others will harvest', here referring to their work in outreach which will benefit other villagers but not themselves. Some also complained that the staff in the centers sometimes attended workshops (and received allowances), even though it is they, the people living with AIDS, who should do so.

They further explained that they had wanted to register themselves as an association with the district office but were told that they needed to pay K3000 registration fee. So far they had been unable to raise that money. Their purpose in getting registered was, they said, "because that is the way to raise funds".

Asked if they would talk about how being HIV positive and ‘living with AIDS’ has affected their lives, they offered these points. First, they said that they have become financially worse off because they spent a lot of money on medicines and trips to/stays in the hospital. They said that they need more funds to start life all over again. Some said that they are made fun of: some say things like, “*maunitsi atha mselula katengeni ena*”, meaning ‘your [cell phone] units have finished so go to get some more’, referring to their need to constantly get ARVs. Then, other villagers and even their relatives will say unkind things when one is sick and in need of assistance for things like water or firewood. For example, some say “*matendawo umatenga ndi ine, izo ndi zako?*”, meaning ‘did you get the disease through me? It is yours!’ Some of the members said that they were also ignored in the recent food distributions (2005-6 was a bad harvest year and food was distributed in early 2006) because in most cases the food was given to the elderly and orphans. One woman said that she found life very difficult because she had lost her husband and yet she was also looking after four orphans and her elderly mother.

Another set of complaints concerned the medical system. The group members said that hospital staff are unkind; one gave the example of a hospital aide removing his blood drip when it was realized that he was HIV-positive and saying ‘*mwatha kale inu*’, meaning ‘you died long ago’ or ‘you are already dead’. Another member said she was told to buy the medicine on her own (from a store) even though the hospital had some, and that the medicine was not for people with AIDS. A woman member was told by hospital staff that she could not get the supplementary food because she was HIV-positive. Yet another woman said that when she went for an examination for body sores, she was forced to remove all her clothes by a male aide as if she was going to be treated but after all that she was not given any medicines. (We learned later that the male aide was subsequently arrested, charged with rape of a patient.)

Despite such concerns and complaints, the group members said that they had not lost hope. They felt that they could still manage to help their families, and they talked of raising goats and chickens, and using *dimba* (irrigated gardens) to raise vegetables for their own consumption and for sale. They were sorry, however, that these plans had not taken shape because they did not have the capital to invest in such activities. At this point, it did seem that while they had been given many suggestions for making a living, they, like the other groups focusing on orphan care, look to raise funds from elsewhere.

Dignitas

As noted, this is an internationally funded organization. Its project in Zomba district is its only international ‘field’ project. This project started in 2004 and is described in the organization’s website as designed to collaborate with the Ministry of Health with reference to responding to the HIV pandemic. Its foci are HIV testing and counseling, prevention of mother to child transmission of HIV, provision of education on the disease, distribution of condoms, treatment and prevention of opportunistic infections and sexually-transmitted infections, palliative and psychosocial care, and treatment of HIV+ people by extending ARV therapy. It describes its approach as ‘community-based’.

During 2006, we found that it moved its headquarters within Zomba town and housed a fairly large staff, expatriate and Malawian, had multiple vehicles and computers, and seemed generally well funded. Conversations with two of the trained nurses (both men) who covered our research area told us that they, and the other field

staff, worked with community volunteers who had been selected (usually on the recommendation of the village chief) as ‘home-based care’ providers. One of these was working in one of our sample villages, a Mai NG. In conversations with her, she said that her husband had originally been the volunteer, along with another man, but after his death, she took over since she had already been helping him in the work. Mai NG met with the two Zomba-based nurses once every week when she had to report on the status of the people in her care. These were people living with HIV/AIDS, people who had accepted to be tested and visited. She, like the other home-based care-givers, provided information and counseling to these patients, especially on where to go for treatment and to access ARVs, and also gave them medicines (not ARVs but pain-killers, anti-biotics, anti-malarial drugs) which she received weekly from the two nurses. Although initially she also said she was providing home-based care to orphans and ‘the sick’, the activities delivered (clothes once given to orphans, a few cleaning sessions in old people’s compounds) were few and far between. Her major focus was on people living with HIV/AIDS. With reference to these, she made it clear that she has to wait for people to ask her to visit, and gave examples of people known to the researchers who were suffering from what she was sure was HIV/AIDS but who refused to let her visit, let alone to accept to be tested and treated.

The field nurses explained that an aim of Dignitas is to help build capacity for diagnosis and treatment of HIV/AIDS in the rural clinics; they hoped that the clinics would then be able to provide testing and treatment to villagers who, as of 2006, had to travel to the two main towns in the area for ARV therapy. In this, the organization was collaborating with the Malawi Ministry of Health and the mission hospitals. An additional goal of Dignitas is to create a network of HBC volunteers who would work in collaboration with the local clinics, over time becoming self-sustainable. In short, Dignitas, like many other NGOs, saw its role as helping establish services that would then be taken over by Malawians, so providing a planned exit for the international organization.

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