Indigenous narratives of HIV/AIDS: morality and blame in a time of change

AUTHOR INFORMATION

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ABSTRACT

While it is increasingly recognized that contextually relevant HIV prevention and AIDS mitigation interventions are more likely to succeed than enforced generic strategies, relatively little attention has been given to understanding the manner in which affected individuals and communities themselves perceive and subsequently experience the epidemic. Drawing upon research undertaken in the Caprivi Region of Namibia, this paper challenges dominant biomedical HIV/AIDS discourse and demonstrates the important role of alternative illness narratives in shaping local understandings of, and responses to, HIV/AIDS. Four inter-linked illness narratives are examined: the relationship between illness and resource use; gender and pollution; religious ideas about morality; and witchcraft accusations. Links are made between these narratives and threats to the social and moral order brought about by socio-economic change. While treatment sought can initially be influenced by the illness narrative employed, an overriding concern to cure the ill person combined with a range of coexisting social pressures to be seen to be doing the "right thing" ultimately play a more significant role in determining treatment.

Keywords: Namibia; HIV/AIDS; illness narratives; blame; stigma; treatment

INTRODUCTION

It is increasingly recognized that contextually relevant HIV prevention and AIDS mitigation interventions are more likely to succeed than generic approaches (White 2002; Lamboray and Skevington 2001). Since the late 1990s, attempts have been made within anthropology to understand the ways in which affected individuals and communities perceive and subsequently experience the epidemic (cf. Parker 2001). However, recent commentary has suggested that there is still a relative dearth of information on perceptions, interpretations, and discourses of HIV/AIDS (Barnett 2004) and that research continues to focus primarily on the objective, visible impacts of the epidemic, with little attention given to more localized understandings and subsequent responses, despite the key role of such understandings in the development of effective prevention and mitigation interventions (Allen and Heald 2004; Livingston, 2004; Bolton and Wilk 2004; Baylies 2002; Mogensen 1997). Drawing upon research undertaken in the Caprivi Region of Namibia, this article explores the complex, dynamic, and contextual frameworks within which different actors interpret and respond to HIV/AIDS. In so doing, the article demonstrates the important role of "alternative" illness narratives in enabling people to explain, make sense of, and respond to illness.

Dominant biomedical approaches to HIV prevention and AIDS mitigation interventions incorporate assumptions about health and well-being in which people will act in a "rational" manner to minimize their risk to HIV infection and, should they become ill, to maximize their opportunities for securing effective treatment (Schoepf 2004). However, it is well documented that high awareness levels do not necessarily influence behavior (Smith 2003; MacPhail and Campbell 2001). Rather, biomedically dominated approaches can overlook the manner in which behavior is related to social conditions, or to consider how communities and institutional customs, norms, and beliefs shape people's attitudes, capabilities, and lifestyles. Additionally, while a biomedical narrative provides information

on *how* a virus works and sickness develops, it may not provide an adequate explanation as to *why* an individual has become infected or ill, explanations of which, in the Caprivi, are essential to understanding how people perceive and respond to illness.

In response to these limitations, and in recognition that levels of degenerative and chronic illness conditions which require long periods of management and care are rising (Bury 2001), increasing attention has been directed toward the use of narrative approaches in understanding subjective experiences of illness (Liddell et al. 2004; Garro and Mattingly 2000; Kleinman 1988). Such approaches facilitate a move beyond biomedical explanations of illness to enable the consideration and examination of "alternative" illness narratives and provides narrators a means by which to communicate what is significant in their lives, to make sense of illness through a narrative structure or "plot" (Mattingly 1994) and re-establish some degree of order and continuity by locating the illness within the context of their own experiences in the "past, present and imagined worlds" (Ochs and Capps 1996: 19).

As well as enabling sense to be made from the "disorder" of illness, narratives are enacted in specific contexts that reflect shared cultural understandings and values. While narratives structure lived experience, experience can also structure narratives. Thus, understanding of illness experience requires looking beyond the text of the narrative and questions of "cultural belief" to examine the broader context in which the narrative is told (Hunt 2000; Garro and Mattingly 2000). This requires recognition of wider social, cultural and economic conditions as well as more localized processes, values and norms (cf. Mogensen 1997, 2000; Farmer 1994). Similarly, it is necessary to examine illness and subsequent treatment seeking as interpretive processes to be understood within the context of socio-cultural relations and the courses of economic and political change rather than positioning them into neatly defined and necessarily cohesive categories (Mogensen 1997).

Dealing with sickness is "a dynamic interpretative process" (Radstake 2000:75); thus, narratives are edited according to who gives them, when, to whom and with what consequences. Once a narrative has been accepted and authorized it persists to influence future narratives (Kirmayer 2000). However, as Ochs and Capps (1996) make clear, control over the production and employment of narratives is central to the constitution of social hierarchies. As such, dominant narratives can be seen to establish and uphold power relations and the prevailing attitudes and values within a community. While research has found that narratives may be employed strategically by individuals and households in an attempt to avoid stigma and enable social acceptance (Bury 2001; Radstake 2000), it is important to recognize that this will be done within the broader context of these power relations. Consequently, while on the one hand, illness narratives are bound up with broader events and processes of change, the extent to which these narratives are accepted and authorized will depend on the social positioning of those putting forward the narrative.

Comparing her findings with those of Farmer (1994), Mogensen (1997) stresses the different ways in which AIDS can be "read" within different social and historical contexts, with her work interpreted through a narrative of pollution and Farmer's a narrative of accusation. This article examines four coexisting and inter-linked illness narratives from the Caprivi Region of Namibia: the relationship between illness and resource use; gender and pollution; religious ideas about morality; and witchcraft accusations. While all have fairly distinct explanations, I argue that they are increasingly interpreted through an underlying narrative of blame caused by threats to the social and moral order brought about by significant socio-economic change in recent decades. Linked with this notion of "order", this article also discusses the ability of some people to more convincingly draw upon certain narratives than others. After examining options for treatment seeking, I argue that while treatment sought can initially be influenced by the illness narrative employed, an overriding

concern to cure the ill person combined with a range of coexisting social pressures to be seen to be doing the "right thing" ultimately play a more significant role.

