
“We Are All Going to Die”: Kinship, Belonging, and the Morality of HIV/AIDS-Related Illnesses and Deaths in Rural Tanzania

Hansjörg Dilger

University of Florida, Gainesville

Abstract

This article explores how moral perceptions of HIV/AIDS-related illness and death in rural Tanzania are related to social and cultural practices of disease interpretation, patient caring and burial in the context of rural-urban migration and HIV/AIDS. Drawing on anthropological discussions of the relationship between death, social reproduction, and HIV/AIDS I argue that moral discourses and practices surrounding the epidemic in Northwest Tanzania are intimately intertwined with local notions of order and disorder. Furthermore, they are tied to individual and collective concerns about the implications that the high numbers of premature deaths among young men and women are perceived to have on the continuity of whole families and communities. Focusing on the case studies of several young HIV-infected women and men who finally died from the consequences of AIDS I show that the infected persons themselves, as well as their relatives, draw on a wide range of—sometimes mutually contradictory—strategies in dealing with the disease in cultural, religious, or moral terms (including the reference to witchcraft or the violation of ritual prescriptions). In conclusion, I argue that the various strategies and practices surrounding HIV/AIDS-related illnesses and deaths have become an integral part of the

negotiation of kinship relations in rural Tanzania, as well as of the moral state of "modern" society in general. [Keywords: Tanzania, HIV/AIDS, family, migration, morality, death]

Young people, young people, commanders of Jesus, friends of Jesus,
soldiers of Jesus.

What's up today? We have this message for you: AIDS, AIDS, AIDS.

What are you doing? AIDS kills.

When you see [those people with AIDS]—

They lose weight, their shoulder bones stick out, their hair thins.

AIDS, AIDS, AIDS kills.

Cigarettes, cigarettes, cigarettes kill.

When you see them: smoke is streaming from their nose,

Like from a car going to Moshi.¹

Cosmetics kill: God has created us Africans with beautiful skin.

But we destroy this skin by using European cosmetics.

We behave like fake Europeans.

What kind of thoughts do you have in your mind?

Song sung by a Choir of the Seventh Day Adventist's Church
on World AIDS Day 1999 in Mara Region, Tanzania

While HIV infection rates in Tanzania have leveled off at 6.5% among the adult population (UNAIDS 2006: 506), individuals, families and communities in rural and urban areas continue to make sense of persistently high numbers of cases of illness and death among middle-aged women and men. Internationally driven prevention, care, and treatment programs have been established throughout the country that have enabled the population to gain a solid sense of the biomedical dimensions of HIV/AIDS. Tanzanians have also been heavily exposed to the anti-discriminatory messages of public health campaigns which emphasize that AIDS is a "normal disease" (*ugonjwa kawaida*) which can affect anyone irrespective of age, class or gender. In accordance with such campaigns, my informants in the Mara Region in Northwestern Tanzania claimed that ascribing a deeper moral significance to an HIV infection "would contribute to the stigmatization of HIV-infected people" and "should therefore be avoided." As our conversations proceeded, however, it became obvious that people in Mara *did* differentiate between HIV/AIDS and other (potentially deadly) diseases such

as malaria or tuberculosis; and that individuals, families and communities conceived of the spread of the disease and the suffering caused by the epidemic in predominantly social and moral terms.

Religious groups and leaders in sub-Saharan Africa have long interpreted the drastic consequences of the HIV/AIDS epidemic as divine punishment (cf., Gruénais 1999: 256–58; Smith 2004; Dilger 2007); with some of them seeing the disease as an “apocalyptic metaphor” (for similar perceptions in Northern America see Palmer 1997). Some communities have attributed individual cases of illness to witchcraft (Yamba 1997; Ashforth 2002) or the violation of a taboo (Mogensen 1995), thus relating experiences of pain and suffering to the alleged misbehavior of infected people or to others who are held responsible for bringing the affliction upon a family or individual. In my research area in Northwest Tanzania an equally elaborate moral discourse on HIV/AIDS has developed which thwarts the politically correct rhetoric that people have otherwise derived from the messages of public health campaigns. Some of my interviewees compared HIV/AIDS to leprosy, a “disease of the past” (*ugonjwa wa zamani*²) which was said “to have hit a family badly” (*imeshika watu vibaya*) since its presence suggested the possibility of witches or thieves in the affected person’s family. Others claimed that AIDS was a “bad disease” (*ugonjwa mbaya*) and a “punishment of God” (*adhabu ya Mungu*) who had become tired of “fornication” and “adultery” (*uasherati*) in contemporary society.³ Less radical views nevertheless entailed elaborate discourses relating the spread of HIV/AIDS to a present shaped by disorder and immoral behavior. Most of my interviewees—young, old, male, female, strictly religious or not—perceived AIDS as a metaphor for the moral breakdown of society, as a symptom of modernity perceived as “ill” (Dilger 1999, 2003: 32ff.). These discourses focused specifically on young women who had regular or temporary employment or who were engaged in small scale trading activities. This group of women was perceived as behaving like “prostitutes” (*malaya*) and therefore as responsible for the spread of HIV. As in the song quoted above, these women—“fake Europeans”—were described as being after men’s money and corrupted by their insatiable desire for Western cosmetics and beautiful clothes (Dilger 1999, 2003: 32ff.).

In this article, I explore how socio-moral discourses on HIV/AIDS, as well as people’s (gendered) conceptions of good and bad persons and behaviors, are related to ideas and practices surrounding HIV/AIDS-related illnesses and deaths. Drawing on the case studies of several young women and men

in the Northwestern Mara Region in rural Tanzania—who were all infected with HIV and some of whom have died from the consequences of AIDS⁴—I will show that they were subject to the same moral views and judgments by their families and communities as described above. While this contributed to the fact that some of them were stigmatized and rejected by some of their relatives, the infected persons themselves—often together with members of their nuclear family—were eager to prove to their extended family and to the local community that they were not “bad” but, on the contrary, “good” and moral persons. In some cases this was done by referring to a person’s religious integrity; in other cases people maintained that the disease in question was caused by witchcraft or the violation of ritual prescriptions, and that the illness was therefore not necessarily the fault of the affected person him- or herself (and, in the case of witchcraft or the violation of ritual prescriptions, that the disease in question could potentially be healed). In most cases discussions about the moral integrity of a person continued after his or her death, making it almost impossible to judge if a specific illness or deceased person was perceived as *either* “good” *or* “bad.” It was rather through the openness of such discourses and the fact that they remained ambiguous about the nature and quality of a specific illness that they became powerful forces in the negotiation of kinship relations in rural Mara, as well as of the moral state of modern Luo society in general. These discourses and practices can thus be understood as different strategies of the same spectrum for transforming the experiences of living with—and dying from—a stigmatized disease into a culturally and morally meaningful experience. Furthermore, they are part of a greater struggle to establish moral control over the immense suffering caused by HIV/AIDS, as well as over the threats to the cohesion of social and familial units brought upon by modernity and recent historical transformations.

