

The power of AIDS: kinship, mobility and the valuing of social and ritual relationships in Tanzania

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The HIV/AIDS epidemic in Africa has become a test case of the effects of globalisation, in that it demonstrates how international processes may affect regional life situations and how ‘the local’ can simultaneously develop in its own way, through the processes of appropriating, modifying, and resisting global influences. Drawing on fieldwork in Tanzania, I show how the Luo in the Mara region define HIV/AIDS as an outcome of modernity and globalisation, which to them have become embodied in processes of migration, the collapse of generational and gender hierarchies, and an increased immorality in contemporary society. While social and moral ruptures in Mara become further condensed in tensions between lineages and AIDS-sick relatives, mourning and burial rituals (including widow cleansing), disputes over inheritance rights, and the attribution of illness to the breaking of a taboo (*chira*) have become essential for negotiating and maintaining social and cultural relationships in an era of AIDS. In conclusion I argue that the concepts of vitality and moral practice may assist an understanding of how different social actors in sub-Saharan Africa have responded to the breakdowns associated with increased suffering and death, and to describe some social and moral developments observable in the context of internationally driven public health campaigns in the region.

Keywords: actor-centered approach, Africa, burial, globalisation, ritual, rural-urban migration, widow cleansing

Introduction

In the last two decades, AIDS has become a global epidemic. Not only are HIV-infection rates — after sub-Saharan Africa led worldwide statistics by a large margin for many years — rapidly increasing in China, India, the Russian Federation, and Eastern Europe (UNAIDS/WHO, 2005). The epidemic has also become a test case of globalisation, which clearly — and sadly — demonstrates both how international processes affect regional life situations and how “the local” develops in its own particular way, through the processes of appropriating, modifying, and resisting global influences (Appadurai, 1996).

In this article, I explore how families and individuals in the Mara region in northwest Tanzania have responded to the massive everyday suffering that the epidemic entails, an event which they perceive as an outcome of modernity and globalisation. While AIDS in sub-Saharan Africa is “likely to shred the already torn social fabric of numerous countries” (Schoepf, 2001, p. 336), communities, families and individuals are struggling to interpret and counteract its disintegrational effects by integrating countless experiences of illness and death into the social, cultural and moral framework of family and community life.

By focusing on the cultural and moral practices that have emerged or been redefined in Mara in the era of AIDS, I argue that the performance of mourning and burial rituals, disputes over inheritance rights, and the attribution of cases

of illness to breaking a taboo (*chira*) have become essential for families to negotiate and maintain social and cultural relationships in the context of an ongoing social and moral crisis. Cultural and moral responses to HIV/AIDS, which were repeatedly stigmatised by internationally and nationally organised campaigns as superstitions and “backward beliefs” (see Gausset, 2001), may contribute to the “re-making of a world” (Das & Kleinman, 2001) now largely characterised by experiences of loss and suffering.

Recognising that the course of the epidemic is inextricably tied to processes of modernity and globalisation (Schoepf, 2001; Barnett & Whiteside, 2002; Farmer, 2003), I first provide an overview of the different positions that have shaped the discourse on HIV/AIDS and globalisation in recent years. I then draw on my own fieldwork in Tanzania and show how the Luo in rural Mara have come to deal with experiences of loss and suffering and what effect the dissolution — or, in some cases, the modification — of family bonds in the context of an advanced epidemic have had on relationships of kinship and belonging. Finally, I outline how the processes investigated in Tanzania fit into social and cultural processes that are observable in the context of AIDS in other southern and East African countries. In a derivation of an argument made by Heald (1995), I argue that the HIV/AIDS epidemic not only has the power to dissolve or transform social relationships and units

on various interrelated levels of global, national, and local organisation, but also that the suffering caused by HIV/AIDS has led to a growing need among individuals and social units to establish control over life, illness and death, and thus to achieve a sense of cultural, social and moral belonging in this era of AIDS (Dilger, 2005 and forthcoming b). The HIV/AIDS pandemic as a “bio-social event” (Rabinow, 1992) has the power not only to destroy or transform, but also to build and rebuild social and cultural relationships in the context of modernity and globalisation.

AIDS and globalisation: different perspectives, differing interests

...to meet a severe and urgent crisis abroad, tonight I propose the Emergency Plan for AIDS Relief — a work of mercy beyond all current international efforts to help the people of Africa. This comprehensive plan will prevent seven million new AIDS infections, treat at least two million people with life-extending drugs, and provide humane care for millions of people suffering from AIDS, and for children orphaned by AIDS.... This nation [the United States] can lead the world in sparing innocent people from a plague of nature.... (U.S. President George W Bush, State of the Union address, 28 January 2003).

In recent years, multiple analyses have been put forth concerning the connections between AIDS and globalisation, from governmental and economic policy perspectives, as well as with activist and academic viewpoints. Different interpretations of these connections can be ascribed to respective interests that shape the way different actors hope to achieve lowered HIV infection rates. For the purpose of this article, I divide the wide variety of perspectives on AIDS and globalisation into opposing opinions — between those who regard globalisation positively and those who are critical of it — a division that highlights, in the event of often highly emotionally charged debates, the near impossibility of arriving at an impartial assessment of the processes associated with the epidemic.

More optimistic is the outlook that regards globalisation as a chance to more effectively (and more rapidly) confront international catastrophes and crises. This position is adopted mainly by institutional and governmental bodies and is shaped largely by their interest in obtaining publicity and funding for the international fight against HIV/AIDS. One of the most impressive outcomes of this global lobbying — whose long-winded and rocky history cannot be reproduced here (see Ingenkamp, 2005) — was that in January 2000, HIV/AIDS (i.e. a health issue) appeared on the agenda of the United Nations Security Council. Similarly, in 2001, the Global Fund to Fight AIDS, Tuberculosis and Malaria was established and slated to annually contribute US\$7–10 billion of governmental and non-governmental funds to the international fight against those diseases. In cooperation with actors worldwide, funds will be provided for programmes aimed at prevention, care and treatment, and which integrate the latest findings regarding best practices related to HIV/AIDS and other infectious diseases.