CONTEXTUALIZING AIDS IN THE CAPRIVI

A combination of factors including civil unrest, apartheid, impoverishment, gender inequalities, and migrant labor have contributed to making Namibia particularly vulnerable to the HIV/AIDS pandemic (UNDP/UNAIDS 1997). By 1996, HIV/AIDS had become the country's leading cause of death and Namibia now has among the world's highest HIV prevalence rates at almost 20 percent of the adult population (MOHSS 2006). Life expectancy dropped from 61 in 1991 to 49 in 2001, and in the worst hit area, the Caprivi Region, from 53 to 41 (National Planning Commission 2003). In 2006, the HIV prevalence rate among adults aged 15-49 in the Caprivi was reported at 39 percent (MOHSS 2006)[1]. A number of factors account for this, including the region's proximity to areas of neighboring countries adversely impacted by HIV/AIDS, its location on a major truck route, civil unrest and the deployment of military forces in the area in the late 1990s, the subordination of women, and high levels of HIV/AIDS-related stigma and denial. The socio-economic characteristics of the Caprivi are also contributing factors, with the region ranking highest on the Human Poverty Index and lowest on the Human Development Index for Namibia (Mendelsohn et al. 2002). Despite such high HIV prevalence, Demographic and Health Survey findings show that only 22 percent of men and 8 percent of women in the Caprivi Region claimed to know of either someone living with AIDS, or someone who had died from an AIDS-related illness. In addition, only 5 percent of women and 8 percent of men surveyed claimed to have undergone an HIV test (MOHSS 2000)[2] and while it was common in this research for people to comment on the increase in illness and deaths in the region, few attributed this directly to HIV/AIDS. In a situation in which HIV/AIDS is so highly

stigmatized, and for the vast majority, lacked any treatment option until late 2003, these figures are perhaps not overly surprising. However, to more fully understand this situation, it is necessary to examine the range of alternative illness narratives upon which people draw and to place these narratives within the wider context of socio-cultural and economic change experienced in the region in recent decades.

When asked about the time when illness and death had started to rise, people agreed without hesitation that the changes in the region had occurred since Namibia gained Independence in 1990. Prior to this time, the Caprivi had been politically and economically isolated from the rest of Namibia, and experienced relatively little interference from the colonial authorities who deployed a system of indirect rule. Fosse (1992) claims that it was not until the South African Defense Force occupied the region in the 1960s that outside influences impacted the Caprivi, and even then, the South African policy of "containment" prevented inter-regional and cross border travel until Independence in 1990. This isolation helped ensure that socio-cultural systems and power hierarchies remained fairly intact; thus, dominant ideas regarding morality and the social order have remained very much influenced by the customary authorities and the Christian church.

While civil and customary laws now co-exist in the Caprivi, the traditional authorities oversee the administration of customary law and cultural matters, and as such play an extremely influential role in mediating social relations. Civil authority structures in the region offer no viable alternative to customary authorities and rarely deal with such social issues, although they play a key role in advocating civil rights as enshrined in the Constitution of Namibia. In the research sites, the customs and norms promoted by the traditional authorities are largely reinforced by the Christian church, which plays a vital role in shaping attitudes and expectations regarding morality and behavior. As with the customary authorities, the patriarchal attitude of the main churches in the region[3] tends to undermine the status of

women and young people, despite the assertion of equality enshrined in civil law. In fact, many older men (as well as some women and younger men) felt that the equal status accorded to women in civil law has been a direct cause of the breakdown in the social and moral order (cf. Thomas 2007a).

During focus groups with elderly men and women and interviews with traditional authorities and church leaders, interviewees frequently stated that the increase in illness and deaths in the region since Independence was directly linked with the changing attitudes and behavior of younger people. While relationships and marriage had previously been overseen by the two families concerned, elders and church leaders reported that the term "marriage" is now often used to mean that a person is in a sexual relationship, without any marriage ceremony taking place and without payment of *lobola* (bridewealth). They stated that a recognized commitment and ceremonial marriage was no longer a prerequisite for sexual relations among young people, and many parents commented that they did not even know that their children were "married" until the woman became pregnant. Older people also reported that since their children were better educated than themselves, they no longer listened to them. Formal education has brought a shift in the concept of "knowledge" in the Caprivi, such that the knowledge of the elders, based primarily on life experience, is no longer considered as relevant to a younger generation which requires other information to overcome livelihood pressures and gain salaried employment. Social pressures placed on young people to conform to modernist ideals and the economic need to get by were reported to have resulted in a breakdown of generational hierarchies and, among young girls, an increase in more casual relationships which offer reward and support. Seen as a breaking down of order by dominant religious and customary belief, such changes were found to reinforce blame directed against younger people for both the spread of HIV and AIDS and

the significant socio-cultural and economic upheavals that have taken place since Independence was gained in 1990.

My research involved a range of qualitative and ethnographic methods over nine months of fieldwork in three rural settlements in the Caprivi Region, namely Sangwali, Masokotwane, and Lusese[4]. One hundred households undertook a livelihoods survey, and participatory methods used in six community meetings initiated discussions of health issues and the perceived impacts of HIV and AIDS. Semi-structured repeat interviews with 18 case study households enabled in-depth investigation into livelihood and coping strategies, belief systems, and the perceived impacts of illness and death. Twelve focus groups (with men, women, the elderly, and widows) as well as solicited diary keeping and participant observation provided further insight into customs and norms, discourses of morality, and local understandings of HIV/AIDS and chronic illness.

All ethnic groups in the Caprivi are descended from the Lozi. Colonial occupation in the 20th century divided identities and allegiances into three broad ethnic groups – Shiyei, Subia, Sifwe – the latter of which is further subdivided. Five main languages are spoken in the region (often inter-changeably), thus most interviews and focus groups included a translator. Data was transcribed as soon as possible after it was collected enabling continuous cross-checking and clarification of information. A significant number of those interviewed (in particular younger people, older men and those working for local government) spoke English fluently, which facilitated the triangulation of data.

RESOURCE USE AND ILLNESS

One frequently encountered explanation of why there had been an increase in illness and deaths in the Caprivi Region was linked to changes in natural resource use and accessibility as well as wider social pressures to conform to "modern" trends.   Women are now

responsible for the majority of the crop cultivation process, leaving men with relatively little responsibility for household food production, while they would once have hunted and fished. However, in customary discourse, it is still "officially" considered the duty of men to provide food for the household, and so men in particular felt that the increase in illness in the region resulted from difficulties in accessing the natural resources that had previously formed an important part of the household diet. The issues were raised in all study areas, but were considered particularly important in Sangwali, where people felt strongly about being "forcibly" relocated away from an area with a wealth of natural resources.

M: Things have changed. When our parents were alive we were still in Rupara. They found things easily – like meat, it was free. But now if we try and kill it we will be charged or taken to prison.
J: Yes things have changed because in the past in Rupara they were eating fish like barbell fish and meat for free. And now, when we came to Sangwali, we found this modern life, where whites are bringing us maize meal and these foods which have made us thin again….Since Independence we have been suffering. (Elderly focus group, Sangwali).