In order to comprehend why my informants in Mara have classified HIV/AIDS as a “bad disease” and why experiences of illnesses and death from HIV/AIDS are subject to a wide range of social, cultural and moral practices in which belonging and continuity within kinship networks are negotiated, it will be valuable here to first examine the concepts of good vs. bad death as defined by Bloch and Parry (1982). I will argue that HIV/AIDS is seen as a “bad disease” not only due to its association with promiscuity and/or because death from AIDS is often particularly painful for individuals and their families (cf., Sontag 1989). The disease’s categorization as bad is also related to the implications that the series of prema-

ture deaths among young men and women in Mara is perceived to have for the continuity of whole families and lineages. After describing the social and moral context of HIV/AIDS in my rural research area in Northwestern Tanzania—which is essentially shaped by social and familial tensions resulting from processes of rural-urban migration—I will outline the different strategies people in Mara have developed to make sense of the suffering caused by the epidemic. In particular, I will describe how concepts and practices relating to HIV/AIDS-related illnesses (such as witchcraft or the violation of ritual prescriptions) as well as practices surrounding death—including burial speeches, the negotiation of the burial place and ritual practice at funerals—shape the ways in which people in Mara have come to deal with HIV/AIDS in their families and community. The conclusion summarizes how the socio-moral practice that has shaped the way people deal with cases of HIV/AIDS is related to broader questions of kinship continuity and belonging and to the ongoing struggle for social and moral order in an era of crisis and suffering.⁵

“We Are All Going to Die”: Death, Social Reproduction, and the HIV/AIDS Epidemic

Baba Ezron⁶: AIDS has become a severe threat. When I went to Kenya recently to attend the funeral of my niece, I saw beautiful compounds where [several members of the owner’s family] had died from AIDS. If you see these things you want to start crying.

Osiemo: Why?

Baba Ezron: AIDS is wiping us out. Even in our villages here, the situation is going to explode within the next three years or so. We are all going to die. AIDS is living here—here, in our villages near the lake. (Interview with Baba Ezron, m, ca. 75. 21st March 2000; my emphasis HD)

In their introduction to *Death and the Regeneration of Life* (1982), Maurice Bloch and Jonathan Parry emphasized that across cultures and throughout history mourning and funeral rites should be understood as a response to the challenge the death of a group member poses to the continuity, fertility, and cohesion of a group. The transition of a dead person from the world of the living to the world of the ancestors is understood in

many cultures as a liminal phase in which those who are unable to successfully conclude this transition pose a threat to the living (cf., Gennep 1960). If, for instance, mourners fail, deliberately or not, to fulfill the necessary ritual requirements for the dead group member's transition to the ancestors' realm the dead can seek revenge and bring suffering upon the community of the living. Thus, while in many cultures a first set of burial rites is preoccupied with the disposal of the corpse, a second phase of mourning and burial rites emphasizes the group's triumph over death and ascribes anew the social roles previously fulfilled by the deceased person (Bloch and Parry 1982: 4f.).

Three aspects are essential to this process. On the one hand, the order, which arises from mourning and death rites is not the *cause*, but rather the *product* of ritual activities. On the other hand, death and burial rites make clear that although death may lead to the pollution of close relatives—if not of a whole community—for many societies death is also a source of life (ibid.: 8): By removing the pollution from the living through elaborate ritual activities, communities and groups re-establish their control over the course of biological events. A third aspect deserves specific attention since it is closely connected to the (ultimately unachievable) reordering of life in the context of HIV/AIDS. Issues of maintaining control over death and dying are bound to a great extent to the cause of death and to the differentiation made between a good and bad death. In the case of a good death such as that resulting from old age, the regeneration of life is mostly unproblematic. A bad death, on the contrary, can threaten the social order of the living to a much greater extent.

Suicide is the most obvious example of a bad death amounting to the negation and rejection of the social order *per se*. However, while my informants in Tanzania themselves would have abstained from classifying a death from AIDS as a "bad death" (*kifo kibaya*), Bloch and Parry's definition (1982: 15ff.) also helps to elucidate their actual categorization of HIV/AIDS as a "bad *disease*." The HIV/AIDS epidemic pollutes not only the individual bodies of relatives and uncountable community members through a deadly and stigmatized disease. HIV/AIDS in sub-Saharan Africa also affects most heavily the economically and socially most productive middle generation, thus disrupting entire societies' and families' life cycles. In this regard, the alarming death rates endanger the generational continuity of lineages and whole communities, and present an enormous challenge to their reproductive capacities. AIDS is then understandably triggering elaborate discussions

of the deeper social and moral causes of the illness and suffering. It also brings into question the ritual and cultural practices necessary for any attempt directed at the reordering of social hierarchies and liabilities.

How deeply HIV/AIDS has affected concepts of life, death, and social reproduction in Tanzania has been described by Philip Setel. Setel (1999) shows how the Chagga in the Kilimanjaro Region relate the consequences of the HIV/AIDS epidemic to the wider historical, cultural, and demographic processes in the region and how these processes are further contextualized within a paradoxical modernity. At the centre of the Chagga discourse is the migration of young men from family compounds beginning in the mid 19th Century due to a growing scarcity of land and resources. Over the next 100-150 years, perceptions of mobility, individual success and social progress which were bound to the (self-)image of young, potent businessmen who had become the epitome of social mobility and development became essential to local perceptions of social and biological reproduction. In the context of HIV/AIDS, however, such ideas have been deeply affected and partially negated by experiences of death and suffering. The discourse has shifted to the social disruption and moral decay in which the behaviors of young traders and businesspeople are seen as the causes of a whole generation's suffering and death (Setel 1999).