Critics of globalisation expose a vastly different picture. Among them are voices that could initially be termed

optimistic, in that they regarded globalisation as a chance to fight AIDS more effectively through international cooperation. Just how successful a global network can be for social AIDS movements is evidenced by the Treatment Action Campaign (TAC) in South Africa and the fight surrounding antiretroviral therapy (ART). In a sensational trial, the TAC — whose main financial contributors were located in Germany, the United States and Scandinavia, and which was supported by an international lobby of sympathisers of varying persuasions (Friedman & Mottiar, 2004) — fought against the (economic) interests of international pharmaceutical concerns. In alliance with the South African government, the TAC successfully argued for the relaxation of World Trade Organization regulations that had blocked the production of generic AIDS medications, and so made an overall treatment of HIV-infected persons in developing countries possible. One outcome of the trial was sustained reduction in the prices of antiretroviral drugs, which fell by more than 98% between 1998 and 2001.

While globalisation clearly offers new opportunities for social movements to enforce social values and human rights against the interests of global governmental or economic alliances — and may thus be seen as a motor and opportunity for the emergent civil society in sub-Saharan Africa (Robins, 2004; Nguyen, 2005) — the discussion surrounding antiretroviral treatment clearly underlines the boundaries and ruptures that currently characterise the global fight against HIV/AIDS. Thus, the comprehensive introduction of ART in sub-Saharan Africa has failed up to this point. This is attributable not only to the lack of infrastructure in the health sectors in the high-prevalence countries (Tawfik, Kinoti & Blain, 2002) or to the considerable stigma surrounding HIV/AIDS, which represents a significant barrier to motivating men and women in Africa to be tested for HIV. Rather, the scaling-up of antiretroviral treatment has also been slowed down by national governments themselves, as exemplified in South Africa, where President Mbeki's government (despite the successful trial against the pharmaceutical companies) prohibited the use of Nevirapine in government hospitals until the ban was overruled by a court decision in 2001. Finally, the introduction of ART can be hampered by a lack of financial resources (which have been largely provided by international donors). While the Global Fund to Fight AIDS, Tuberculosis and Malaria received contributions of approximately US\$1.45 billion in 2004 (Global Fund, 2004), the fund lags far behind its original annual fund-raising goal of US\$7–10 billion.

The fact that the course of the AIDS epidemic in Africa is directly tied to the unequal distribution of poverty, wealth, and power in a globalised world¹ makes clear how strongly the success of the fight against AIDS depends on the interests of those who have access to the necessary resources. How firmly the distribution of international resources is in turn rooted in the safeguarding and expansion of the donors' own interests is exemplified by The President's Emergency Plan for AIDS Relief (PEPFAR) in the United States, launched in 2003. According to the plan, between 2003 and 2008, US\$15 billion will be poured into programmes that focus strongly on abstinence and anti-abortion campaigns, thus threatening to undermine the efforts of other global players (including UNAIDS) that have promoted comprehensive sex education and condom distri-

bution.² Similarly, President Bush's emergency plan is driven not only by its avowed humanistic goals of preventing future HIV-infections or prolonging the lives of people with HIV/AIDS in Africa, but the U.S. government, along with other institutions such as the UN Security Council or the World Bank, also fears that the predicted collapse of some African economies due to the AIDS epidemic will negatively impact the global economy in the medium term (World Bank, 2000). Another fear is that orphans who lack social and educational support will migrate to industrial regions and contribute to destabilising social and economic systems in Western countries (Schönteich, 1999).³

AIDS in Africa as an outcome of globalisation: from structural violence to an actor-centred approach

While scenarios that emphasise the implications of the high HIV-related morbidity and mortality rates in Africa on global well-being may be well-grounded, this focus can seem ironic when one considers that the AIDS epidemic in sub-Saharan Africa may be an outcome of modernisation and globalisation processes themselves. Starting in the early 1990s, anthropologists and social scientists linked the course of the HIV/AIDS epidemic in 'developing nations', as well as among socially disadvantaged groups in industrial nations, to the historical, economic and political conditions in groups or societies. Schoepf (1992 and 2001) and Farmer, Lindenbaum & Delvecchio-Good (1993) argued that in those countries and social groups where HIV is transmitted predominantly through heterosexual intercourse, the spread and course of the epidemic are determined by globally, nationally and locally produced structural forces such as class, ethnicity and gender. Farmer (1996a) further grouped these analyses under the concept 'structural violence' and pointed out that in the context of globally driven poverty, political dependence, and a lack of access to health services and education, not only individuals but also entire groups with similar social backgrounds are subject to increased risk of illness and suffering.

In the African context, this macro-structural approach was applied most elaborately by Barnett & Whiteside (2002). In *AIDS in the 21st Century*, the authors argue that the history of Africa, so dramatically shaped by international influences, has led to an "abnormal normality" on the continent (Barnett & Whiteside, 2002, p. 129). From the beginning of the slave trade to the present, according to this view, Africa has been a toy of power and economic interests. In the colonial period, people, traditions and languages were arbitrarily formed into national entities that still partly lack the legitimisation of their populations. In the postcolonial era, wars of independence, military coups and Cold War interests have shaped living situations on the continent. And finally, the structural adjustment programmes launched by the International Monetary Fund and the World Bank since the 1980s often intensified the pressure on local gender and power relations and created a "risk environment" enabling violence, sexual exploitation, and now the HIV/AIDS epidemic to thrive (Barnett & Whiteside, 2002, pp. 124–156).⁴

In this article, I do not in principle question the far-reaching historical, economic and political roots of HIV/AIDS, because the course of the epidemic (especially with regard to its gender-specific dimensions) has been

unquestioningly molded by political-economic powers and dependencies (Baylies, 2000). Nevertheless, the sometimes one-sided views of macro-economic and macro-social approaches trigger a slew of critical questions. In particular, the concept of structural violence — only vaguely defined by Farmer, and which has its roots in the violence and conflict research of the 1970s (Galtung, 1975) — has been criticised repeatedly in the social sciences (Roth, 1988). While the concept of structural violence in a policy-making or human-rights context can convincingly point to the sometimes deplorable state of affairs in a globalised world, it loses definition and explanatory power in empirical micro-studies, since it keeps the interrelationships between the global and local causes and effects of violence as open and associative as possible (in order not to obscure the wider connections). This is especially clear in Farmer's writings, in which he binds his analysis of the epidemic as a result of global injustice to an (utopian) appeal that the fight against it can be achieved only through a "fundamental transformation of our world" (Farmer, 1996b, p. 38).