As this conversation emphasizes, people were previously able to gain access to food resources without charge via the resource-rich area of Rupara. Since Independence, natural resources in the area have been subject to enforced restrictions, violation of which lead to a fine or imprisonment. Permits are now required to hunt, fish, and collect plants from the area, and since Independence, people are perceived to be "suffering" because they are less able to obtain these nutritious foods. Instead, people rely upon maize meal, now the staple diet in rural Caprivi, and other foods thought to have been brought in by "outsiders". Not only do these foods have to be paid for (few households produce sufficient crops for the year), they are also considered to have "made us thin again", since they have low nutritional value. As well as issues of accessibility, changing attitudes meant that people no longer ate foods that

were understood to have medicinal properties, and were instead eating foods that lacked nutrition, and were actually considered to be detrimental to health.

Malaria was there [in the past] but people were not *dying* of malaria you see because they were eating this fruit they collect in the forest. Some they are bitter, some they are not so sweet, but when they combine in one body they have a function to do. Now, if you are with TB you must drink milk. But the thing that people used to drink was milk from goats. That one is better, and the best thing to cure malaria, but now we are not drinking this goat's milk. Because if I drink milk from goats they [other people] will laugh at me. This is high time [modern times] – there is fresh milk [cow's milk]. The other thing, there were not these different types of food, like sugar, bread – they were not learning about these. Cooking oil, now if you eat much cooking oil you will be getting heartstroke. Now they are saying there is a disease for sugar, he is sick from sugar (Simon, community meeting, Sangwali).

Simon perceives malaria to be more virulent and deadly than before, not because HIV/AIDS results in a weakened immune system, but because people are no longer eating the wild fruits that they believed helped treat malaria. Despite considering that goat's milk has properties more beneficial to health than cow's milk, he explains that people now drink the latter as it is considered more "modern". Foods previously found in Rupara have been replaced in the household diet by food from the shops that are perceived to be causing ill health. It was frequently mentioned that young people would not eat many traditional foods, and finding "acceptable" foods was a particular problem for those who had taken in orphans from town. While eating "traditional" foods was widely thought to enhance health and reduce the likelihood of illness, influential belief from young, educated people meant that eating traditional foods had become considered a cause of ridicule.

G: In the past we were not eating food like sugar, and these biscuits. We ate mbuti [wild fruit] which is like chloroquine, it was like a medicine to prevent malaria, but no-one eats these now.

G: Those who are educated will laugh at you if you do. So now we are suffering and people are dying.

B: We ate a lot of wild fruits. When you compare someone who is old with someone younger, they are different as the older ones were strong from eating fruits. (Elderly focus group, Masokotwane).

Bernard's claim that younger people are not as strong as in the past suggests the increase in illness can be blamed upon changing attitudes among younger people. Narratives regarding order, disorder, and respect for dominant rules and values were clearly evident in the study sites, with blame among older people directed primarily towards younger people and women. Such narratives of blame are of particular relevance in recognizing notions of pollution and disorder upon and within which HIV/AIDS is understood in the Caprivi Region.

POLLUTION AND DISORDER

Contact with "pollutants" through the breaking of taboos is considered both a cause and an explanation of illness in the Caprivi Region. Unbalancing the accepted *status quo* through contact with tabooed matter creates "disorder" (Douglas 1993), leading to contamination, illness, and possible death. While this has commonly been associated with "traditional" illnesses thought to have a social or spiritual explanation rather than with "modern"[5] biomedical illnesses, the distinction is becomingly increasingly blurred, suggesting that people are drawing upon a range of evolving narratives to explain recent changes in illness.

In the Caprivi, "pollutants" tend to be found within bodily fluids such as blood and semen and through contact with death. As avoidance of contact with such "pollutants" is not always possible, adherence to stringent moral codes and protective rituals are considered necessary so people can attempt to both defend themselves and restore "order". However, changes regarding behavior and expectations, particularly among young people, compromise

their ability and willingness to adhere to such moral codes and rituals, therefore creating "disorder" exemplified through increasing illness. Violation of a taboo is thought to cause illness within the perpetrator, but may also be transmitted to another person with whom they come into contact through sexual relationships, or more general contact such as the serving of food or drink or sharing of utensils.

In line with findings elsewhere in southern Africa (cf. Wood et al. 1997; Mogensen 1997; Ingstad 1990), the transmission of disease in the Caprivi is frequently associated with concepts of "pollution" that originate in the female body. In particular, pollution is believed to originate in the blood of a woman at times linked to bodily processes such as menstruation, when the blood is "hot". Polluting substances are believed to be especially perilous when associated with behavior considered culturally taboo, such as menstruation or abortion. However, if behavioral codes and ritual procedures are followed, danger of contamination is minimized. While a number of pollution-based illnesses are believed to exist within the Caprivi Region (cf. Lumpkin 1996), "*kahomo*" is considered of particular importance here since associations are often drawn between it and AIDS.

Kahomo is believed locally to have long existed throughout the Caprivi Region, and a similar condition has been reported in neighboring Zambia (Bond 1998; Mogensen 1997). In its most commonly experienced form, kahomo is described as an illness that affects a man who has had sexual intercourse with a woman who has recently miscarried or aborted, and not gone through the accepted purification ritual. If the man then has sex within the days following his infection, he may also transmit kahomo back to the woman who aborted, or to another woman. The symptoms of kahomo are reportedly similar to those of HIV/AIDS and include coughing, swollen joints, diarrhea, and wasting. People interviewed identified different types of kahomo: "traditional" kahomo which, if the correct purification rituals were followed, was curable and for which no-one was to blame; and a more recent type of

incurable kahomo widely perceived to be brought about through women breaking dominant social and moral codes. As Susan explains, suffering a miscarriage is one example of the former, while abortion falls under the latter category.

S: Sometimes you can have an abortion while you are married, and your man will know about the pregnancy. Like when you make an abortion – not yourself, but maybe because you were sick [miscarriage]. When you make an abortion you have to go to either your mother or your grandmother, it's where you go to sit for even a month. After you have had treatment that's when you can come together with your husband again. Then there is the abortion which is difficult, it's different …
T: It's done by yourself, like if you don't want to have a child.
S: Like if I'm not married and I get pregnant … I just make an abortion, me alone I'll keep it a secret, my mother won't know. Then my boyfriend he comes to me again and I'll just make with [have sex with] that boyfriend. I'm supposed to tell the boyfriend and wait a month before he comes to me, but me I'll just meet with him, sharing blankets – then *that* abortion is when men can get affected.

As Susan states, it is reportedly easier for a woman to seek purification if she has miscarried, since she is unlikely to be considered personally responsible for the loss of the child. Seeking purification after an abortion, however, is "difficult", since it is likely to be self-induced (abortion is illegal in Namibia) and violates the woman's procreational role in Caprivi culture. Many women may therefore be reluctant to disclose their condition to other people, including close female relatives, particularly in cases in which the woman is not "officially" married, since she may not expect to receive support from her relatives.