The connection between AIDS and changes in local perceptions of social and biological reproduction is also addressed by Aldin Mutembei in his work on Western Tanzania (Mutembei 2001). Among the Haya, concepts of life/birth and death/dying are closely related to concepts of the social person who passes through various life stages and through a cycle of rituals that are part of the wider reproductive cycle and the flow of life in general. Strong emphasis is placed here on the fertility of men and women: Children ensure the economic and cultural survival of their lineage and its spiritual continuity since they are the prerequisites for their parents becoming ancestors. In the HIV/AIDS epidemic, this flow of life is disrupted because many young men and women die before they have married and/or given birth to children. In addition, ritual and social practices to be performed at different life stages in order to make a man or a woman a full social being (e.g., in relation to birth, marriage, and death) are disrupted. For the Haya, death from AIDS symbolizes therefore not only a disturbance of the social equilibrium, but even a "final death" and a "socio-cultural drama." When ritual requirements cannot be fulfilled and young people die without leaving children from "legitimate relationships," the

spiritual survival of whole lineages and even the continuity of the Haya as a group can no longer be guaranteed (Mutembei 2001: 108f.).

Among the Luo in the Mara Region, this sense of finality and the breakdown in reproductive processes in the context of HIV/AIDS is expressed, on the one hand, in apocalyptic and aesthetically powerful claims such as, "AIDS is wiping us out!" (*Ukimwi inatumaliza!*) or "We are all going to die!" (*Tutakufa wote!*). On the other hand, it is embedded in a moral discourse on migration, gender, kinship and social reproduction that existed even *before* the outbreak of HIV/AIDS and is now charged with new meanings in the context of death and suffering.

Mobility, Kinship and Gender: The Social and Moral Context of HIV/AIDS in Rural Mara

You—young people of today. You refuse to respect your elders. You want us elders to respect *you*—because you have *money*. It is true that you are more educated than we elders are. However, it is *me* who will teach you the things of the family—until the day I am going to die...(Kuria, f, approx. 70 years old. March 18, 1996; my emphasis)

The Tanzanian Luo represent—compared to the Luo in neighboring Kenya—only a minor ethnic group in the country.⁷ Most live from farming cassava and maize and from a growing fishing industry established on the shores of Lake Victoria in recent years. The small incomes of rural families are supplemented through cattle herding,⁸ poultry, small-scale businesses and trading activities (e.g. the sale of agricultural surpluses) and sometimes through jobs at local hospitals, dispensaries or in one of the local governmental or church offices. However, while most Luo families have become very creative in combining different sources of income, in most cases this mixture of money-earning activities does not provide a sufficient basis for paying school fees, treating diseases at local health institutions or at local healers, or for purchasing clothes or food which is not provided by individual agricultural activities. Thus, a lack of resources—which has been exacerbated by the effects of structural adjustment policies that placed the costs for healthcare and education largely on the shoulders of families and communities—have forced people to migrate to urban centers in search of jobs and material wealth.

Most families approve and support the younger generation's out-migration which, even before the onset of the "neoliberal era" (cf. Ferguson 2006), led young men and women to urban centers such as Mwanza or Arusha, and even to Dar es Salaam, more than 1000 kilometers away from Mara. For the extended families of migrating men and women there is reasonable hope that the money earned in the migration process will, in the long run, benefit those staying behind and succeeding generations. According to the values of reciprocity and egalitarianism—which represent the fundamental ideals of the Luo social order and which extend not only to partners in marriage, but also to nominal fathers, brothers and sons—the patrilineally and virilocally organized families expect that the fruits of labor and trading activities will be generously distributed among the relatives of migrants (cf. Butterman 1979: 64; Shipton 1989: 17). This generally accepted ideology applies not only to males of an extended family but also to young women, who—even after they have followed their husband to his household in the urban area—are expected to contribute to the income of their new families, as well as to the income of their families of origin.⁹

While there seems to be broad agreement over the mid- and long-term goals of the migration movement to urban centers—which ideally results in the re-settlement of the migrants and their families in the countryside—individual migration processes are also accompanied by regular complaints and growing tensions within nuclear and extended families. Similar to the Chagga (cf. Setel 1999), migration movements among people in Mara are embedded in a broader social discourse in which the benefits of migration are matched by dangers to the cohesion of social and familial units. Rural families are critical of relatives who have acquired some wealth in towns and forget about their rural families, refusing to give the latter their due share of what they have earned. The migrants themselves, on the other hand, complain that their rural families expect too much from them and that the demands they are confronted with from their parents, brothers, or uncles are often disproportionate. In general, deviant, i.e., selfish behavior, is met by moral condemnation—sometimes also by accusation of witchcraft directed predominantly at the migrants themselves, but in some cases also at rural family members suspected of being after the money of their more successful migrant relatives (cf. Geschiere 1997 on Cameroon).

In the era of HIV/AIDS, the discourse on the ambiguities of migration and on tensions resulting from social and spatial mobility has taken on a new quality. Thus, while even before the outbreak of HIV/AIDS, migrant

family members were accused of causing inner-familial conflicts,¹⁰ the tensions between migrants and their relatives have increased due to the disease. Migrants are suspiciously viewed as being at increased risk of HIV infections, and of transmitting the virus to sexual partners in the countryside during visits, on vacation, or on other occasions such as funerals or marriage festivities. Many HIV-infected migrants also return to their rural families at the final stage of their illness—placing increased financial and emotional burdens on their rural relatives who are unable to cope with the returning sick.

This moralistic and stigmatizing discourse on a polluted urban life, the loss of control over family members and HIV/AIDS, focuses particularly on young women. In light of HIV/AIDS, the growing involvement of women in business and trade activities has led, according to my informants, to a growing emphasis on economic transactions in sexual relationships, as well as an increased blurring of gender and generational hierarchies. A morally conservative discourse on sexuality and gender relations has evolved that encourages submissiveness and decency in the sexuality of women and emphasizes the importance of trust and moral integrity in the selection of sexual partners. Against this background, young women's "excessive desire" (*tamaa*) is, according to my informants, a metaphor for the moral dangers of a monetarized and individualistic modern society in which the dissolution of former social hierarchies based on gender and age has led to decreased control over family members and, at the same time, to increased sexual promiscuity and the spread of HIV (for a more detailed account of the blaming of women for the spread of HIV see Dilger 1999, 2003; for the Haya in Western Tanzania see Weiss 1993).

