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Some Dilemmas of HIV/AIDS Prevention and Coping in a Zambia Village¹

Abstract

The paper examines the activities of researchers in a multidisciplinary HIV/AIDS prevention project in an African rural setting. Like most such projects on health promotion, it entailed trying to pass on superior knowledge on how to save people from dying of AIDS. It draws on an ethnography that spans over a decade of HIV/AIDS prevention in Zambia to show some of the problems inherent in applied projects that do not problematise the very idea of capacity building that aims to empower local people to deal with their own problems. It is argued that such researchers ought to reflect on questions such as what it entails to say that people cope (or are coping) with a given situation of stress and uncertainty; whether this means that such people draw from a range of resources to counter the impact of the situation, or simply drift along with the inevitable and are, thus, able to reduce the impact; and what kind of knowledge is internalisable so as to make its recipients think it prudent to act in accordance with its precepts. It is argued social scientists working with HIV/AIDS prevention ought to examine these kinds of underlying assumptions in their work, otherwise they end up creating increased uncertainty and leaving the people they study more vulnerable than before. Examples from the project are drawn to illustrate these issues, to conclude with some tentative points on why it is necessary to be modest about knowing what is best for others, particularly in HIV/AIDS prevention.

Preamble

I take as my point of departure two sets of issues that are intrinsic to the activities of social scientists involved in HIV/AIDS research and prevention. The first is: what does it entail to claim a superior knowledge that, if successfully transferred to and accepted by local people, will save them from dying of AIDS? The second one, a corollary of the first, is the further question: given that such knowledge exists, what is the distinctive essence that makes it internalisable so that the recipients of such knowledge would think it prudent to act in accordance with its precepts? Such questions lead to a further sub-set of related issues on what it means to say that a particular group of people are able to cope with their problems; and in what manner do social scientists

involved in applied research (that is, in effect, what we do when we become involved in AIDS prevention) contribute to making the people they study cope with the contingencies of everyday life. These are the kind of questions that I believe we ought to address before embarking on HIV/AIDS prevention. It is because we never explicitly examine such questions that we, at the end of the day, find that we have not achieved a great deal in our efforts. At worst, that we have contributed to heightening uncertainty in the lives of the people we study.

My paper is therefore both an accusation as well as a confession. I am one of those who wanted to do some good and must now cast a reflective look at the activities in which I was involved. I thus examine the well-meaning activities of a group of researchers involved in what was broadly termed 'a health promotion project' even though its ultimate objective was to reduce the spread of AIDS, and the unintended consequences of those activities that unambiguously led to the aggravation of the situation they sought to improve. I draw on more than a decade of HIV/AIDS research in Zambia where my colleagues and I have been working intermittently since 1990. I shall focus specifically on Chiawa, a village in Zambia where our project was based, discuss what we did as well as what propelled our efforts and, with the aid of hindsight, conclude with some general reflections pertinent to the broader theme of uncertainties of everyday life in contemporary Africa.

Capacity Building, Coping and All That

The specific perspective of our project crystallised after a series of workshops, during which we grappled with what would be the most appropriate and effective methods for studying sexual behaviour in Africa.² Influential scholars such as Caldwell and his associates (Caldwell et al. 1989) had, at the time, postulated the existence of a distinct African model of sexuality which was causally related to the rapid spread of HIV/AIDS on the continent, and a flurry of activity had arisen to find out how to change the risky behaviour that was to blame. We also saw our workshops as necessitated by previously bungled efforts to study African sexuality mainly through the use of questionnaires that tore sexuality from its social contexts, with many rapid appraisal methods and in the so-called KAP (Knowledge, Attitudes, and Practice), later KAPB (Knowledge Attitudes, Practice, Belief/Behaviour) studies (cf. Schoepf 2001:342), that assumed a rather simplistic notion on the nature of the relation between knowledge and practice. Most of these early studies of African culture and AIDS failed because many an African villager was unwilling to answer intimate and sometimes offensive questions about their sexual behaviour. Indeed, we used some of the questionnaires for our own exercises in our workshops. We subjected each other to questions such as: How many times did you have sex this past week? During your sexual act, where did your partner put his sexual organ?, and similar questions. We expected our colleagues to choose from a multiple range of answers on the modalities of their sexual act itself, as had

been the applied in the efforts to understand African sexuality (Schoepf 1991). The exercises brought home to us the absurdity and uselessness of such questionnaires. For an anthropologist, the problem was the fact that such questions tore sexuality from its embeddedness in wider sexual relations and put it under scrutiny. It is the removing of sexuality from its broader context that makes it lewd, vulgar and offensive. Brooke Schoepf is right when she observes:

Some early studies of culture and AIDS in Africa, undertaken at the behest of biomedical researchers, were less than competent. Novices to African studies produced rapid assessments and cobbled-together surveys. The worst literature searches tore bits of erotica from context [...] Sweeping statements were made about a special 'African sexuality' [...] (Schoepf 2001:340).

It was also partly in reaction to such claims that some Africanists felt they had to strike a blow for a more nuanced view of things (Ahlberg 1994; Heald 1995). Grappling with appropriate methodology to understand the sexual behaviour of Africans in three workshops led us to formulate our own specific approach to studying AIDS in Africa. We launched our project 'Community Capacity to Prevent, Manage and Survive AIDS'³ in early 1991. We thought of the project's name as significant because it conveyed a distinct perspective that was new at the time and, as it has turned out, far ahead of its time: the notion that local communities had an important role to play in combating HIV/AIDS, and that the contribution of local communities was a prerequisite to the sustainability of development projects in general. This is, of course, something no one would dispute today. However, in the early stages of the HIV/AIDS epidemic this was not the case. For example, one of the anonymous reviewers who scrutinised our project for SAREC, the potential funders for the project, wrote:

This reviewer is sceptical of the weight the project attributes to communities. Communities in Africa, which largely comprise people with low levels of literacy, can hardly be expected to play any significant role in an epidemic such as AIDS that is basically a medical problem.⁴

Our research team comprised a multidisciplinary mix of bio-medics and social scientists: medical doctors, nurses, anthropologists, sociologists, bringing together the combination of skills which we perceived as needed to combat the steadily growing number of infections. The cornerstone of AIDS prevention then, as now, was focused on specific issues such as how to bring about sexual behaviour change (conceived then as limiting numbers of sexual partners, and using condoms), treatment of secondary infections, and the counselling of persons affected by the epidemic. We realised from the beginning that for a multidisciplinary research team to function well, there must not be any hierarchy between the disciplines involved in the collaboration. The contribution of each discipline must be regarded as equally important for dealing with the problem at hand. But early in the course of our work, it was clear that the bio-medics saw themselves as the legitimate vanguard in the fight against the

epidemic. They exerted a predominance that was sanctioned by the international biomedical forces, the national governments, as well the local communities wherever they worked. Even if the absence of a cure for HIV/AIDS was later to draw attention to the need for input from other disciplines, and gave rise to a new discourse on the need for inter-sectorial strategies in prevention, the medical dominance in HIV/AIDS research has continued to this day (see Schoepf 2001). Anthropologists in the field of AIDS research often still find themselves struggling as no more than underlabourers to the bio-medical side of any purported team work. Apart from being sometimes licensed by society to deal with diseases, the training and specialisation of bio-medics enables them to make a more visible contribution in any interdisciplinary collaboration where AIDS is concerned. This is what occurred with our team. We, the social scientists, had nothing equivalent to offer. Unable to make such visible contributions to the people among whom we worked, we soon found ourselves frequently trying to legitimise our role in the interdisciplinary partnership. However, we were not swayed from the conviction that we too had a role to play. We tried to comply with the expectation that we would help design strategies for promoting sexual behaviour change, or that we would find out why people did not use their local clinics, for example. An important part of all this would be to first try to understand local constructions of sexuality and the people's aetiologies of disease transmission. Like our medical colleagues, our activities were, even if not as distinct as theirs, somehow predicated on the assumption that we too possessed some superior knowledge that would prevent people from getting infected with HIV/AIDS. This was the assumption that propelled our activities, and was given some legitimacy as local young men in the villages we worked began to demand condoms or ask our advice on some aspects of AIDS prevention. Nonetheless, there was a kind of crisis that hampered our efforts, which for lack of better terms, might be regarded as the crisis of legitimacy and creditability. There were no easy returns from the input of the social scientists, whereas the contributions of the bio-medical part of the team were frequently visible. The bio-medics could treat infections or dispense palliative drugs, whereas social scientists do not appear to make such visible contributions. The social scientists collected information, seemed to ask questions repeatedly, claiming that they were there to learn from the people – as well as to teach, perhaps. What rescues the social scientist in such situations of collaboration in health projects may well be their sustained presence in field research contexts. 'Being there' in itself is what serves, above all, to convince the local people that the social scientists are truly interested to learn about local life, and that they are committed to help find solutions to the problems, the reason for the existence of that particular project in their midst.