I argue that explanations for the spread of HIV can be found only if attention is paid to causes or mechanisms at the regional level, and only if the formation of individual and collective behaviour in relation to the epidemic is examined with regard to specific social, cultural and moral contexts (for Tanzania, see Weiss, 1993, and Setel, 1999). In contrast to the approaches mentioned above, my emphasis is less on the constraints (Farmer, 1996a) and more on the options that shape individual and communal agency in relation to HIV/AIDS. My focus is on cultural interpretations of suffering and the way that cultural meaning and practices (as well as strategic interests and moral and emotional needs that guide these practices) reproduce and modify societal structures in an era of increased social and moral challenge (see Ortner, 1984, p. 144).

Following an overview of the methodology of my fieldwork in northwest Tanzania, I elucidate how the Luo in the Mara region see HIV/AIDS as predominantly a humanitarian catastrophe of modern life and as a threat to social and familial networks. In this sense the Luo are largely in agreement with the suggestion that globalisation has created the foundation for the unhindered spread of HIV.⁵ At the same time, during this moment of crisis, people in Mara have developed a need to give meaning to their experiences of loss and suffering and a need to reflect on the quality of social and moral relationships in the context of crisis.

Methodology

Research was carried out during several stays in Tanzania between 1995 and 2003. In 1995/96, the fieldwork focused on young people's moral perceptions of HIV/AIDS, as well as intergenerational and gender relations within the context of modernity (see Dilger, 1999 and 2003). Between 1999 and 2003, I studied relationships of care and support in extended kinship networks in the Mara region, as well as through observations at NGOs and in a Pentecostal church in Dar es Salaam (see Dilger, 2005).

Fieldwork was carried out in both rural and urban settings, but this article refers largely to data collected in the

Mara region along Lake Victoria. I conducted approximately 70 semi-structured and narrative interviews with HIV-infected men and women and their families.⁶ The interviews were conducted in the national language, Kiswahili, and were supplemented by participant observation (e.g. at burials) as well as countless informal conversations with people in the villages, with doctors and nurses at local hospitals and dispensaries, and with traditional healers and church leaders.

The research area in Mara consists of a semi-urban centre and numerous villages and settlements. The area is mainly populated by Luo, an ethnic and linguistic group comprising about 223 000 speakers in Tanzania, who thus represent only a small percentage of the country's total population of approximately 35 million. The area is characterised by its isolated location and poor infrastructure. During Tanzania's socialist *Ujamaa* phase, the government neglected the area. Since the political and economic opening of the country in the 1980s and 1990s, the region has received only marginal support from government or developmental policy programmes.

At the time of my fieldwork, HIV prevalence in the Mara region was reported at 9% among blood donors (United Republic of Tanzania, 2001). HIV prevention efforts were carried out sporadically through government and nongovernment campaigns. Therefore the main sources of HIV-related information for young people and adults were their relatives, friends, schools, and the media and religious organisations. In most cases, care for people with AIDS was organised within kinship networks; local hospital patients found to be HIV-positive were almost always turned away. In 1999 and 2000, ART was not available either in the Mara region or in Tanzania at large.

Mobility, AIDS and modernity in northwestern Tanzania

'In former times, people had a good life. They lived from farming, cattle-keeping and fishing.... Children and young people were educated and raised by the extended family and by the community. Today, everything has changed: there is no education by the family anymore, there is only school.... Today nothing is for free. Money has taken over and you have to pay for everything.... Today there are sexually transmitted diseases and I don't know what else: AIDS....' (Female, age 22; interview on 28/02/1996)

Luo⁷ families in rural Mara live predominantly from farming and increasingly from fishing. They supplement their income through small-scale trade and sometimes through the employment of one or more relatives in one of the local hospitals, in health clinics or administrative offices. In very few cases, however, are these activities sufficient to earn enough money to pay for higher education, the treatment of diseases either by healers or at a hospital, or for food and clothing. Droughts in recent years and the lack of trade and work possibilities in situ have therefore led to the out-migration of young men and women to urban centres such as Mwanza, Arusha, and Dar es Salaam, where they look for material prosperity, which is also intended to benefit people in their home regions.

The migration of young people which has characterised rural Mara for more than three decades is encouraged and often actively supported by the migrants' patrilineally and virilocally⁸ organised kinship networks. The families that remain behind hope, that according to the principle of reciprocity (which establishes bonds of mutual obligation between migrants, their spouses, and their respective lineages), the fruits of labour and trade will be evenly distributed. This acceptance in principle extends to the male relatives of a lineage, as well as to young women who are expected to contribute to the income of the new family after having moved into their husband's compound as well as to their lineage of origin. On the other hand, however, migratory processes, which ideally end with the return of the worker or person involved in business, are constantly accompanied by family members' complaints of a lack of gratefulness or willingness to help on the part of those who have succeeded in the city, or the migrants' complaint of excessive demands by rural relatives.

For the people in Mara, the ambivalence about workers' migration has been exacerbated by the growing HIV/AIDS epidemic and has been increasingly tied to the risks they associate with the processes of modernity and globalisation. As argued by Comaroff & Comaroff (2004, p. 329), modernity in Africa (and elsewhere) is essentially about the tensions and dilemmas that result from often unsolvable conflicts between various oppositional forces that coexist in contemporary societies and that are defined by different social actors and institutions as either 'modern' or 'traditional'. In rural Mara, the dilemmas associated with modernity (*maisha ya kisasa*, meaning 'life of today') are understood to be the result of a clash between traditional kinship-based systems of production and reproduction and their modern counter-institutions. While the essence of the former is represented by subsistence farming, the adherence to rituals and traditions, education in the family, and a lineage-controlled sexuality, the latter is characterised by the collapse of gender and generational hierarchies, the valuing of money, the widespread acceptance of Western science, and the omnipresence of an uncontrolled and excessive sexuality. It is the perceived dangerous connection between mobility and money in the modern world – and especially the mobility of young working and business women who are blamed of being "greedy for money" (cf. Weiss, 1993; Dilger, 1999; Setel, 1999) – which in the eyes of people in Mara lead to a loss of control over family members, and thus to more promiscuity and the spread of HIV.

The discourse on the 'malcontents of modernity' is of course not a new one in the Mara region, and, even before AIDS, family members who earned money in the city were perceived as the triggers of social conflict and cultural alienation.⁹ However, the conflicts between money-earning relatives and their extended families have increased with the spread of HIV: not only do migrant workers who become infected in the cities present an actual danger to rural inhabitants as they may spread the virus to village residents, but most HIV-infected persons also return to their rural families upon the outbreak of an AIDS illness, which in most cases implies a scarcely manageable increase in economic, social and emotional strains for kinship networks.