Morality and Exclusion in the Context of HIV/AIDS Illness

The moralistic and stigmatizing discourse on AIDS, the "bitterness of money" (cf. Shipton 1989), and the dangers of social and sexual mobility is not restricted to the discursive level but has very concrete effects on the ways in which families deal with HIV-infected and AIDS-sick relatives. Discourses on the allegedly uncontrolled and monetarised sexuality of migrants contribute, on the one hand, to the stigmatization of those whose lifestyles are said to have led to HIV infection and who depend on the solidarity of their rural relatives once they become sick.¹¹ In 1999/2000 there was a widely shared feeling among my informants that

those who knew about their HIV infection and yet continued to infect others should be excluded from public and social life. Many of my informants referred to the example of Leper villages in which Leper patients were settled in wide parts of Eastern and Southern Africa by colonial and post-colonial governments in the course of the 20th Century (Vaughan 1991: 77ff.). One farmer who, according to what I was told by other people in the village, was infected with HIV himself and whose wife died several months after our interview even argued that all AIDS patients should be isolated in camps and cared for by the government:

Osiemo: What should society do with those who spread HIV on purpose?

Samson: The government should build camps for all those found to be infected with the virus. This is the only way that people will start to be afraid of [having sexual relations] with them. *Inside* the camp they should be allowed to move around freely and to have sex. If, for instance, your wife tested HIV positive, you should be allowed to go with her.

Hansjörg: Don't you think that this would mean isolating people with HIV? Would you, for instance, agree that your relatives should be forced to live in a camp like this?

Samson: If someone tests positive and his wife does too, they should go. That is not isolating people—it is part of preventing the further spread of AIDS.

Hansjörg: What about you personally? Would you agree to live in such a camp if you were found to be HIV positive?

Samson: Yes, I would agree to go if the government provided food and medicine. I am not afraid. (Interview with Samson Mrungu, m, 38 years old. March 21, 2000; my emphasis)

On another level, the moral discourse on social mobility, gender and AIDS legitimizes the poor care that is, in some cases, provided to sick relatives in rural areas. As Thomas has written with regard to Namibia, caring may be a tiresome burden involving “preparing food and medicine, bathing the patient, cleaning sores, carrying immobile patients to the ‘toilet’ or to sit in the sun or shade, and washing soiled clothes and sheets. Such activities not only demand considerable physical effort, they require substantial periods of time away from livelihood and social activities that take place outside the courtyard” (2006: 3178).

In rural Mara, anger toward HIV infected relatives, who were blamed for having "invited" the disease with their careless and immoral lifestyles, were mixed with personal fears of HIV infection, as well as fatigue resulting from the difficulties of nursing and caring required by AIDS patients who could no longer wash themselves, often had diarrhea and/or open wounds. This exhaustion—experienced predominantly by female caregivers—was even stronger if HIV infected migrants, who had neglected their rural relatives over several years, returned to their home villages and became an unexpected and almost unbearable burden. It was also exacerbated by the fact that at the time of my research there existed neither governmental nor non-governmental support for the carers of AIDS patients in the villages—in contrast to other areas of Tanzania where home-based care organizations have been mushrooming from the mid- to late-1990s onwards.

The strains and tensions which characterized individual experiences of illness in the context of rural-urban kinship relations often led to severe ruptures between families and their sick relatives and could become a severe threat to familial relationships and cohesion. Thus, at the turn of the century there was a small but growing number of HIV infected young widows and unmarried young women in Mara who were suffering from the increasingly poor care they received from their husbands, their husbands' or their parental families and who, left to their own fate, died alone, with only minimal support from relatives or other community members. However, while experiences of suffering and lack of resources had become an integral part of the growing HIV/AIDS epidemic in 1999/2000, lineages and families were nonetheless struggling to counter such ruptures and to address the circumstances which were, according to their view, the underlying causes of the family's or individual's suffering. One expression of these endeavors were claims made by HIV infected persons or their families that a certain illness was not caused by HIV, but rather by witchcraft or the non-observance of ritual prescriptions.

AIDS, Witchcraft and *Chira*

If in 1999/2000 a man or woman in rural Mara fell sick and, despite efforts to treat him/her at local health institutions or by local healers, the person did not return to a state of health, families, neighbors, and often the sick persons themselves inevitably began to speculate that the illness might be caused by HIV. Such suspicions, which often became the basis for rumors

beyond kinship networks, were strongest if the person became thinner, started losing hair or displayed other physical symptoms associated with HIV/AIDS such as, *herpes zoster*, sudden fever or diarrhea. Suspicion was further strengthened if a man or woman allegedly led an immoral lifestyle, i.e., if he/she was having sexual relationships prior to or outside of marriage, living in town for some time, and particularly if he/she had earned money before falling sick. As one young man put it: “AIDS is killing only those who have money” (*Ukimwi inaua watu wenye pesa tu*).

While most people in Mara would have been convinced by a “social diagnosis” that attributed a specific illness episode to HIV/AIDS, this did not hinder people from speculating about other causes for an individual’s suffering.¹² Suspicions of witchcraft arose most often if a money-related quarrel or any other conflict arising from jealousy within a family or a lineage had occurred prior to the outbreak of illness. Joseph (m, 23), told the story of a man (A) who had been digging for diamonds in the mines of Arusha and who had fallen sick shortly after a dispute with a brother (B) from his patrilineal family. Preceding this dispute, (A) had asked (B) to build a house for him in his home village since he did not have the time to supervise the lengthy construction process, which required the continuous presence of a reliable person to oversee the expenditure of money and building materials. When (A) returned to Mara for a visit—expecting his house to be almost completed—he found that only a small section of the house had been built but all the money he had given to his brother had been spent. (A) accused (B) of stealing the money but the two men could not find a solution to the conflict and (A) returned to the mines.