The illegal and tabooed status of abortion means that it is not known whether cases have actually increased in the Caprivi Region since Independence. However, it was clear that older people, and some young men and women, perceived that the increasingly "immoral" behavior of many young women meant that a rise in abortions was likely. For older people

and those with strong religious beliefs, HIV/AIDS can be interpreted as a manifestation of traditional illnesses that have acquired a new virulence because of disrespect for the moral codes dictated by traditional culture. When asked if it was a problem that parents were less involved in regulating their children's relationships than in the past, Jeremia's comment was typical:

Yes it's a problem because you won't even know if your child is pregnant and if she does an abortion, when she comes back again she will share a chair with her father which will bring death. (Jeremia, elderly focus group, Sangwali).

To Jeremia, the behavior of women who fail to adhere to accepted purification rituals is deemed irresponsible and is seen as endangering the health of others. During a collaborative workshop between the Ministry of Health and traditional healers, one man stated that if a menstruating woman cooked for her husband, the husband risked contracting a cough which may develop as TB, and ultimately HIV/AIDS. While such extreme interpretations are not commonplace among younger generations, they retain significant influence among older people in explaining increased levels of illness and death. Such beliefs provide not only an explanation of the cause of illness, but also a source of blame, therefore fuelling both remorse and stigma. Because new forms of kahomo and AIDS are both frequently associated with the violation of accepted moral codes, and share similar symptoms, it is of no surprise that the two are often linked. While debate existed regarding the nature of these links, they were both generally considered the justified outcome of immoral behavior, an attitude reinforced by all religious leaders interviewed in the study sites.

RELIGIOUS INTERPRETATIONS OF ILLNESS

All of the Christian churches in the study sites played a key role in influencing understandings of morality and sexuality, factors that are clearly inter-related to perceptions of illness and death in the Caprivi Region. While instances of fortune are often attributed to divine intervention, strong religious beliefs endorse the notion that illness is a self-inflicted punishment for culturally unacceptable behavior, and HIV/AIDS is therefore interpreted within this framework of understanding. While the behavior of children is considered an exception, it was reported that they too, may become ill as a punishment for the wrong-doing of their parents. It was commonly stated that the upsurge in illness and deaths was the enactment of apocalyptic events foretold in the Bible.

The Bible says at the end of the world people will be dying and go back to the dust they were made of. People who read the Bible will understand why people are dying now. It is the time - the Bible says you will see diseases that cannot be cured. So with HIV/AIDS you can go to the hospital, to the traditional healer, and it cannot be cured – so it is the time. (Matthew, elderly focus group, Lusese).

Interviews with church leaders revealed similar beliefs and attitudes regarding illness. All expressed a degree of sympathy towards those who were ill and claimed that church members would help the household concerned with prayers, visits, and material goods. However, as with the breaking of taboos, illness and death are considered the consequence of immoral behavior, with blame laid upon the individual perceived to have committed the offence.

I think this [HIV/AIDS] is a punishment. If you are a parent, you will tell a child don't do this and this, and he still does it, he will die. Who caused the problem, it's himself. We believe that AIDS is killing people, and they are the people who want AIDS…..we talk about AIDS – "don't go for AIDS, you are a Christian, don't go for committing adultery" – it's there in God's law, he doesn't want people who go for adultery. If they go there and commit and you've heard the message, it's your own

problem. You will die there. Then we know that if you die there, then when God comes, you are going to be punished. (SDA preacher, Sangwali).

Such attitudes express a commonly-held belief that those who become sick through HIV/AIDS have become ill because by consciously flouting moral codes they deserve or "want AIDS". The possibility of recovering from an illness was also thought to depend upon the behavior of the individual, with the degree of punishment administered considered to reflect the magnitude of wrong-doing. Martin stresses that while malaria is curable, HIV/AIDS is not, and a particularly serious offence must have been committed by the ill person.

With HIV/AIDS, you have to think *why* is there no treatment? It is a punishment from God, while malaria is a common disease, even a doctor can cure that. But if God says so, you will be punished. And if the disease has no cure, you know that there is a reason why and they are being punished for that. (Martin, Lusese).

Despite such views, church leaders claim they would not personally judge a person who they suspected had HIV/AIDS, since that person would be judged by God. While reference to God's will does, to an extent, remove some of the blame placed on the individual, it was clear that such strongly held and public narratives of blame were extremely influential in the study sites, and that such beliefs contribute to HIV/AIDS-stigma and subsequent narratives and coping mechanisms adopted. Interviews with households afflicted by illness also revealed that while church members had contributed to funerals, and in cases had provided spiritual support to the ill person, many felt that the church had been of little assistance to them.

Although the majority of people interviewed declared strong religious beliefs, it was apparent that for many, they co-existed with long-held beliefs in the existence of witchcraft.

While religious leaders professed not to believe in witchcraft, a number of church-goers felt that beliefs in witchcraft were upheld by the Bible[6], and, as Colson (2000) found in Zambia, may actually have been strengthened by religious beliefs that proclaim the powers of evil. For others, there was a reluctance to admit to personal beliefs in witchcraft and an initial denial that traditional medicine (generally associated with the occult) would be used if a household member became ill. However, in virtually every case study household in which a person had been ill, a traditional healer or witchdoctor[7] had been sought at some point, supporting Ashforth's (2002:126) contention that the occult is too complex to be reduced simply to "belief" or "non-belief". While many people struggled against beliefs in witchcraft, particularly when it was considered to adversely compromise their religious or modernist beliefs, they ultimately drew upon a diversity of narratives to explain and manage their situation.

WITCHCRAFT NARRATIVES

Evans-Pritchard's (1976) seminal work on the Azande calls attention to the strong associations between beliefs in witchcraft and misfortune. In the Caprivi, a wide variety of misfortunes may be explained by witchcraft, including failure to obtain employment or to marry, poor school grades or bad harvest, and illness and death. Witchcraft accusations are also associated with major socio-economic change as well as strained social relations within a society (Mavhungu 2002; Ashforth 2001). Writing about the Caprivi during the 1960s, Kruger (1963:11) explains; "the notion is that all people should grow old and die from old age: if anything happens to them before then it is the result of machinations of evilly disposed persons." Given the considerable socio-economic changes and the significant increase in illness and death among the economically productive age group of Caprivi, it is

understandable that witchcraft beliefs and accusations are common and widespread, and are overwhelmingly perceived to be increasing.

Witchcraft narratives in the Caprivi are not confined to those in rural areas, but are also common in the town of Katima, including among people working for government ministries and NGOs. These narratives are also upheld by the traditional authorities, who are periodically called upon to arbitrate in local witchcraft disputes. In such cases, three traditional healers are called upon to question the accused and examine the accused's witchcraft "tools". If found guilty, the accused faces a fine of up to 20 cattle, a proportion of which are given to the *khuta* (traditional authority). The traditional authorities therefore benefit from upholding witchcraft narratives, although it is important to recognize that they have long been an integral part of life in the Caprivi Region.