Against this background, in increasing measure, the HIV/AIDS epidemic symbolises a crisis in social relationships, and in doing so it turns the social mobility of business and work migrants into a critically and morally charged discourse. It is the perceived dangerous connection between mobility and money in the modern world — and especially the mobility of young working and business women who are blamed for being “greedy for money” (Weiss, 1993; Dilger, 1999; Setel, 1999) — which in the eyes of people in Mara leads to a loss of control over family members, and thus to more promiscuity and the spread of HIV.

Morally charged discourses on AIDS, the “bitterness of money” (Shipton, 1989), and the dangers of social and sexual mobility in the modern world should not be mistaken for a conservative rhetoric, such as exists among elder and younger Luo men who try to impose restrictions and regulations on the sexualities of young women. Young and elderly women in Mara often play an active part in the creation of these discourses and also in blaming other women for the spread of HIV (Dilger, 1999). In the same way, the moral discourse on AIDS and migration is not a detached social and moral construct restricted to the level of language only; on the contrary, it exhibits concrete effects on the handling of HIV-infected persons and people sick with AIDS. Thus, discourses on the uncontrolled and commodified sexuality of a young and mobile generation result, on one hand, in stigmatisation of those who through their ‘immoral lifestyle’ have become HIV infected in the cities. On the other hand, this perspective legitimises the sometimes poor care of the sick, since rural families often feel less responsible for AIDS-sick relatives who they perceive to be guilty by way of their own misfortune. I have frequently observed that the strains and conflicts characterising the course of illness in the context of rural-urban dynamics lead to severe ruptures between sick relatives and their families. Especially, young widows and unmarried daughters sick with AIDS illnesses are often in a marginal position in their families and are at times not adequately cared for; in the very rare cases where neither their late husband’s family nor their family of origin are willing to care for them, they are even left to die alone.¹⁰

Experiences of family break-ups can seriously bring into question the kinship bonds between extended families and their HIV-infected or AIDS-sick members. Such rifts may be counteracted, often following the death of a relative, in the negotiation of inheritance issues as well as in ritual practices among lineages. The reconstruction of kinship bonds and belonging is addressed in the following sections.

Negotiating inheritance conflicts

Conflicts that mark the course of AIDS illnesses often continue after death, especially if the late family member was a married man. The arguments that flare up between widows and their husbands’ lineages surrounding the property of men are thereby the continuation of a fundamental conflict that generally represents tension between the well-being of nuclear families and the well-being of extended kinship networks. As a rule, a widow in Mara views herself as justified, together with her children, to dispose of her husband’s property — even more so if her

husband’s family cared little for him during his illness. Lineages, on the other hand, want to retain control of the estate of a late relative and view that as a legitimate claim against the background of local common law (see Potash, 1986). Parents or peer generations could traditionally count on help in old age from the younger generation, or when ever called upon, especially if they had paid for the education of their sons or brothers. If a young man’s early death interrupts this idea of social security, families see it as a justified compensation if his property is used to satisfy a part of the expected benefits now lost. An HIV-infected widow recounted the events after her husband’s death in 1992 when she was 30 years old with a 9-year-old son:

‘After the death of my husband, there was no joy in my life. My husband’s relatives took all his property.... There were things of value¹¹ that my late husband and I had stored in Musoma. My sister-in-law went there and took everything with her.... Until today I haven’t heard again about the whereabouts of these things. I was here [in the village] at that time, dealing with the burial [of my husband].’
(Interview on 11/08/1999)

Apart from property claims that lineages may make based on common law,¹² many families in Mara assume that the widow of a man who died from AIDS is also HIV infected and likely to die soon. Not only do the families fear that they will be responsible for having to assume care of the widow once she gets sick; they also worry that the widow will allow her late husband’s property to benefit her own lineage or will spend its value on often costly treatment for herself. Therefore lineages frequently attempt to force (younger) wives out of their families before the death of their male relatives and in this way to secure their inheritance.

While the question of inheritance can lead to serious conflict between widows and their in-laws, the two parties rarely allow the situation to come to a complete break. On the contrary, both may have an interest in keeping the kinship bonds intact. Widows have national jurisdiction on their side and can assert their rights in court to sole hereditary title (assuming they are able to overcome the hurdles of the Tanzanian legal system). In general, however, they tend to avoid open conflict with in-laws in court because they do not want to risk losing their own or their children’s membership to their husband’s or father’s lineages. Children who are counted as part of their father’s lineage have claim to his land and property following the death of their mother; therefore, integration in the patrilineage is an essential strategy for securing a child’s future, and most widows I interviewed tried to stay on good terms with their late husband’s family.

Lineages, on the other hand, frequently attempt to acquire control of the property of their male relatives and thus to negate the claims to care by the widows. Yet they are also aware that without a widow’s consent the bureaucratic impediments in the way of acquiring estates or employee benefits cannot be surmounted. Consequently, instead of bringing about a break with the widow, they may press for the appointment of a guardian (*msimamizi wa mirathi*) who comes from the patrilineage and who will guarantee that the deceased’s inheritance is used only for the children or the long-term improvement of the widow’s

living situation. In this way, the families have insurance that their relative's property will not be lost through the widow's death but rather will be managed in their own interests and/or for the benefit of the children of their deceased relative.

It would now be too narrow-minded however to attribute the maintenance of kinship relations exclusively to the respective material interests of the participants. Aside from emotional bonds, which despite all conflicts usually remain a feature of relationships between patrilineages and widows, the necessity for kinship continuity accords with ritual requirements that must be fulfilled following the death of a relative. Understanding the connection that many Luo make between AIDS illnesses and the breaking of taboos helps to make this clear.