Immediately after his return, (A) fell sick and, according to Joseph, was diagnosed with HIV at a local hospital in Arusha. The news rapidly reached (A’s) rural home. However, the people in his village, and particularly (A’s) family doubted the HIV-positive diagnosis. Some said that (B) was jealous of his brother and killed him by witchcraft; others, however, agreed with friends and relatives in Arusha, who had been close to (A) and said that he had died of AIDS: according to them, (A) had earned a lot of money working in the mines and had spent all of it for “prostitutes” (*malaya*). It was only “natural,” concluded Joseph and other villagers, that (A) had been struck by “this bad disease” (*ugonjwa mbaya huo*).

While witchcraft was often used by people in Mara to explain cases of illness, more often an HIV infection gave rise to speculations that the violation of ritual requirements in the infected person’s family had led to

his/her illness. As in many other societies of Southern and Eastern Africa (cf., Douglas 1966), people in Mara have maintained defined regulations and prescriptions which are a reflection of the social order and lead, if neglected or disobeyed, to illness in a family or even in the wider lineage. Most of these norms concern the regulation of sexuality and involve strict rules on *how*, between *whom*, and in which *periods of time* sexual intercourse is allowed or even prescribed, and in which cases the neglect of these regulations may cause illness (cf., Heald 1995). However, while in other parts of Southern and Eastern 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 other domains of their social and reproductive life (Parkin 1978: 151). Thus, detailed prescriptions and prohibitions not only refer to periods of menstruation, breastfeeding and pregnancy; but also to agricultural work, house-building, and the more critical periods of life such as, for instance, the death of a relative. In the case of farming activities, for instance, the owner of a compound is supposed to have sexual intercourse with his first wife before he can start harvesting or sowing.¹³ Only then should the grown-up sons—who are already married but have not founded their own compound—have intercourse with *their* wives and start farming. Obeying these regulations, which all follow the principle of seniority, is crucially important since carelessness and negligent behavior can cause *chira*, which, if not treated with traditional medicine (*manyasi*), leads to death.

The increased delocalization and weakening of kinship bonds resulting not only from rural-urban migration and the strains of economic hardship but also from the growing HIV/AIDS epidemic has led to the discourse on *chira* gaining in popularity (Hammer 1999; Geissler and Prince 2005; Dilger 2005, 2006).¹⁴ This has to do with the fact that—as Mogensen (1995) has argued for the analogous disease *kahungo* in Zambia—*chira* is very similar to AIDS with regard to its symptoms as well as the ways in which contamination is transmitted. *Chira* is a wasting disease that causes gradual weight-loss and diarrhea. Furthermore it affects not only those who have neglected ritual prescriptions, but sometimes their male children, their marriage partners or other extra-marital sexual partners. *Chira* is thus, similar to HIV/AIDS, an “infectious disease.” On the other hand, HIV infection marks, as argued above, a perceived disturbance in sexual and reproductive relationships and is at the same time associated with the moral decay of modern societies. In this regard,

the reference to *chira* represents a locally and culturally meaningful reply to the challenges of the HIV/AIDS epidemic and to modern life in general which requires the careful re-ordering of sexuality, fertility and the reproductive order at large.

“Hiding HIV/AIDS” or “Hiding *Chira*?”: The Masogo Family

During my research, discussions of *chira* most often referred to the failures of individuals and families to respect ritual prescriptions associated with agricultural or house-building activities. In one instance, I visited a compound where two sons in one family had recently died and where the widow of the elder son was apparently affected by some kind of wasting disease. The father of the two sons—Enosh Masogo (m, ca. 70)—was convinced that his sons had died of AIDS. He told me that his elder son had worked as a policeman in Southern Tanzania and had returned to his father’s compound shortly before his death. One of his son’s former girlfriends had previously been ill “with the same symptoms” and died. A doctor at the local hospital had furthermore informed Enosh about his sons’ HIV infection though, he emphasized, he had not passed on this information to his sons, his daughters-in-law, or other close relatives for fear of stigmatization and rejection.

For the two widows of the late sons, as well as for other family members of Enosh’s extended family, the case was not so simple. According to them, the death of the two young men had been caused by *chira*, which had affected the whole family because the building order on the compound had not been observed. While the owner of a compound and his wife/wives usually build their house(s) at the eastern end of the compound, the sons are supposed to build their “first” houses (*simba*) to the right and left of their father’s house in successive order according to age, with the result that the youngest are furthest from their father’s house, approaching the compound’s main entrance gate. In the case of Enosh Masogo, the building order had been followed when Enosh started building his compound in the 1970s. However, the land on which Enosh built had been allocated to him by the Ujamaa government and had previously belonged to his neighbor. After the government officially abandoned Ujamaa politics in the mid-1980s, the neighbor built a fence at the western border of Enosh’s compound, thus demarcating the borders of his compound. Since visitors could no longer enter Enosh’s compound from

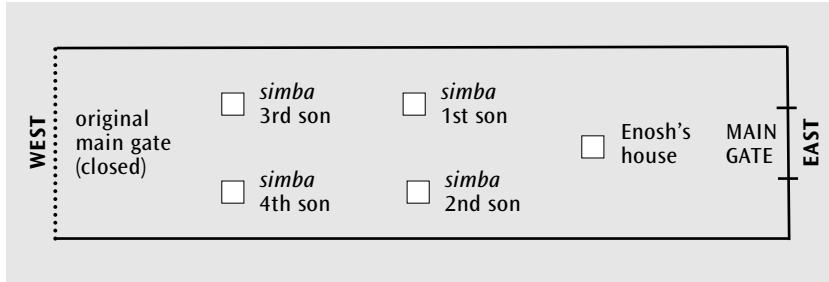


FIGURE 1: The building order on the compound of Enosh Masogo: when the original main gate in the West was closed and shifted to the East in the early 1990s, the sons of Enosh became the owners of the compound. This was also the time when *chira* started to affect the family.

the west, he had to shift his main-gate to the east. This was problematic insofar as his sons who had built at the western end were now in the position of “owners” of the compound because their houses were built opposite the main-gate. Thus, whenever Enosh had ritual intercourse with his wives, it was as if he performed the ritual act *before* his sons who were now positioned as the owners of the compound. According to the defendants of this version, this was a classical scenario in which *chira* entered a compound (see Figure 1).