Illnesses "caused" by witchcraft may manifest in a variety of forms and, as with kahomo, symptoms are often similar to those associated with HIV/AIDS. As with new forms of kahomo, all people interviewed felt that illnesses thought to be caused by witchcraft were more difficult to cure than in previous times, as witchcraft is thought to be becoming increasingly powerful. While some forms of witchcraft result in a relatively quick death (e.g. car accident or heart attack), others manifest in long-term illness which may last over several years. One commonly cited form of witchcraft, for example, involves the sucking of blood by a chameleon, resulting in a slow, wasting illness. People interviewed also said that increasing use of "*thobolo ya kaliloze*", an imitation gun made from human bones, hair, and teeth, enables long-distance witchcraft in response to increased trends in mobility and dispersal of kin, since it can be used to transmit illness or death to a person living far away in other areas of Namibia or abroad. As with kahomo, there is debate as to the links between the symptoms of HIV/AIDS and witchcraft demonstrated in the following conversation from men in Lusese.

D: It's confusing – these witchdoctors can use different ways of killing people – like these guns they use, if they shoot you, you can just start to look like someone who has HIV/AIDS. So you can't say if that person has AIDS or if it's witchcraft as they are similar diseases.

G: If you go to the traditional healer he will tell you that person has been witched but it might be HIV/AIDS – but the healer will say that you were witched by a chameleon and the symptoms are similar so you cannot tell which one is which.

Q: So if someone witches you with a chameleon then the symptoms are similar to having AIDS?

D: Yes, you can't tell the difference.

Q: Did that happen before – were people witching with the chameleon before and were the symptoms still like those of AIDS in the past?

C: We heard it was there but it was not so much. It came from Zambia.

Q: So when did the chameleons and the guns start becoming a problem?

C: It started at the same time that HIV/AIDS came. Because these people are clever, they decided they would start witching people just the same way that HIV/AIDS is done. (Men's focus group, Lusese).

As the conversation emphasizes, not only can the symptoms of HIV/AIDS and witchcraft manifest in similar forms, but cases are also believed to have risen significantly at similar times. While the rise in witchcraft accusations is clearly interlinked with an increasing rise in AIDS-related illness and death, it is also bound up with wider economic changes in the region.

Witchcraft accusations are intrinsically linked to widening economic inequalities as increasing opportunities for advancement and promotion arise (Niehaus 2001); thus, as research elsewhere has found (cf. Ashforth 2001; Colson 2000; Bond 1998; Farmer 1992), the overwhelming explanation for witchcraft in the Caprivi is jealousy. Community and inter-household trust and cooperation can be undermined by increasing social and economic heterogeneity (Moser 1998), a situation commonly reported in the Caprivi, where increased

reliance upon a cash-based economy to meet even subsistence needs has played a major role in distorting traditional social hierarchies. Witchcraft is said to afflict people of all ages, but is widely considered to be a particular problem among the economically productive age group, who are most likely to be educated and own assets which generate jealousy. Rather than direct accusations at the macro or "impersonal levels of misfortune" (Ashforth 2001:216), accusations are directed at those thought to have a personal motive for malice, and are almost always directed at a person close to the victim such as a relative or work colleague. Prior to Independence, older male relatives were considered the likely perpetrators because they were most likely to inherit tangible assets from the deceased and were considered the most powerful and accomplished at witching others. However, it was frequently commented that younger men are now able to obtain cash to either purchase witchcraft powers, or to pay a witchdoctor to carry out the act on their behalf. The limited ability of young women to obtain cash surplus to their immediate requirements meant they were rarely considered capable of witchcraft. In contrast to narratives of pollution, the narrative of blame in witchcraft cases was therefore directed primarily at men. For older men in particular, the rise in witchcraft was seen to be interlinked with the breakdown of generational hierarchies in which status based on economic success undermines "traditional" power structures and in turn, results in a perceived decline in respect by young men for their family and their elders.

As well as its association with socio-economic change, most research informants claimed that witchcraft is considered a possible cause and explanation of illness in cases when illness can not otherwise be readily accounted for. Even among individuals claiming not to believe in witchcraft, external pressures and expectations, and a determination to explore all possible avenues of treatment, were found to result in witchcraft becoming a common explanation for illness. However, research informants reported that while many

people genuinely believed that they had been witched, for others, usually those who had been diagnosed, or were suspected of being HIV positive, witchcraft narratives acted as a form of denial and a strategy to help prevent stigma and rejection. While there are clear connections between the upsurge in witchcraft accusations and the increase in HIV/AIDS in the Caprivi, the extent to which they are perceived as related or separate issues varied widely, and did not appear to be strongly linked to factors such as age, gender, or even education. Even Home Based Care (HBC) workers engaged in witchcraft narratives and explained that witchcraft accounted for many of the illnesses in existence. When asked whether witchcraft or HIV/AIDS was the biggest problem in the area, most focus group participants felt it was not possible to distinguish between them, since the symptoms were similar. However, Ernest's comment emphasizes a commonly held opinion that in comparison to HIV/AIDS, issues of witchcraft are being neglected.

They are similar but they are both increasing. But witchcraft is bigger because with AIDS people are getting lessons on how to protect themselves, but with witchcraft there are no lessons given to people. (Ernest, men's focus group, Lusese).

Among those who know that they are HIV positive, witchcraft is likely to be considered a more socially "acceptable" illness narrative than HIV/AIDS. While HIV/AIDS is seen by many, particularly older people and those with strong religious beliefs, to be self-inflicted and therefore preventable, witchcraft is beyond the control of the individual, and blame for the illness can be externalized. In many cases, therefore, witchcraft narratives can be seen as an active coping strategy which enables the ill person to receive continued care and sympathy, and permits open discussion of the illness without stigmatizing the household. However, accusations of witchcraft can result in emotional distress, long-term divisions within families, and subsequent loss of key social support networks with adverse implications for livelihood

security (cf. Thomas 2007b). Ernest's statement is logical when seen in a context in which witchcraft narratives are long-established and widespread. It is also understandable when interviews with representatives from government ministries and NGOs in Caprivi revealed that despite realizing the impacts of witchcraft beliefs and accusations, little was actively being done to address such issues. While this may be partly accounted for by the difficulties of devising appropriate responses to such "unconventional" issues, it was clear that many of those interviewed either themselves drew upon witchcraft narratives, or were influenced by the thinking of others.

TREATMENT SEEKING IN THE CAPRIVI

When asked about the relationship between illness narratives and treatment seeking, the vast majority of those interviewed explained that the illness diagnosis would in turn influence the type of treatment sought and the resources required to tackle the disorder. For example, if TB (a common form of AIDS-related illness in the Caprivi) was perceived to have been transmitted through violation of a taboo, it was likely to be perceived and treated as a "traditional" rather than a "modern" biomedical illness. However, when asked about their treatment seeking *experiences*, it became clear that beyond the initial treatment seeking stage, illness narratives employed did not necessarily determine treatment sought. Instead, people would try a variety of different treatments in the hope of finding a cure within the context of factors such as treatment accessibility, previous experience, and pressure on resources. At the same time however, pressure was placed upon carers to ensure that they were seen to be acting in accordance with the opinions of others.