Impurity and danger: ritual widow cleansing

As in other regions of southeastern Africa, the Luo in Mara have clearly defined regulations and prescriptions based on concepts of purity and danger that are a reflection of social order (Douglas, 1966) and that involve strict rules on how, between whom, and in which periods of time sexual intercourse is allowed or prescribed (Heald, 1995). While in most other parts of southern and East Africa these rules refer to a few clearly limited periods, such as during pregnancy or while a mother is nursing, the Luo have extended these rules to numerous areas of their social and reproductive life, such as relating to agricultural work, house building, and 'more critical' periods of life, such as following the death of a relative (Parkin, 1978). Most of these regulations follow the principle of seniority, which generally rules relationships within Luo lineages. In the case of agriculture, for example, the Luo prescribe that a compound owner must have sexual intercourse with his first wife before he can begin a new phase of fieldwork (e.g. sowing seed or harvesting).¹³ Only then can the married sons, in order according to age, have sexual relations with their wives and finally begin their own farming work. The observation of such rules of order is of fundamental significance since they consider that non-observance will bring with it an illness called *chira*, which will be fatal if not treated with traditional medicine.

With the advent of AIDS there has been a resurgence of interest in *chira* because AIDS illnesses are often ascribed to the non-observance of ritual prescriptions (Hammer, 1999; Dilger, 2005; Geissler & Prince, 2005). As Mogensen (1995) has analogously described for *kahungo* in Zambia, this interest is explained in that *chira* is very similar to HIV and AIDS in its contagiousness and symptoms: *chira* makes itself felt through diarrhea and slow weight loss. Furthermore, it affects men and women who have not behaved according to relevant regulations and prohibitions, and, depending on the severity of their violation, it may affect their children, spouses or extramarital sexual partners. Finally, *chira* raises moral issues that have become critical to Luo families with regard to AIDS. Illness from AIDS marks a breakdown in sexual and reproductive relationships, and is associated with a general depravity and immoral modern society. Thus it is comprehensible that death from AIDS demands a revision of sexuality, which

with recourse to *chira* finds a locally embodied and above all, significant equivalent.

According to my Luo informants, men and women in Mara may be affected by different types of *chira*. While the non-observance of regulations concerning house construction or farming can be relatively easily healed through traditional medicine (Dholuo: *manyasi*), the non-observance of prohibitory precepts applying to burials or periods of mourning results in an often fatal *chira*. Furthermore, since in many regions of East Africa the death of a relative is considered contagious (Whyte, 1990), the impurity of close relatives and, above all, spouses of the deceased person can be carried over to others through sexual acts. Consequently, before the spouse of a deceased person can resume her sexual and social life, she or he must be ritually cleansed through a sexual act. Only in this way is control over the fertility and sexuality of the lineage restored, and with it an elementary precondition for the continuity and success of the extended family in daily life (Whyte, 1990).

In the context of AIDS, widow cleansing,¹⁴ which is most frequently carried out by a distant relative (*mrithi*),¹⁵ was also problematised by my interviewees in Mara. In particular, the wives of men who perform the ritual sexual acts fear a possible infection with HIV, and this often results in conflicts between widows and the wives who want to impede their husbands from performing such acts. Similarly, several older men I encountered called for the abandonment of the ritual and pleaded for the adoption of substitute acts, such as ones that are usually carried out for older women after menopause. Among other substitute acts, these men discussed the possibility for the *mrithi* to leave his coat in the widow's house and thus to symbolically claim his 'ownership' of the compound (Kiswahili: *mwenye nyumba*).

However, while the number of voices against widow cleansing through sexual relations is increasing in rural Mara, there has occurred among the Luo, in contrast to some regions in Zambia (see Malungo, 2001; Offe, 2004), neither the complete abandonment of the ritual nor any fundamental change in it. On the contrary, many families still consider it imperative that widows undergo sexual cleansing following the mourning period. One elder man described the dilemmas associated with the adoption of substitute acts, which arise particularly if a young widow continues to have 'illicit' sexual relationships after she has been cleansed "through words":

'You can do this only with elderly women. For instance, a relative of mine was cleansed not through sex, but through words several years ago. This cannot be done with young women, even if they agree to be cleansed in this way — but then they are having sex secretly, with a man from outside [of the lineage]. As a result she and her children may get chira. It is difficult to find an answer to this question....' (Male, age ~70; interview on 08/04/2000)

Young men in particular expressed their approval of the cleansing ritual, which does not mean that they saw no danger in its execution. Their concerns, however, had less to do with possible HIV infection than with the danger of the widow's impurity. According to many younger males

interviewed, the massive number of deaths from AIDS is leading to a situation in which people do not fulfill their ritual obligations or do not observe the required mourning periods. Consequently, widows, if several of their relatives die in a short period of time, can carry numerous taboos, which cannot all be broken by a single brother of the deceased. Especially because of this danger, many young men actively support the cleansing ritual, which in their opinion has an effect not only at the individual-familial level but also at the cultural level, by helping to establish order and avoid further affliction.

Younger widows themselves were only partially critical of ritual sexual relations. Many women were aware that in some cases men may have inhibitions concerning breaking their taboos. Widows also try to avoid conflicts with the wives of their *mrithi*, which can erupt from the ritual cleansing and sully their name or the name of their lineage. However, few widows I spoke with questioned the necessity of the ritual; on the contrary, many expressed fear that they and their children could get *chira* if they were not ritually cleansed. Some women felt it was gratifying if a man carried out the cleansing act and thus restored her honour. Especially if rumours circulated in the community that a widow was HIV infected, the ritual cleansing publicly proved that a man from her in-laws' family trusted in her health and that she — if she and her *mrithi* both stayed healthy over the course of time — clearly could not be infected with HIV. Most widows therefore took a very pragmatic approach to the act of ritual cleansing and tried to find a 'permanent' *mrithi* who would protect them from the dangers of *chira* and potential pollution and who could help them avoid repeated disputes with their late husband's lineage. This view was expressed most aptly by a 55-year-old widow who lost two daughters to AIDS illnesses:

*'According to Luo tradition every compound has to have a man. If I keep my mrithi as a husband, I avoid the trouble to look for a different man to perform the act with every time something happens.'*¹⁶ (Interview on 22/03/2000)

Ritual burial

Another aspect in the reordering of familial bonds is the execution of ritual treatments designated for an 'appropriate' burial. The performance of ritual burial ensures that the deceased's spirit will not seek revenge; especially in cases where relatives were denied solidarity and support during illness, the danger is high that the spirit of the dead will bring affliction to a compound through a curse (Dholuo: *chien*). In those cases, however, in which a deceased is shown the respect due to him or her and is properly buried, he or she is said to bless those remaining behind and to inhibit further misfortune.