While Enosh himself strictly rejected the version of *chira*—claiming that his relatives were only “ashamed” to admit the *real* cause of his sons’ and their wives’ illness—other family members and the two widows who, according to Enosh, were themselves infected with HIV, kept to it vehemently. They sought treatment for *chira* at various local healers and repeatedly accused Enosh of “hiding” the *true* cause of the afflictions that had struck the compound. If Enosh did not make any effort to re-establish the required building order, they claimed, e.g. by switching houses with one of his younger sons, all of his other sons together with their wives and possibly even their children would die from *chira*.

When I returned to Mara in 2003, Enosh was still skeptical about his family’s insistence that the series of deaths on his compound was caused by *chira*. However, when another of his sons started to display the typical symptoms of HIV/AIDS, he followed the advice of a local healer to rent a room for his son in the nearby semi-urban center. In this way, the healer claimed, the danger of contracting *chira* could be avoided.

Death, Burial and Ritual Practice

While conflicts between people with HIV/AIDS and their relatives—as well as within and between nuclear and extended families—often determined the experience of illness and dying from HIV/AIDS, once a person had died these tensions gave way to the endeavors of the surviving families to emphasize kinship ties and the belonging of the late relative to his or her respective kinship network. Thus, on the one hand, the conflicts that had preceded the death of a relative often became enmeshed in discussions on the place of burial, the buying of coffins etc. On the other hand, however, the mutual accusations that had shaped experiences of migration and the course of individual illness and dying were replaced by families' intensified attempts to reconstruct not only the moral integrity of the dead person, but also of the wider kinship network in general.¹⁵

This reconstruction¹⁶ took place, on the one hand, during burial ceremonies where any mention of HIV/AIDS, witchcraft or *chira* as the possible causes for a relative's or community member's death was suppressed and relegated to rumors and/or metaphorical allusions. Typical in this regard was the funeral of Dina Elam, the daughter-in-law of Enosh Masogo and the widow of his elder son. After my first visit in September 1999, Dina became very sick and rapidly lost weight. When I visited her again six months later, she lay in a dark room, on a mat on the floor, secluded from family life and with only minimal support from her late husband's family. Ten days later Dina died. At her burial, there was suppressed talk among the funeral guests that Dina had died from AIDS: the symptoms of her illness had been too obvious, along with the fact that her condition had not improved even after Dina had been treated with different types of traditional medicine. However, none of the funeral speeches recounting Dina's life and illness *explicitly* mentioned AIDS or any other *specific* type of disease leading to her death. Allusions were made to the fact that Dina “had been sick for a long time” (*ameugua muda mrefu*) and that “she had been bothered by different types of disease” (*amesumbuliwa na magonjwa mbalimbali*)—expressions which have become synonymous with the general conclusion that someone has died of AIDS, thus sparing close relatives the public “shame” (*aibu*) of the disease. Similarly, none of the funeral guests contradicted Dina's aunt (her father's sister), who had been one of the few people who had taken care of her sick niece. In her burial speech, Dina's aunt remembered how good Dina's “character” (*tabia*) was and how “faultless” (*bila kasoro*) her niece's lifestyle had been—*despite* the difficulties Dina

had experienced in her marriage. At the same time, Dina's aunt emphasized that God himself had taken her niece to "live in his house"—thus contradicting any potential objection which could have ascribed Dina's death to her "immoral" or "sinful" lifestyle:

Mama Ezron: Dina was a good child throughout her life; she had a good character, she loved her work and she was very clean (*msafi sana*). Throughout the time I spent with her I saw no mistakes in her behavior. [...] She *did* have difficulties in her marriage, however; she ran away [from her husband] and came to live with me for some time. After she had returned to her husband [in Central Tanzania], the trouble started again. Finally, Dina decided to study more and to take up classes at a college [for teachers]. However, she did not succeed at school because her health was not good. I want to thank God. Dina was bothered for a long time. But God has decided to separate her from us and from now on she will live in his house. (Burial speech of Mama Ezron, March 2000; my emphasis HD).

Apart from burial speeches, the moral integrity of dead persons and the net of kinship relations were (re-)constructed in a series of ritual actions governing "proper" burial. These burial efforts were essentially motivated by the concern that the dead could take revenge on their relatives if the ritual and social prescriptions were neglected. Particularly in those cases in which acts of solidarity and support had been denied to a dying relative, extended families often paid careful attention to ritual requirements, since only if the dead were properly buried would they bless those still living. When such (ritual) gestures of respect and reverence towards the dead were denied, however, the deceased's ghost could send a "curse" (Dholuo: *chien*; Kiswahili: *laana*) to his family's compound, which might cause further suffering among the late relative's family and descendants for an unknown period of time.¹⁷

The first decision to be made in the proper burial of dead relatives was *where* they were going to be buried—a question which may have serious political, cultural, and legal implications as the court case on the burial of S.M. Otieno in Kenya in the mid 1980s has shown (Cohen and Adhiambo 1992). In the era of AIDS, many young men and women become sick and die in far-away towns, but even poor Luo families undertook every (financial) effort to bury the corpses of their dead relatives at home, i.e. on

their own or their father's compound or, in the case of married women, on their husband's compound. Many of my informants were conscious of the fact that the money spent on the transport of a corpse from far-away cities to rural homes often exceeded the total sum spent for sick family members. One older Luo woman told me, "Our society loves corpses more than sick people." However, while there have been—even preceding HIV/AIDS (cf., Goldenberg 1982: 291f.)—heated discussions in Luo communities about the economic advantages of burying migrant family members in the towns where they passed away, most families have developed other strategies to reduce the costs for the transport of a corpse. Extended family members in towns sent their dying relatives home on the bus or train fare which was incomparably cheaper than airplane or hired car. The sick often strongly resisted this idea of going home as they feared the unhygienic conditions, the poor care, and the often inadequate medical treatment in the countryside. However, in most cases sick patients had to concede to the pressure of their rural and urban relatives—particularly if they depended on the care and support of their urban kin, who had provided the required money for medical treatment in private or public health institutions, or for the often costly services of urban healers.