"Modern" Health Care

Since Independence, government and health care workers have attempted to promote health care of relevance to the needs of those in rural areas of Namibia (el Obeid et al. 2001) and 84 percent of the population now lives within 10km of a health facility (Mendelsohn et al. 2002). Use of modern health care facilities incurs a charge, and when medicines are not available at the hospital, people are required to purchase more expensive medicines at the pharmacy. As hospital nurses provide only medical care, for example, taking temperature and administering medicines, the patient's family must tend to any additional needs the patient may have. A usual scenario, therefore, is for a female relative to remain at the hospital with the patient. This has significant implications for the household involved, not only in the cost of traveling to the region's sole hospital in Katima, but also on the time spent away from other livelihood activities. While early hospital treatment can reduce the debilitating effects of opportunistic infections, households less able to mobilize resources were found to rely upon other forms of treatment, and only resort to the hospital once the patient had become extremely ill. Such delays meant that it was common for patients to die within days of reaching the hospital.

While the majority of people interviewed felt that modern medicine was a preferable first option in treating modern illness, many frequently commented that people were disillusioned by hospital staff who failed to explain adequately the cause of illness afflicting their relative. There were two interlinked explanations for this: 1) many perceived that a culture of secrecy prevailed within the hospital, and 2) people were unable to communicate with many of the foreign hospital doctors. Interviewees repeatedly stated that the hospital workers were concealing the truth from patients and their families about the cause of their illness. A number of people such as Samuel felt that the hospital purposefully failed to inform people of their HIV status and contributed to misunderstandings and to allegations of witchcraft.

The problem is the hospital doesn't tell you straight what's wrong with you, and sometimes they don't write it on the death certificate, so people are confused….it's dividing families so it would be better if they told people and they would know it's HIV/AIDS and not witchcraft. (Samuel, Masokotwane).

Several factors may cause this belief. First, with the exception of anonymous unlinked sero-sentinel data, all HIV testing and disclosure is consensual; thus, a patient may refuse an HIV test. If a test is carried out, the hospital has no legal right to inform the patient's relatives of their loved one's HIV status, even after the patient's death. Many people do not realize this fact. Secondly, it is acknowledged by Ministry of Health (MOHSS) staff that there has been a history of under-reporting of AIDS deaths in the Caprivi Region. In 2000-2001, for example, only 10 deaths at Katima hospital were recorded as AIDS deaths (DCC/RMT 2002). According to a hospital representative, under-reporting occurs when families aware of their relative's HIV status request that AIDS is not stated on the death certificate, for fear it may affect their life insurance benefits. However, this applies only to the minority in salaried employment, suggesting other factors may account for low HIV recording. Although the hospital reported improvements to the accuracy of their data collection, the attitudes of many people remain influenced by earlier accounts of under-reporting.

For many years there have been no Namibian doctors working at the hospital, which relies greatly upon foreign doctors. At the time of the research, the majority of these doctors spoke some English, although none spoke any of the Caprivian languages. It is hardly surprising, therefore, that many people in the study sites felt confusion and often despair when the hospital failed to cure their relatives, since staff were unable to convey an adequate explanation for the illness or death. Similarly, people claimed that they could often not read what had been written on the patient's health passport, and if they could, they did not know what the implications of the illness were. There was also considerable frustration at the frequency at which the clinics would close without warning, often for several days at a time.

People may therefore travel considerable distances for treatment, taking valuable time away from livelihood activities, only to find that the clinic is closed. Such experiences partly account for the continued importance of traditional healers in the Caprivi Region.

Traditional Healers

Despite attempts to suppress traditional healers in Namibia during colonialism, their role remains strong in the Caprivi Region, with more experienced healers interviewed claiming to work 20 to 30 days each month. Beliefs that modern medicine lacks culturally appropriate explanations for illness and that modern health practitioners treat the symptoms but not underlying causes of illness are important reasons why people continue to consult traditional healers (LeBeau 2002). Lumpkin (1996) found that there was at least one traditional healer per 300 people in the Caprivi, while those at a healer's workshop held in Katima in 2004 estimated the figure to be one healer per 40 people, due largely to increased mobility and demand for healers from neighboring countries. The proportion of healers available therefore far outweighs the modern health facilities available in the Caprivi, providing a greater degree of choice, and for many, the possibility of treatment without traveling long distances to the clinic or hospital. Long waiting times and fear of being judged by others as well as complaints regarding the lack of compassion of many nurses towards those with AIDS (White 2001; LeBeau et al. 1999) are also reasons why traditional healers remain important. Although healers fees were usually higher than those charged by the clinic or hospital, the fact that they are often located nearby, saving on travel costs and time away from livelihood activities, and may accept payment on credit or in goods, can also make them a preferable option to modern health facilities. As healers are often known to the ill person, they may also constitute a preferable option if the illness is considered embarrassing, although some people may opt for the relative anonymity provided by modern health facilities.

Following the relaxing of border controls at Independence, healers' fees rose sharply in the Caprivi due to an influx of Zambians, who are generally perceived to be stronger healers than Namibians (Lumpkin 1996). Healers interviewed for this research claimed that while they made an initial charge, they would not charge additional costs should the patient fail to get better. However, case studies revealed that this was not always the case, and that healer's fees could easily amount to several hundred Namibian dollars despite eventual failure to cure a patient. The potentially high cost incurred by seeking treatment from a traditional healer means selection of a suitable healer is important. Healers are often chosen on recommendations based on other peoples' experiences and if they are able, households may spend significant resources if they feel that a particular healer should undertake the treatment. In one case study household, for example, the father of an ill girl had paid N\$600[8] to travel to Zambia to obtain medicines from a healer recommended to him. All of the healers at the healers' workshop affirmed that they could not cure HIV/AIDS, although they claimed to play an important role in treating some related opportunistic infections such as skin sores.

SELECTING TREATMENT

Attempts to provide a holistic health care system, in which both traditional and modern medicine can be offered simultaneously, have so far remained limited in the Caprivi Region. Despite sporadic attempts at collaboration by MOHSS workers and traditional healers, modern and traditional medicines are generally considered as separate sectors. In the initial stages of illness, the selection of treatment was usually based on the symptomatic manifestations of the illness and beliefs regarding the cause of the illness. However, failure to treat the disorder using the chosen treatment may lead to a reconsideration of options available. Decisions regarding subsequent treatment options are often influenced by the past experiences of those concerned, as Ntwala illustrates.