The first matter that must be decided for proper burial is the burial place — a matter with far-reaching political and cultural implications, as the burial of the Luo lawyer SM Otieno in Kenya, who died in 1986, proved (Cohen & Atiene Odhiambo, 1992). Throughout the HIV/AIDS epidemic in Mara, many men and women have fallen ill and died in urban centres and have had to be returned at enormous expense to their rural homes. Nevertheless, even poor Luo

families usually spare no expense or pains to bury male relatives on their father's compound or, in the case of married women, on their husband's compound. Many of those I interviewed were aware that this expenditure was often out of proportion to that spent on care for the sick. An older Luo woman said, *'Our society loves corpses more than sick people.'* However, while a heated debate was occurring among the Kenyan Luo even before the outbreak of the AIDS epidemic, regarding whether or not it would be more sensible to bury relatives in the cities where they die (Goldenberg, 1982), families in Mara have developed other strategies to lower the costs of transporting corpses. One is to send sick relatives from the city back home to die since a bus or train ticket is far cheaper than transporting a corpse by airplane or a specially rented car. Those sick often protest because they are afraid of unhygienic conditions, inadequate care and deficient medical treatment in rural regions. However, in very few cases are people able to resist family pressure, particularly if in the urban centres they are dependent on familial care and are not able to pay for their own treatment. Subsequently, tragic scenes may occur, as when a severely emaciated relative steps off a bus in their home village — visible to all — dependent on their rural relatives for care and solidarity until their imminent death.

Before a relative's corpse can be buried, other ritual prescriptions must be observed. A young man and his wife usually belong to the husband's father's compound and will be buried there. Difficulties occur however if a man or a married woman's husband has already become engaged in the process of establishing his own compound in the village. This is especially problematic if a man has already received land from his father but has not completed the construction of his house there. Comparable difficulties arise if a man was assigned property in his home village but has also built a house in the city. In both cases, a provisory hut made of twigs must be built on the land of the deceased, in which the corpse must 'sleep' at least one night. This hut is called *akumba* in Dholuo — a noun derived from the verb *okumbore* for 'curved' or 'inclined', which refers to the construction of the hut (see Figure 1). The symbolic and physical unity between the deceased, his house, and the land that belongs to him and where he will be buried is restored only after the corpse has spent a night in the *akumba*.

The last step in ritual burial is the formal breakup of the burial ceremonies (Kiswahili: *kutawanyika*, meaning 'scatter', 'sow'). In contrast to the burial of a married man (see above), the burial of a married woman can be concluded only once her husband has dreamt of sex with his late wife. This dream indicates that the danger that comes from the deceased wife's spirit has been removed and that the husband can resume having sexual relations with another woman or, in the case of a polygamous marriage, with his other wives.

If the deceased wife had adult children, the man will share with his sons that he 'dreamt his dream' (Kiswahili: *nimeota ndoto*). Following this, the oldest son leaves the funeral together with his wife and carries out ritual sexual relations in his own house. Only then can the oldest daughter leave the place of burial, then the second-oldest son, the second-oldest daughter, etc. The ritual cleansing through sexual



Figure 1: View of an *akumba* in Mara region (photo: Hansjörg Dilger)

relations lifts the impurity of the oldest son or daughter upon the death of the mother and thus is the necessary precondition allowing the younger siblings to leave the funeral and resume their daily lives. Furthermore, through the ritual sequence the family members affirm their status within the lineage, which in the context of extended families concerns age and gender, and in the process they claim the inheritance due to them. Finally, the correct adherence to the ritual sequences grants protection from further affliction, since *chira* will strike those families who do not properly observe the prescribed age and gender hierarchies.

One difficulty arises today in the disbanding of funerals as a result of extended families rarely living together in one place. In one polygamous family I interviewed, first one of the grown daughters and shortly thereafter her mother died of AIDS (both had lived in Dar es Salaam temporarily and returned to their home village in the final stage of their illness). The impurity that resulted from the death of both relatives appeared to be very high, so the family placed great value upon the strict observation of the ritual order in the breakup of the funerals. Thus, once the oldest daughter of the family had returned to her residence in Dar es Salaam, she had to telephone her family with the message that she had arrived in her house and had had sexual intercourse with her husband. Only then could her younger siblings leave the funeral and resume sexual relations with their spouses.

Outlook: moral practice and vitality in the context of AIDS and globalisation

At the beginning of this article I argued that the HIV/AIDS pandemic may be understood as a consequence of processes of globalisation and modernisation, in that internationally and historically created social, economic and political conditions have prepared the groundwork for the virus to spread extensively. Simultaneously, however, AIDS acts as a kind of motor for globalisation since in the international fight against HIV/AIDS, strategies that are based on Western concepts of disease and disease prevention are imposed (often without modification) on Africa and other regions. Critics of modernisation have already expressed concern that with the increasing establishment of HIV/AIDS programmes, 'traditional' and 'community-related practices' in Africa will completely disappear and that "the social [will] dissolve into a hermetic system of medical programming" (Gronemeyer, 2002, p. 136).

My research in Tanzania provides evidence that families in Mara share the concerns expressed by globalisation's critics since HIV/AIDS for them has become a symbol of cultural alienation and a metaphor for modernity and its negative consequences (Dilger, 1999). Nevertheless, this article indicates that this fear addresses only half the process that characterises the responses of people in Mara to AIDS. While my interviewees had very detailed knowledge

regarding the biomedical information communicated by HIV/AIDS campaigns, the behaviour of individuals and groups in dealing with the condition was based less on this knowledge than on the state of familial and social relationships. At the interface between rural-urban migration, changing kinship relations, and the moral discourse on AIDS, a practice is emerging that connects the very different fates of HIV infected individuals and their families, the effects that countless AIDS illnesses and deaths are having and have had on the community. That is, the treatment of AIDS cases among people in Mara, as I have shown, is subject to a 'moral practice' that regards the illness as a consequence of individually and socially undesirable development and renegotiates the moral and social rules in the context of the crisis (Dilger, 2005).