Although our project was concerned with the capacity of a community to cope, manage and survive AIDS, we never problematised the very notion of coping itself. We merely assumed the import of the concept as it was employing

in AIDS discourse, vaguely, perhaps, as how the people managed to go on living despite the horrendous havoc the epidemic was causing, the kind that must have led some writers to regard as an 'under-reaction to AIDS in sub-Saharan Africa' (Caldwell et al. 1992). Since we were working with people who were living with HIV/AIDS, we should have posed the question: what does it mean to say that people cope (or are coping) with situations of stress and uncertainty? Is the idea predicated on the presence of resources of some kind that people are able to draw on to counter the impact of the situation? Or does it mean that they simply drift along with what they perceive as inevitable, and are thereby able to reduce the impact? As I have already admitted above, we did not pose such questions.

My interest in these issues has germinated from more than a decade of work in the field of HIV/AIDS. Every once in a while my reflexive exercises shake me out of my reverie, and I am faced with the question: have I really made a difference with my activities? The truth is that I have come increasingly to doubt that my training as an anthropologist had equipped me with the tools to make a difference in HIV/AIDS prevention in Africa. For example, I had been trained to approach other cultures and ontologies as working alternatives to my own, not as things that I would try to change, even if they were to be perceived as cruel and inimical by some cross-cultural ethical standards. However, in working with applied issues, and specifically in HIV/AIDS prevention, what was often expected of me was being able to provide alternatives to others' ways of doing things; my own ways not only, presumably, deemed better than theirs but also as something that would also improve life for those I studied. Thus, I was expected to tell people that their practices of widow inheritance and polygyny, for example, were dangerous – they would do well to stick to one partner. The assumptions and premises that had guided their action through countless years of tradition were now dangerous and destructive. Yet the simplicity of the message made it unnecessary to convert it into an explanatory model that would make them see that it was the conjunction of some present historical factors that made their practice unhealthy. In a situation without AIDS, for example, their cultural practices would be safe and appropriate. But there was neither time nor reason to expand and explain such complicated factors. To be effective the messages I was made to pass on had to be simple and unambiguous: stick to one partner, do not inherit a widow, do not practise dry sex, etc. While not doubting the need for such unambiguous messages, doing so has bothered and continues to bother me. This is not merely because I perceived myself as sharing an identity with 'the natives', as it were, but because what I propagated as certain knowledge was neither certain nor complete; nor was it even a suitable alternative to that indigenous ones I sought to replace. These are, of course, issues that anthropologists, who have ever applied their disciplinary perspective to practical social problems, would have encountered and

often had to grapple with. They are important enough to warrant continuous introspection.

Promoting Coping Capacity and Preventing HIV/AIDS in Chiawa

One of the ways of empowering people in development research is to devise strategies that would enhance the capacity of local people to manage their own problems. Capacity building has thus become one of the most favoured phrases in development discourse; it also serves partly as one of the most important criteria for assessing projects in the development aid field. Building capacity cuts both ways: there is that of enhancing the partner organisations, mainly in the South, to deal with specific problems, and there is that of equipping institutions in donor countries with the expertise to deal with those kinds of problems. Thus, for example, our grant from SAREC came from a special fund that was earmarked for the promotion of excellence in HIV/AIDS research in Sweden, as well, of course, as in the partner countries in the South. Despite the conditions of this special fund, one unarticulated objective was the same as the one always present in development cooperation encounters between North and South: that of enhancing capacity in the South. Yet no one quite knows exactly what is meant by or how to measure 'capacity'. The important thing is that it is believed that we get value for money and achieve progress by enhancing the people we study. Enhanced capacity is also desirable, development agencies would assure you, because it is most likely to lead to sustainability; conceived as problem solving strategies that are most likely to remain even after the foreign aid workers have packed and left.⁵ In HIV/AIDS, research one way of building capacity was to help people to 'claim the disease as their own', in the words of one early proponent of the point of view (Chikankata Hospital Home Based Care Programme).⁶ Only when communities affected by AIDS acknowledge *ownership* of the epidemic, would they be likely to contribute seriously to solutions to manage and prevent its further spread.