One of my sons was sick. I was praying for him, and people came here and told me I should take him to a traditional healer. I told them to pray first, but then I also decided to go to a traditional healer. But the day after the treatment from the healer my son passed away. From that day I realized traditional healers are not reliable. Instead, if I had kept on praying to God, maybe I could have prolonged his life. But because I stopped praying to take him to the healer, I lost my son. (Ntwala, Masokotwane).

Ntwala asserts that she no longer trusts traditional healers following the death of her son, implying that she would not go to a healer again for treatment. However, while such experiences may influence treatment seeking behavior, they do not necessarily predetermine future behavior. During the subsequent interview with Ntwala, it emerged that she had in fact returned to a traditional healer when her daughter became ill in 2003. She explained that she had already been to the hospital four times before she tried the healer, and that she ultimately went out of desperation as her daughter's condition failed to improve. Such behavior demonstrates that when one treatment fails to work, alternative options are reconsidered. Because of the incurable nature of AIDS, a long series of attempts are likely to be made to find possible treatments, greatly depleting the resources of the household. The following case study illustrates how a variety of avenues may be explored to cure an illness, many of which may be time consuming and expensive.

| Background to Precious and Chalix: | Precious moved from Zambia to her husband Chalix's village in 1993. In 1999, Chalix became ill with respiratory and stomach problems. Over the months, his health fluctuated, but in 2000 he died at the age of 49. |
| Initial diagnosis and treatment: | When Chalix first became ill, Precious tried to treat him with medicines such as paracetamol that could be purchased nearby. Still ill after three months, however, his mother believed he was suffering from spirit possession as the symptoms |

were similar to those that had afflicted him when he was younger. She and her husband, together with Chalix's sister, decided he should go to a healer, despite Precious and Chalix initially not wanting to and claiming not to believe in them.

Choosing a healer:	Because the healer who had previously treated Chalix had died, it was necessary to identify a new healer. During this time, a healer from Lisikili (40km away) was in the village treating another patient. Although neither Precious nor Chalix knew the man, many villagers who had attended a drumming ritual to heal the patient reported that the man had called Chalix's name. The family persuaded Precious to take Chalix to the healer before he left.
Second diagnosis:	When they found the healer, he told Chalix that he had been cursed, and without treatment would die. Precious reported that Chalix had initially not believed this since he had nothing to be jealous of. The healer did not name the witch but confirmed that it was an uncle of Chalix's. Fearing for his life, they felt they could not ignore the healer's words, so asked him to come to the house with medicines that would keep the evil spirits away. The healer did this for free, but advised Chalix that he should also take medication from him.
Second attempt at treatment:	Because it was cheaper for Precious and Chalix to travel to the healer's village than to pay for him to come to theirs, they went to Lisikili, where Chalix was 'cut' and washed in traditional medicines. For this, the healer charged N$500, paid using savings from Precious's fish selling business, as well as Chalix's parent's pension and his sister's teaching salary. Chalix felt well for several weeks, but then became ill again, and the healer was again called by the family.
Purification:	The healer came to purify Chalix's village, since Chalix's parents believed the witch was still actively trying to kill him. For this, one of Chalix's chickens was killed and the blood applied to him, Precious, and their children. Following a

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drumming ritual, the healer placed medicine at the village edge to keep away the witch. This cost N$300 and a cow, which was given by Chalix's father.

Third attempt at treatment:	Again, Chalix initially felt better following the purification. However, when his health deteriorated again, the family took him to the clinic since they could no longer afford the healer and were by now doubting his ability to cure Chalix. At the clinic, Chalix was given chloroquine, but this failed to improve his health.
Fourth attempt at treatment:	At this stage, Chalix became very ill, and the family took him to hospital in Katima, where he died later the same day.
Decisions over burial:	Rather than burying Chalix in his father's village as is customary, his mother, fearing the perpetrator of the witchcraft would return to the village, decided he should be buried in Katima, despite the expense of securing a plot there.

For Precious and Chalix, treatment seeking was not a one-off event, but a succession of attempts over several months to find a cure. As was common among households afflicted by long-term illness, the cost of treatment seeking was high – in this case, N$800, a cow, and a chicken for the healer, as well as clinic and hospital fees (approximately N$25) and transport costs to and from Lisikili and Katima (approximately N$150). Case study interviews revealed that once any cash savings had been depleted, assets disposed of to cover treatment costs included money from pensions, salaries, and remittances, cattle, chickens, furniture, mattresses and radios. The communal land rights arrangement in Namibia means that it is not possible for households to sell land to raise cash. While this increases dependency upon the disposal of other assets, it does help to ensure that land remains available for orphans and other remaining relatives. The case study emphasizes that when household members no longer have cash available, they are dependent upon contributions from others to seek further treatment options. This has particularly adverse implications for households with weak social

capital and those reliant upon insecure horizontal transfers. Following the depletion of her own savings, Precious was fortunate to receive help from Chalix's parents and sister. However, as a widow these support networks are no longer guaranteed should Precious herself become ill (cf. Thomas 2008). Beyond close family members, few of those interviewed had received external assistance with treatment costs, and those who had had only received basic medicines such as Oral Rehydration Solution or paracetamol. The case study also highlights an issue that has become particularly important since the recent introduction of anti-retroviral (ARV) drugs in the Caprivi. Because other sources of treatment were being pursued, Chalix was not taken to the hospital until he had become so severely ill that he died the same day, a scenario well recognized by staff at Katima hospital.

EXTERNAL FACTORS INFLUENCING TREATMENT SEEKING

Decisions regarding the care and treatment of a person afflicted by illness are rarely the responsibility of one person alone. Instead, a number of people within and beyond the household may influence care and treatment seeking responses and may differ in their beliefs and understandings of the cause and remedy of the illness. Even within a household, it was not uncommon to find members holding differing views as to how best to procure treatment. While the desire of household members and concerned relatives to explore all possibilities for the treatment of an ill family member is axiomatic, wider social pressures and expectations to pursue treatment were also placed upon the household concerned. Some interviewees commented that a failure to pursue all possible avenues of treatment may be deemed irresponsible by other people within the community, resulting in hurtful gossip and possible denunciation of the household. This concern was particularly evident among women, who as the prime carers are the most likely to bear the brunt of criticism. The following case study

shows how such external pressures can influence household decisions regarding treatment seeking.