Concern for the current state of social and cultural relationships among families in Mara is now not only a regional peculiarity but, in the era of AIDS, it also fits into a broader contestation of social and cultural relationships, as can also be observed in southern and Eastern Africa. The *dynamic* of this process can be described by the concept of "vitality" — a concept, as anthropologists Probst & Spittler (2004, p. 8) critically note, that marks above all an unexpected and astonishing difference, "a contrast to popular images and understandings of modernity and globalisation and the way these ideas are thought to change and have an effect upon the world we live in". The use of the concept of vitality in connection with AIDS may indeed be astonishing. After all, we associate catastrophic scenarios of economic and social breakdown and above all immense suffering with the AIDS "development crisis" (Fredland, 1998), associations that leave little room for the vitality for Africa predicted by academics. Still, I want to assert after close evaluation, it seems not misguided to apply this concept to the processes I have described: if one considers that although the AIDS pandemic involves the deaths of so many, *survival* is also at stake. Against this background, the vitality proclaimed for, above all, urban Africa, in relation to the processes of globalisation, becomes the basic condition for the continued existence of entire families and societies.

The processes that lead to maintenance and often modification of social and cultural relationships (through the activation of local resources) and that are simultaneously the central aspects of local responses to globalisation (namely resistance, creativity, revival, self-ascertainment, appropriation, and finally expansion) (Probst & Spittler, 2004, pp. 12–24) occur in at least three areas, addressed in this article and summarised in the sections below.

The realm of ritual

Ritual practice in sub-Saharan Africa is, as pointed out by Comaroff & Comaroff (1993), one of the central areas where life situations are transformed in the context of modernity and wherein a discussion regarding social transformation opens up. In the context of AIDS, this becomes especially clear with regard to the sexual cleansing of widows, which in many parts of Zambia, for example, now occurs through the substitution of nonsexual acts. Today, it is often enough if a widow or widower slides over the half-bare body of a man or woman; alternatively they can jump or slide over an outstretched cow and the animal subsequently becomes the

property of the person being ritually cleansed (Malungo, 2001). Among the Bemba, a string of pearls is wrapped around a widow's wrist by her in-laws; the widow is considered 'free' only when the string tears (Offe, 2004). As a whole, these alternative forms of widow cleansing, which have arisen or been reactivated in recent years and in which supra-regional influences are assimilated, are evidence of the strong capabilities for innovation by these traditional institutions (Malungo, 2001; Offe, 2004).

Yet, the outward change or substitution of ritual acts cannot constitute the only condition for describing a cultural practice as 'vital.' The mourning and funeral rituals of families in Mara are mostly associated with sexual acts, and their essential features have either remained the same or have been reinforced. In my opinion these can also be regarded as vital, insofar as the maintenance of social and cultural order is much more dominant in these rituals than are public health concerns. To dismiss this emphasis on ritual requirements as displaying ignorance with regard to 'medical facts' or as self-destructive and 'economically irrational' behaviours would imply that the public health or the economic policy paradigms are the only 'rational' ones, or that the ability to adapt to the conditions of modernity is defined solely by successfully implementing the guidelines of public health campaigns. Such a stance would also neglect the fact that a basic aim of the rituals surrounding death and burial is to reestablish control over life and death. Funeral rites are not only an expression of the pain a group feels over the loss of a relative or any other group member; they are also essential for reordering a group, as they ascribe anew the social roles previously fulfilled by the person who has died (Bloch & Parry, 1982). This is even more so if people have died of the consequences of a stigmatised disease such as AIDS, which can be characterised, in the sense of Bloch & Parry (1982, p. 15), as a "bad death" (see also Dilger, 2005, p. 143, and forthcoming a).

Local interpretations of illness, treatment and healing

In this sphere one can recognise a reciprocal fusion of medicine, morality and religion characteristic of southeast Africa. In the mingling of biomedical concepts with local conceptions of misfortune, questions about the 'how' as well as the 'why' of illness are addressed. Heald (2003, p. 228) emphasises the inseparable unity of these aspects in the treatment of illness: "The message... is not simply one about public health, it is also about politics and about the nature of the community. It is about the nature of belief, about the social conditions and practices which sustain and naturalise different worldviews."

The community-related and moral aspects of people's confrontation with AIDS appear especially obvious in the association of the illness with certain indigenous categories. In relation to witchcraft (Yamba, 1997; Ashforth, 2002), the breaking of taboos (Mogensen, 1995; Wolf, 2001), or the effects of spiritual and demonic powers (Dilger, forthcoming b), illness is usually traced back to the improper conduct of the ill person or perhaps to a careless relative. In other cases, it is ascribed to the mischievousness of fellow human beings or to invisible forces in a morally corrupt world. Either way, communities not only outline socially relevant models of conformity (the expression of which

addresses how individuals should have *ideally* behaved in relation to their family or other social unit), but, above all, these various interpretations of illness demonstrate a way of correcting improper conduct, ritually, through traditional medicine or through healing prayers, and thus represent a 'hope for healing'.

It remains to be seen whether these idioms of illness, treatment and healing will disappear completely through the introduction of ART; perhaps they will mix with other forms of religious or traditional healing, and in the process reveal to what extent the respective families/individuals perceive a conflict. Recent anthropological research on Uganda has shown that the dilemmas associated with the introduction of ART are likely to become the source of increased social and ethical tensions, because in families and communities where many members are HIV-infected and resources are limited, the decision must be made *who* will receive costly ART and *why* (Whyte, Whyte, Meinert & Kyaddondo, 2004).¹⁷ It is not difficult to imagine that these tensions may even increase if the introduction of ART is not accompanied by the establishment of an appropriate health infrastructure, which is itself necessary to prevent the introduction of ART from leading to heightened biological resistance against the medicines, and thus to an increase in deaths and suffering (Tawfik *et al.*, 2002).

The redefinition and emergence of communities of solidarity

Communities are responsible for the care of people with HIV/AIDS and other social groups affected by the epidemic. As in the Mara region, this process can be a gender- and age-specific one in which younger women especially, but also widows and children, tend to fall out of familial solidarity networks. Developments in this area take place within lineage networks themselves, where affirmation (i.e. emphasis on kinship belonging) stems from fulfilling ritual requirements as well as economic interests or emotional needs (as shown in the case of inheritance conflicts). On the other hand, my research in Tanzania has shown that in urban centres Pentecostal churches and NGOs, for instance, constitute centres where women (especially) can find social protection and safety. While many religious and nonreligious NGOs in Dar es Salaam have built their services for people with HIV/AIDS around the concept of 'living positively' (Bujra & Mokake, 2000; Dilger, 2001), Pentecostal churches have become attractive to their followers primarily because of their spiritual AIDS healings. Furthermore, several Pentecostal congregations have developed into informal networks of solidarity, which, similar to the home-based care programmes of NGOs, are responsible for the care and support of people in need, such as those affected by HIV/AIDS (see also Dilger, 2005, pp. 271–279, and forthcoming b; and for HIV/AIDS and acts of caring in an apostolic church in urban Botswana, see Klaitz, 2001). Finally, research in Zimbabwe and Malawi has shown that children can create support networks for child-headed households, which represents an alternative to the conventional forms of government and non-government forms of orphan care (Foster, Makufa, Drew & Kralovec, 1997; Wolf, 2004).