Armed with similar assumptions, but certainly not in such clear terms, we descended into the village of Chiawa in 1990, to help the people fight HIV/AIDS, but presenting our efforts in terms of general health promotion.⁷

Chiawa is situated in the lower Zambezi valley, between the Mindwe Hills and the Kafue River. The inhabitants, who numbered around 8000 when we conducted household survey around 1992, were predominantly Shona-speaking who preferred the name *Goba* as the term for self-ascription (Bond and Wallman 1993). The Goba profess to be a matrilineal group with an uxori-local residential pattern (a post-marital residence in which a couple resides with the wife's family or kin). I stress *professed*, because the real situation was different. The household survey we conducted at the beginning of our research revealed not only a higher number of male-headed households, but a post-marriage residential pattern that was predominantly virilocal. Several factors may be seen as having contributed to this changing social structure.

Some were economic, others political at the core, but both kinds served to dilute some of the ideal models the people of Chiawa had about who they were. Already in the 1970s Lancaster (1974) noted this changing pattern that was incongruent with professed tradition. Later anthropologists (Leavey 1989:28; Bond 1993; Dover 1995) writing on the Goba, also dealt with the transformations in Goba residential pattern, showing, for example, how most young men in Chiawa strove to establish their own compounds, partly because they wanted to avoid economic reciprocity within a wide kin-group, and partly because they sought to be independent of their wives' kin groups.⁸

Chiawa was ruled by a charismatic Chieftainess, who never tired of extolling her plans to carry her people into the twentieth century. She would explain that while the rest of the world was moving into the twenty-first century her area was still, in her own words, 'backward and primitive'. Thus she had been instrumental in bringing some international development aid projects to Chiawa. A European Union project was already on the verge of eradicating the tsetse fly, a Japanese company had recently dug boreholes in some of the villages that provided most villages with safe drinking water; and now, of course, was there was the Swedish HIV/AIDS prevention team.

The main economic activity in the area was subsistence farming augmented with fishing and poaching. Many of the villagers also had riverside gardens which provided them with extra food while they awaited the harvest of maize, the main staple, *nshima* (a kind of porridge that is eaten with stew). Recurrent droughts in the past decade had made such subsidiary economic activity imperative. Occasionally, during serious periods of drought, the government stepped in with food distribution in so-called 'work for food' projects, in which households contributed their labour such as repairing roads for rations of maize flour. Some young people were employed on a nearby commercial farm (Bond et al. 1993).

When we began to work in Chiawa in 1991, the people had recently returned to their homes, having been evacuated during the Zimbabwe liberation war in the 1970s. The people were only allowed to return in the mid-1980s when peace had been achieved. The returning groups brought with them new kin constellations, spouses and affines who belonged to other ethnic groups such as Tonga and Korikori, who introduced elements of their own culture into the new local social organisation.

While traditionally the Goba of Chiawa had been sedentary and matrilineal, some of the post-evacuation groups were patrilineal and semi-nomadic. The introduction of cattle herding had become possible with the eradication of the tsetse fly, which somehow introduced a new kind of conflict into the social organisation of the new Chiawa: the usual one emerged from cleavage between the sedentary groups, in this case, the Goba, on the one hand, and the cattle herding groups such as the Tonga, on the other.