Nancy lives in Lusese with her two young children, her grandmother, and two young orphans. Her parents and her five uncles and aunts (aged 30 – 50) and their spouses had all died in the past five years. Witchcraft was suspected as the family had a large herd of cattle. Since 2001, Nancy's sister Peggy (age 23) has lived with her periodically during times when she is very sick. The symptoms of Peggy's illness are consistent with AIDS-related illness. Peggy has been to hospital six times and to the private doctor in Katima twice. The hospital has tested Peggy for TB, but it was not diagnosed. Despite the family's previous experiences with witchcraft, Nancy claimed that her strong religious beliefs meant she did not want to take Peggy to a healer. Nancy felt that her decision to delay visiting the healer had been deemed irresponsible by other people in Lusese, particularly since the plight of her other relatives, stating: 'We know that they are talking – saying that maybe because all our parents have died we must be very stupid because we didn't go to the traditional healer.' In response to this accusation, and out of desperation, she did eventually take Peggy to a healer who claimed she had been witched. Treatment from the healer had cost N$2000. When I last saw Nancy, Peggy's condition had deteriorated, and she was receiving both modern and traditional treatment concurrently.

Nancy takes her ill sister to the healer not only because the hospital has failed to cure her, but because she feels pressured to do so by others in the community. This implies that people may spend valuable resources on treatment options to appease others and avoid public condemnation, even if they themselves claim not to believe in the treatment. It is also possible that people seek out traditional healers to allay gossip that the illness is HIV/AIDS.

STRATEGIZING NARRATIVES OF BLAME

By strategically mobilizing illness narratives, an account of the illness represented in public may be very different from beliefs or knowledge among household and close family members, particularly when AIDS is known or suspected. Similarly, individuals who know they are HIV positive may choose not to disclose their diagnosis even to close family members, and may instead make public a belief that they have been witched. In such cases, denial or secrecy may be seen as a preferable coping strategy to publicly admitting the truth, for fear of being isolated and ostracized by others and bringing the household into disrepute (Radstake 2000; Bond 1998; Meursing 1997). However, such strategies risk the breakdown of support networks should the family then accuse a relative of witchcraft. Nina was one of the only people interviewed who knew, or was willing to admit, that her relatives had died from AIDS-related illness. However, following the diagnosis she and other family members involved agreed that they would keep it a secret among themselves, because "as soon as you start telling others, that's when they start fearing to come close to you". The illnesses were therefore explained publicly as the consequence of witchcraft.

As Ochs and Capps (1996) explain, some individuals and households find it difficult to convince others to accept and authorize the illness narratives they employ. Power hierarchies and dominant ideas about morality and acceptability had a clear influence on this situation in the Caprivi Region. Despite efforts to portray an illness in a manner favorable to the afflicted household, many reported that an older married woman considered to have a "moral" lifestyle was likely to receive more sympathy and understanding than a young unmarried woman reputed to have "moved around" and had several sexual relationships. Similarly, a person perceived to uphold strong religious beliefs will also tend to be considered less likely to be affected by HIV/AIDS than a person not attending church. As the following comment stresses, those who become ill while in employment were also likely to receive more sympathy than those who were not.

If it's people who had high positions [jobs], you can say that it's witchcraft because people are fighting for those positions. But if they are not working and they get sick – like if it's an STD and they then die – that's his own fault because he went looking for that disease and he wanted to die (Nina, Masokotwane).

As Nina stresses, accusations of witchcraft are accepted in cases in which the ill person was working, since there was a reason for others to be jealous. If the person was not working, however, the illness may be considered self-inflicted since jealousy is unlikely. Such beliefs reflect wider changes in the Caprivi in which economic heterogeneity has brought increasing contempt for those unable to look after themselves (cf. Thomas 2006). This in turn influences the manner in which the ill person and the household are perceived and subsequently treated within the community.

CONCLUSION

This article has demonstrated that a purely biomedical approach to HIV/AIDS is insufficient in comprehending local understandings of, and responses to, illness. Acknowledging and examining the role of alternative illness narratives has enabled contextual understanding of the ways in which HIV/AIDS is assimilated into existing representations of disease and illness and the ways in which these understandings are bound up with the significant socio-cultural and economic change experienced in the Caprivi Region since Independence. The increase in illness and deaths in the region is widely perceived to have emerged as a result of changes in resource use and accessibility, as well as changes in behavior that violate moral codes and uphold religious and customary assertions that explain illness as a consequent and justified punishment for behavior considered beyond the bounds of acceptability. An upsurge

in accusations of witchcraft can be seen as a direct reaction to changes in socio-economic attitudes and the increase in illness and deaths, and can influence decisions regarding subsequent treatment and coping responses. However, while witchcraft accusations may avert stigma and shift blame away from the ill individual, they can place significant tension upon social support networks at a time when the household is particularly vulnerable.

Treatment seeking is a complex and dynamic process that has been shown to lead to substantial erosion of assets through treatment costs and time spent away from livelihood activities. This is reinforced not only by the long-term nature of AIDS-related illness, but because key decisions over treatment and care are influenced by pressures and expectations beyond the immediate household. The findings discussed here also imply that those with a relatively strong asset base may receive more sympathy and assistance than those who do not. Witchcraft narratives offer a more plausible explanation when a person owns assets which motivate jealousy, while those who do not are thought to have brought the illness upon themselves.

The "alternative" narratives discussed in this article are located in a particular context and moment in time. The Caprivi Region has undergone significant socio-cultural and economic change since 1990 and the disruption to the social and moral order and resulting narratives of blame are widely considered to play a central role in explaining increasing illness and death. Alternative narratives provide an important insight into the ways in which people reflect on, create understanding of, and respond to illness. Rather than seeing them simply as cultural barriers, recognition and understanding of these narratives is central to the success of any HIV prevention and AIDS mitigation interventions, particularly in circumstances in which the number of people who actually know or disclose their HIV status is so low. Using local interpretations as a starting point and incorporating the positive aspects of these narratives into HIV/AIDS interventions could instigate useful dialogue on the

epidemic which is unlikely to be gained through the widespread and continuing imposition of

a top-down biomedical narrative.   36

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NOTES

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[1] At the time of this research, HIV prevalence in the Caprivi stood at 43%.

[2] Laboratory reports from Katima hospital confirmed testing levels in the period prior to the research were low at approximately 700 people annually in 2001 and 2002.

[3] The most well attended churches in the study sites were the Seventh Day Adventist, Roman Catholic, Faith Apostolic, and Dutch Reformed churches. Interviews with community members and with representatives from each of these churches found no major differences in attitudes regarding morality and behavior.

[4] While the three study sites faced different livelihood vulnerabilities, they did not differ markedly in socio-cultural practices, beliefs, or interpretations of HIV/AIDS and other illnesses.

[5] Although there are overlaps between them, the terms "modern" and "traditional" were widely used by informants. The former refers to treatment available at the clinic and hospital while the latter refers to treatment available through traditional healers.

[6] References were made to Exodus 20, and Deuteronomy, Chapter 18, verses 10 – 12.

[7] The term "witchdoctor" was used by those interviewed. In general, a witchdoctor performs witchcraft, usually thought to be harmful, while a "traditional healer" treats and cures illness.

[8] This equates to approximately 5-6 25kg bags of maize meal.