Taken together, the developments outlined here indicate

that breakdowns and social divisions taking place in the context of AIDS in Africa (and in the the context of the particular history of the continent) may meet with diverse responses from individuals, families and communities. The future of the epidemic will be influenced by *how* people interpret and deal with these breakdowns resulting from the epidemic, and *how* social and cultural relationships are reshaped as a result. Thus these developments — which can be extremely conflict-ridden and painful for those involved and which have to be situated in specific contexts of globalisation and modernity — merit closer attention by AIDS researchers and public health specialists in the future.

Notes

- ¹ According to UNAIDS/WHO (2005), in the United States and Western Europe, all persons in need of antiretroviral treatment today "have a reasonable chance of receiving it", while in sub-Saharan Africa only 1 million of 6 million people in need of ART in 2005 had access to life-prolonging drugs.
- ² See Kohlmorgen (2004) concerning the hierarchies and contradictions that characterise the relationships between actors in the international HIV/AIDS alliance.
- ³ It should be emphasised that the focus on security is not the only ideological and political framework that has shaped responses to HIV/AIDS over the last two decades. Among other issues, the epidemic has also been conceived as a development issue as well as a human rights issue (Ingenkamp, 2005).
- ⁴ From this perspective, it seems ironic that the World Bank today has become the main funder of HIV/AIDS prevention programmes. As Parker (2000, p. 44) writes, "much the same institutional constellation that gave us the policies of international debt in the 1970s, and structural adjustment in the 1980s, today leads the global fight against an epidemic that its own previous policies did so much to structure".
- ⁵ This connection also was made in the former Zaire, where as early as 1988 AIDS was called "*Salaire Insuffisant Depuis des Années*." This local interpretation of the acronym SIDA refers to the connection between internationally initiated structural adjustment programmes, increasing poverty, and the rise of the epidemic in the 1980s (Schoepf, 1998).
- ⁶ Due to the strong stigma associated with HIV/AIDS, and due to the fact that not all people with HIV are tested in hospitals or dispensaries, it was often difficult to know whether a person was actually HIV-infected or not. During my research, I relied less on medical test results than on the information provided by people with HIV/AIDS themselves and by their families, and also on rumours that circulated among the village population claiming that a certain person was HIV-positive. For a theoretical and methodological reflection on this aspect of my research, see Dilger, 2005, pp. 78–85, 309).
- ⁷ Speaking of the Luo in Mara region does not mean that life in northwestern Tanzania is not shaped by considerable social and economic differences and conflicts that are based on relationships of gender, age and socio-economic status. However, as my interviewees themselves referred to the "Luo ways of life" or to "Luo traditions" (Kiswahili: *mila ya wajaluo*) when explaining how individual and collective behaviours are shaped in the context of AIDS and modernity, I adopted this emic category for the analysis.
- ⁸ After the wedding a wife moves to the compound of her husband's patrilineal group.
- ⁹ See, for instance, the intriguing short stories of Agoro Anduru (1981 and 1982), an author from the Mara region who described the dangers and immoralities associated with urban life in

Tanzania in the 1970s and 1980s. Anduru lived in Dar es Salaam until his death in 1992.

- ¹⁰ It is difficult to state whether and in what way the migratory background of HIV-positive women and men has affected the quality of care and support through kinship networks in Mara. Given the fact that most people living with HIV whom I talked to in my research had left their home villages at some point of their life, differences in the quality of family care were based rather on sex, age, marital status, the number of (grown-up) children, and the quality of preceding family conflicts more than on the patient's history of migration as such (see Dilger, 2005, pp. 102 and 288). Furthermore, a deficiency of support and care for AIDS-sick relatives should not be blamed solely on the lack of family solidarity. The difficulty of caring for AIDS patients, who often are not even capable of washing themselves and may have open wounds or diarrhea, leads to increasing fatigue for mostly female caregivers who may have already cared for several family members before their deaths (UNAIDS, 2000). Additionally, certain weariness in the provision of care-giving is understandable if the sick, who have not themselves cared for their rural family members for years, return home and rather become an unexpected and hardly bearable strain to them.
- ¹¹ Appliances and machines for a hair salon that she and her husband had planned to open in Musoma.
- ¹² Decisions concerning the futures of widows and their children are mostly made in the context of lineage councils at burials. Access to these councils, and the right to speak in them, is restricted to elderly and/or married men in a lineage. Married women of any age are rarely admitted to these meetings.
- ¹³ These prescriptions relate only to agricultural products for which sowing and harvesting are closely connected to the rainy and dry seasons (e.g. corn and millet), and do not concern the staple cassava, which is continually worked in the field.
- ¹⁴ The cleansing of widowers is subject to different requirements (see the following section on burials).
- ¹⁵ *Mrithi*: in Kiswahili, a man (mostly a late husband's married lineage brother; see Potash, 1986, p. 61) who is chosen by a widow (often in agreement with her husband's lineage) to perform the acts of ritual cleansing. The *mrithi* is also expected to adopt economic and social responsibility for the children he may father with the widow (*levirate*).
- ¹⁶ For example, after burials or during farming periods.
- ¹⁷ Dilemmas concerning the distribution of ART will also be experienced at an international level. Barnett & Whiteside (2002, pp. 7–8) write, "With the development of antiretroviral therapies (ARTs), the epidemic defines who is saved...and who is left to die from the disease and its impacts. In its distribution across the continents and in relation to access to drugs that can save lives, it is a global epidemic that defines the excluded of the world — the wretched of the earth. Above all, HIV/AIDS defines those who can purchase well-being and those who cannot."

Acknowledgements — Earlier drafts were presented at the research colloquiums of the Humanities Collaborative Research Center of the University of Bayreuth; at the Institute for Ethnology, University of Cologne; at the Institute for South Asian Studies, University of Heidelberg; and at the Institute for Advanced Studies, Berlin. I want to thank the participants at those events for their constructive comments.

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