Chiawa as a Venue for HIV Prevention

Chiawa seemed a most appropriate venue for such a project on HIV/AIDS prevention. Situated in the Zambezi valley about 130 kilometres from the state capital of Lusaka, it was in fact still quite remote and very rural. Geographical proximity to the capital town of Lusaka did not necessarily mean closeness in terms of easy access. Even with the best four-wheel drive vehicles, it could take as long as four hours during the rainy seasons to reach Chiawa. A more relevant factor, from the point of view of HIV/AIDS, was the fact that Chiawa was also home to a large commercial farm that had begun to attract migrant workers from around the country, who numbered up to 3300 at the height of the agricultural season. A majority of these workers were young males. The workers lived in barrack-like structures, which lacked the most basic facilities, such as toilets and clean water, conditions that did not make cohabitation of spouses possible. It had at the time begun to be generally accepted that migration contributed to the spread of HIV/AIDS. We therefore hoped to observe some of the factors that fuelled the epidemic at close quarters (cf. Hunt 1989). For example, because the young men had a regular income, they were considered attractive as prospective husbands for the local girls. We watched the emergence of beer bars around the commercial farm. Local young women came to the bars to find husbands. But as most of the men had wives back home, all that the young women of Chiawa could find were occasional liaisons, which quite soon evolved into transactional sexual relationships. Our research activities included explicit efforts to teach people about STIs (sexually transmitted infections), community feedback exercises in which research findings were converted into drawings by a local artist, into graspable information which extracted much discussion from the people. We felt all along that our health promotion in Chiawa had made an impact. Yet it is now not at all certain that we had achieved much at the end of it all.

Ten years or so later these factors must be seen as having probably contributed to the present situation in Chiawa, where AIDS mortalities have increased sharply. Statistics from a village school in Chiawa for 2002 show that over thirty percent of the pupils in a school of 600 had lost a parent during the year.⁹ I have no statistics for the present HIV prevalence levels in Chiawa district although current World Health Organisation figures indicate a national level for Zambia of about 1,000,000 adults are infected, which is 21.5 percent of the adult population (WHO 2003). Local people, as well as the Ministry of Health in Zambia, generally acknowledge that the Chiawa area has some of the highest infection levels. Almost every week, deaths occurred of young men and women in their most productive years. Most households have to take care of children who have lost their parents to unknown diseases, most likely HIV/AIDS-related. The project folded in 1999, despite an effort to turn Chiawa in to a 'field laboratory' in which issues of health promotion could be studied in controlled settings. The researchers have packed their bags and left for home, to

become successful academics and renowned researchers in the field of HIV/AIDS. The project had in all produced five Ph.Ds, an equal number of MA degrees, and dozens of fine papers in academic journals, not to mention several Minor Field Studies by young students who attached themselves as journeymen to AIDS prevention specialists in rural Africa. The story of HIV prevention in Chiawa has still to be written; but despite the tone of this account all was perhaps not in vain.

One Conception and Practice of Applied Anthropology

I have, of course, described a context typical of many rural societies in Africa these days, with all the co-factors that sometime conjoin to make an African society vulnerable, not only to HIV/AIDS, but to other calamities as well. In Chiawa our attempts to get people to alter their behaviour started with an effort to make them realise that HIV/AIDS was their own problem and that only they could come up with strategies to deal with it. Two research assistants lived in the Chiawa, one conducting conventional anthropological fieldwork, the other a public health specialist, following up the objectives of the project. Their presence in the village and recurrent efforts by other members of the project to apply various interactive methods, which sought to actively involve the people in the ultimate task of prevention, made the people accept our project as different from those that descended upon them to collect survey data and disappear. For example, we employed and trained local people as interviewers, and we used focus group discussions to highlight the importance of AIDS as a common problem. We also involved them in how to improve health in the village in general. In all our activities, we always had the support of the Chieftainess Chiawa. Among the visible achievements we made in the course of our research were: carrying out what we termed 'community feedback' exercises in the form of mini seminars, where research findings were converted into easy-to-grasp pictorial representations and discussed; an increase in the demand for health information and condoms; and persistent questions about various health hazards that affected them. Another important indicator of enhanced capacity was that we successfully facilitated the process of an application by the people of Chiawa to the micro-projects' funds from the World Bank to reconstruct the local clinic. Further we were also able to secure a steady supply of essential drugs kits for the clinic. And, dubious though it might be, we did succeed in the course of the years to contribute to the high level of AIDS awareness in the area. We propagated VTC (Voluntary Test and Counselling) in accordance with the recommendations of UNAIDS (The Joint United Nations Programme on HIV/AIDS), although we were not convinced it did any good in a context where they were no support therapies for people who were tested. All they would know was that they would be dying of a frightful disease for which there was no cure. Nonetheless, for some time we could pride ourselves with saying we had achieved some degree of behavioural change, contributed to the ability of the

people to deal with their health problems – the primary reasons that had brought us to Chiawa.