Before the dead body of a relative could be buried, further ritual prescriptions had to be observed. Difficulties with the burial of a dead relative arose particularly in those cases where death had occurred at a stage when a young man—or in the case of a married woman, her husband—had not yet established his own compound. Among the Luo, a young man and his wife usually belong to the compound of the husband's father and are buried there. The situation is more problematic, however, if a young man has already started—but has not yet completed—to build a house on his *own* rural compound which has been allocated to him by his father. Similarly, there arose problems if a man owned his own piece of land in the countryside but had built a house in town. In both cases, a provisional hut had to be built on the land of the dead man where the corpse "slept" (*kulala*) for at least one night. This hut is called *akumba* in Dholuo—a noun which is derived from the verb *okumbore* (being inclined/being bent) and which refers to the way in which the hut is built (cf., Dilger 2005, 2006). Only after the corpse had slept for one night in the *akumba* was the unity between the dead person, his house, and the land to which he belonged established—symbolically as well as physically—and the corpse could be properly buried.

The last step to be observed in the ritual prescriptions associated with funerals was the "formal breakup" (Kiswahili: *kutawanyika* = to spread, to sow) of the funeral. If, for instance, a married woman had died, the funeral ended once her husband had dreamt that he had sex with his late wife. It was only then that the danger posed by the death of his wife was lifted and that he could have intercourse with another woman or, in the case of polygynous unions, with his other wife/wives. If the deceased woman had grown-up children, her husband had to announce to his sons that he had "already dreamt the dream" (*nimeota ndoto*). After that his oldest son left the burial together with his wife, and only after the couple had sexual intercourse in *their* house, could the eldest daughter leave the funeral, and after her the second-eldest son, then the second-eldest daughter, etc. This ritual cleansing through sexual intercourse—through which the impurity caused by the death of the mother was removed—was thus a necessary condition to be fulfilled before a younger brother or sister could leave the funeral and take up their individual lives again. On the other hand, the members of an extended family reassured themselves—through the performance of these ritual acts—of the status they were having within their lineage according to age and gender and, thus, with regard to their hereditary rights and the ritual obligations connected to this status. In the last instance, the ritual practice provided protection from further harm as *chira* could afflict the family if age and gender hierarchies were not observed in the required way.

One difficulty in the breaking up of funerals during my research was that large families often did not live in the same place. This problem arose among one of the polygynous families I interviewed, in which one of the grown daughters and shortly thereafter the mother—the first wife of the father—died of AIDS. Since the pollution resulting from the death of both women seemed strong, the family considered it crucially important to strictly observe the ritual succession in the ending of the burial ceremony. Thus the family's oldest daughter, upon arriving back at her residence in Dar es Salaam, had to telephone the message that she was in her house and had had sex with her husband. Only then could her younger siblings leave the funeral.

Conclusion

In response to the question about what they *knew* about HIV/AIDS most of my informants in Mara told me how HIV is transmitted, how to protect

oneself from infection, or how one should *supposedly* behave towards people with HIV/AIDS. However, while even before the introduction of antiretroviral treatment public health messages about HIV/AIDS were widely acknowledged among people in rural Mara, social and cultural practices surrounding episodes of HIV/AIDS-related illness and death were shaped less by information drawn from governmental or nongovernmental HIV/AIDS programs and much more by the shared sense that HIV/AIDS had become synonymous with a modernity that had mostly negative outcomes for familial, social and economic development, and the moral and reproductive order at large. At the turn of the century, for most of my informants death from AIDS meant not only the end of an individual life-course, but—because of the extent of dying and suffering—was increasingly connected to uncertainties about the future of whole families and communities.

The perceptions of AIDS as a metaphor for an immoral and dangerous modernity were reflected in the ways families and communities had come to cope with numerous cases of illness and death among relatives and community members. At the time of my research, dealing with the suffering of people with HIV/AIDS was shaped by a “moral practice” (Dilger 2005: 35–46), which aimed less at reducing the suffering and the pain of an individual person or of the individual body. This moral practice of illness was rather the embodiment of hopes and fears that people experienced in the face of a deadly and stigmatized disease, at the same time giving expression to values and ideas that emphasized the social relatedness of illness, i.e., its connectedness to other people and the wider social and cultural development of society. This moral practice enforced, as I have demonstrated with regard to the discourses on witchcraft, *chira* and the “deservedness” of HIV/AIDS illness, stigmatization, blame and tension within familial and larger social units. Equally, it could lead to tendencies among families and communities to exclude people with HIV/AIDS from social and public life. At the same time, however, the moral practice which surrounded cases of HIV/AIDS illness and death gave expression to families’ and individuals’ longing for continuity within kinship and other social units in the context of rural-urban migration. Thus, while people in Mara claimed that systems of reciprocity were not functioning “properly” in the context of migration and social mobility—and while there were multiple tensions between migrants and their families which could also lead to severe conflicts in the context of illness and dying—kinship

belonging was constructed and reconstructed throughout various stages of illness, dying and death by people's insistence on a culturally defined practice surrounding cases of HIV/AIDS-related illnesses and deaths.

This striving for continuity within a family was often strongest shortly before, or following the death of a person, when conflicts, which occurred throughout the course of the illness were set aside and nuclear and extended families invested everything to ensure the proper burial of their relative at home. These sometimes violently enforced kinship claims over the body of a relative did not necessarily represent a "lack of respect" for the self-determined death of the individual. Rather, burials in home villages, the uncountable graves in family compounds, and ritual burial practices were the manifestation of the striving of local families, in the face of a world that was said to be falling apart, to re-establish social relations and spiritual control over living and dying family members. This practice was (and is) part of an ongoing struggle for (an ultimately unattainable) social and moral order in which questions about the belonging of the individual to his or her family have become entangled not only with the identity and the destiny of whole lineages, but also with questions about Luo culture and identity at large.

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ENDNOTES

¹Town in Northern Tanzania. *Moshi* in Kiswahili means "smoke," "steam."

²My research interviews were all conducted in Tanzania's national language, Kiswahili.

³In recent years religious leaders and organizations have increasingly refrained from issuing stigmatizing statements concerning people with HIV/AIDS. However, a more "neutral" approach in dealing with the disease on the *organizational* level does not mean that religiously motivated notions of sinful and immoral behaviour do not continue to shape families' and individuals' actual views and practices surrounding HIV/AIDS-related illnesses and deaths.