But had we? One of the first indicators of enhanced capacity emerged in 1994, when after a series of community meetings the local Headmen of Chiawa sent for a witchfinder to come to help them uproot evil, with the consequence of sixteen villagers being accused of witchcraft and killed through poison ordeals in an effort to show they were innocent. I have recounted this sad episode in the history of Chiawa elsewhere (Yamba 1997). Here I wish only to highlight what may well be a paradox of information transfer in connection with HIV/AIDS prevention. We propagated the biological model of disease transmission and the importance of getting the local people to take their own problems into their own hands to do something about them. This should logically have led them to use condoms and/or to resort to changing their sexual behaviour. But enhanced capacity in this case meant turning to a witchfinder to help the people of Chiawa uproot evil, the manifestation of which was, for them, very visible in the sharp increase in HIV/AIDS infections and mortalities. Evil was not only evident in the increase in AIDS-related deaths, but in some recent misfortunes such as road accidents and attacks by man-eating crocodiles in the Zambezi. It could, of course, be validly argued that they had resorted to the witchfinder not because of enhanced capacity resulting from our work, albeit not the kind intended by us, but because they had always done so in the past.¹⁰ Such a contention, however, weakens when we consider the fact that the last time a witchfinder worked in Chiawa was in the early 1960s, despite the periodic occurrence of crises similar to the one that precipitated their requesting the services of another witchfinder. Moreover, the witchfinder of the 1960s was not invited after consultative community meetings. He was someone who was passing through the district, and was consulted as a witchfinder by many local people.¹¹

Capacity Building and Coping in Retrospect

It is now time to switch our gaze at the present, to cast a reflexive look at the consequences of our activities to improve life in Chiawa. The following is how the picture looks like as from the July 2002. According to the local people themselves – without any form of statistics or hard facts to legitimate their claim – Chiawa has had very high HIV/AIDS-related deaths in the past four years. Most households now contain either a person or persons living with HIV/AIDS. For instance, many have experienced HIV/AIDS-related deaths. In one of the schools where we once held community feedback exercises in our effort to share research findings with the local people, 33 percent of children in the school of 330 had lost a parent during the year 2002, most probably as a result of HIV/AIDS. The commercial farm that was the major source of livelihood for many young people and their dependents (even if as I have shown, it unwittingly could be seen as having contributed to the spread of AIDS), had

gone bankrupt. A new company had taken over the farm, promising initially to turn the Chiawa into the breadbasket of Zambia. News of the arrival of a vibrant new employer created a brief period of euphoria, heightened and affirmed by the new President of Zambia, who was present at the opening of the new farm. No sooner had the newspaper articles faded than the new owners of the farm sacked all but 120 workers. The farm clinic, which our project had been instrumental in establishing to offer health care to the workers, was closed. The migrant workers had left; what was the point in retaining the clinic?

But, more than that and worse than that, is the fact that the new owners of the farm are now attempting to evict about 200 households in villages that have existed since pre-colonial times. The new owners claim that they own the land and have thus the legitimate right to evict any persons found there. The villagers say they are on tribal land, with rights enshrined since time immemorial. Such rights, they claim, cannot be transformed into European systems of ownership. They then sought help from their Chieftainess who, to their utter despair, thinks the new owners are right. The villagers must vacate the land. They must obey the law, they were told. The villagers reminded their Chieftainess that it was her duty to uphold the traditional law that makes the sale of tribal land illegal. The Chieftainess was particularly incensed by the fact that the villagers are led by a young man whose party label is UNIP (United National Independence Party), and not MMD (Movement for Multi-Party Democracy) to which she belongs.¹²

To compound matters, the people of Chiawa have had three successive years of drought. They now subsist on the distribution of food by the World Food Programme through a number of religious NGOs, some of whom demand 'food for work'. The 'food for work' system demands that each household contribute a number of able-bodied persons to work on some communal project, such as mixing concrete for some local buildings, or filling potholes so that tourist cars can reach the Zambezi safari lodges, where the rich visitors pay over a hundred and fifty US dollars a night to experience 'primitive Africa.' The problem is that there are many households in Chiawa which cannot send an able-bodied person to work for food for the household's members. Households consisting of aged and frail grandparents, who often also have orphans to care for, and households with persons incapacitated with AIDS or other illnesses, cannot send anyone to work for the day's ration. This idea of food for work is perhaps one of the most demeaning strategies ever employed to help people in need. It is certainly beneath the dignity of many of the people of Chiawa.¹³

That is the situation in Chiawa, today. To recapitulate, AIDS deaths are now occurring at an alarming speed in the area, and this suggests that the AIDS-related diseases must result from HIV infections that must have occurred around the time our HIV/AIDS prevention activities were regarded as being at their most successful stages – if indicators such as number of condoms

distributed and professed self reported reduction in number of sexual partners were anything to go by.