⁴Due to the strong stigma associated with an HIV/AIDS diagnosis—and due to the fact that during the time of my research (1999/2000) not all people with HIV in Tanzania were test-

ed in hospitals or dispensaries—it is often difficult to state in hindsight whether a person was *really* infected with HIV or not. During my research I had to rely less on medical test results than on the information provided by people with HIV/AIDS themselves, by their families, and finally on rumours which circulated among the rural population claiming that a certain person was HIV positive. For a theoretical and methodological reflection on this aspect of my research see Dilger 2005: 78–85, 309ff., forthcoming.

⁵This article and its conclusions are based on research carried out in the Mara Region between 1999 and 2000. Previous fieldwork in the region (1995/96) focused on young people's moral perceptions of HIV/AIDS, as well as on intergenerational and gender relations within the context of modernity. Research conducted in 1999/2000 focused on the question how the numerous illnesses and deaths resulting from HIV/AIDS have affected ritual and social practice, e.g. with regard to widow cleansing and burial, as well as with reference to relationships of care and support for those sick and dying from AIDS. While free antiretroviral treatment was introduced in Tanzania starting in 2004, this paper will not be able to deal with the effects that the provision of ARV has had on socio-moral practice in the context of HIV/AIDS.

⁶The names of my interviewees and my research assistant (Osiero) have been changed throughout the text.

⁷While Luo speakers in Kenya represent 13.8% of the total Kenyan population, there are only about 280,000 Luo speakers in Tanzania which has a total population of 34.6 million people (www.ethnologue.com/show_language.asp?code=luo; 4th October 2007). Not all Luo living in Tanzania are proper Luo. In the mid 19th Century their ancestors migrated from today's western Kenya to the north western part of the Mara Region in Tanzania which borders on Lake Victoria in the west and Kenya in the north. The Suba and Kine groups—who settled in this region before the Luo—were assimilated by the Luo immigrants through marriage, but also as a consequence of violent disputes. Today, the descendants of the Suba and Kine consider themselves Luo and maintain that “the traditions of the Luo” (Kiswahili: *mila ya Wajaluo*) are the standards against which decisions at important stages of life (birth, marriage, house-building, funerals) are set.

⁸Cows are kept mainly for the payment of brideprice and for slaughtering at funerals; however, they are also kept as a reserve for times of crisis.

⁹Most women who chose to migrate do so because they have relatives in an urban centre or have a husband who has established himself (more or less successfully) in town. The migration of wives is often interrupted by their extended stays in the rural areas—depending on the social and economic conditions back home in their villages, and also on the number of children the migrating couple has. The situation of widows may look different, especially if widows have managed to inherit the property of their late husband which often includes a house that was built in the urban centre.

¹⁰See, for instance, the intriguing short stories of Agoro Anduru (1981, 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.

¹¹The practice of “returning home” in the case of serious illness is regarded with ambiguity by the HIV-infected migrants themselves (see below).

¹²This search for other causes of illness was encouraged by the fact that local health institutions often refused to inform an HIV positive person about his/her disease, thus leaving patients and their relatives in doubt about the nature of their own or their family member's illness. The repeated hospitalization of a man or woman entailed in most cases an HIV test, however this test was often secret and the results were, if at all, conveyed only to the patient's close relatives—often combined with the advice to remain silent about the diagnosis. Those patients who were informed of their diagnosis often

kept it a secret out of fear that they might be stigmatised and rejected by their families and by the community at large.

¹³These prescriptions apply only to agricultural products (e.g., maize or sorghum), whose sowing and harvesting are closely connected to periods of rain or dryness, but not to staple food such as cassava, which is continually, i.e. not only seasonally, worked in the fields.

¹⁴It is difficult to assess if and how discourses on witchcraft and *chira* in rural Mara have been reinforced due to the HIV/AIDS epidemic. There are no historical sources available for the Luo in Tanzania which discuss whether *chira* was a prominent issue before the outbreak of HIV/AIDS. For the Luo in Kenya, it has been stated that *chira* played a prominent role in urban contexts in the 1970s (Parkin 1978: 149–164); and that there has been a rising focus on *chira* in the context of HIV/AIDS in rural areas (Hammer 1999; Geissler and Prince 2005). Equally, my Luo informants in Tanzania claimed that *chira* has become more relevant with the onset of HIV/AIDS—a claim which is also underlined by the fact that during my research *chira* was seldom associated with cases of illness that were *not* similar to HIV/AIDS with regard to their physical symptoms.

¹⁵It might be argued that the ritual and cultural practices that I am describing below are part of *any* burial in the Mara Region and are therefore the usual way of way of emphasizing belonging and relatedness beyond death. However, if one has experienced how strongly conflicts and mutual accusations may shape the course of illness and the way people with HIV/AIDS are dying in rural areas, it is difficult to perceive the reconciling words of relatives at funerals—or the subsequent endeavors to provide a proper burial—*not* as a way of reconstructing kinship bonds or of re-establishing the moral integrity of the deceased.

¹⁶It is not possible here to describe in detail which ritual practices are required for a proper burial, nor to which practices have changed as a result of HIV/AIDS (for a good overview of funeral rituals among the Luo in Kenya see Goldenberg 1982: 282–291). In particular, I will not be able to discuss the ritual cleansing of a widow, which in rural Mara continues to be practiced and is an essential part of the renewal of life even in the context of HIV/AIDS (for a detailed presentation of the practice see Dilger 2005: 146–54, 2006). In general, it can be stated that burials have become shorter over the last ten years, lasting sometimes only a week instead of a month (as has been the case with the burial of an old man I attended in 1995) and with people complaining heavily about the series of funerals they have to attend in the context of AIDS.

¹⁷The danger was described as being especially high in the case of women or young girls, who were not married at the time of their death. If they were buried within their father's compound they could attract evil spirits and unleash infertility among their female relatives. For this reason, whenever possible unmarried women and girls were buried on the compound of their brother-in-law (i.e., the husband of a married sister), who provided the deceased with the status of a co-wife. On the liminal situation of (young) women in patrilineal kinship networks in Uganda, and the challenges this liminality entails for their burials in the time of AIDS, see Whyte 2005.

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