Concluding Points: Weaving Fragments into an Easy Whole

The story of Chiawa encapsulates what may well be the fate of many African communities, which occasionally encounter well-meaning busybodies, such as me, who think they can make a difference. But they quite often do not. They often expand the horizons of expectation and possibilities which remain at the end of the day illusive as ever. A proper ending to this paper, therefore, would have been a section entitled 'The trial of the development anthropologist': prosecuting as well as defending the legitimacy of activities of such a figure, with all the pros and cons of the necessity for such a person's work.¹⁴ The prosecuting attorney would be a development policy bureaucrat, while the presiding judge would be an epistemological neutralist, who would decide whether the consequence of the anthropologist's work does not in reality create situations where risk and uncertainties increase extensively. The anthropologist would, I should expect, claim that if such was the result of anthropology in development work, as exemplified with the case of Chiawa, then it must have been due to unintended consequences, rather than outcome of direct agency or intentions. We can only guess what the verdict would have been. I choose not to end with such a trial, but must content myself with number of points in an effort to give some semblance of coherence to this paper.

The Anthropologist in Development Research

From what I have said above, the role of the development anthropologist seems not only improbable but also logically impossible. One cannot hope to improve something, unless one's presumption is to replace it with another that is better or superior to what was there to replace.¹⁵ Furthermore, the anthropologist's training is not designed to embrace the kind of ethnocentrism entailed in replacing indigenous technologies, for example, or other cultural constructions that underpin the actions of the people studied. So, while I would imagine the development anthropologist as someone who unwittingly contributes to uncertainties in the lives of those she or he studies, the role of an anthropologist who approached social problems as a concerned advocate, would have been defensible, and certainly of greater use. In Chiawa, the sum of our activities must only have heightened the uncertainties that prevailed locally. Our attempts to change the sexual behaviour of the people, by imparting correct knowledge about the modes of transmission of sexually transmitted infections, only led to people embracing alternative aetiologies regarding the cause of HIV/AIDS. That was the principal reason why they invited a witchfinder to come to help them.

Local Disparities or Hegemonic Localisms

Concern with global forces and how they impinge on local situations often leads many social scientists to interest themselves in an asymmetrical encounter in which Africa is both exploited and its problems perpetuated. Such a perspective also leads us to juxtapose the global to the local, and even argue, on occasion, that this encounter is part of what creates uncertainty and aggravates the inability of local villagers, like the people of Chiawa, to control their lives (by this, read: a causal link between globalisation and modernisation, whatever the theoretical blueprints they conjure up, as well as, risk, uncertainties, witchcraft, etc, in Africa). But in resorting to this attractive but overworked dichotomy, I think we overlook what I want to term hegemonic localisms, which are operative in probably most local contexts in Africa. We need to scrutinise and analyse the disparities that exist locally. In Chiawa, hegemonic localism was evident in the contestation and struggles for control of resources by a segment of the population. On the one hand, there was the alliance of the Chieftainess – now obviously the ally of a white commercial farmer – and her sub-chiefs, and, on the other hand, the common villagers struggling to retain their right to remain in their villages. The former had the power, for example, to identify which households were ‘vulnerable’ and therefore deserved food aid. In such an environment, it hardly needs pointing out that there would be a tremendous increase in desolation and uncertainty. Each decision an individual makes in such an environment entails much risk, since it would be made under circumstances that are both hostile and constraining. Further, each decision involves risk of some kind irrespective of whether it is a calculated one, or one that we might regard as inevitable.

Applied anthropologists – particularly those working with AIDS prevention – also contribute to the heightening of uncertainties in local life because they begin by supplicating local hegemonic forces so as to legitimate their work and gain support for their activities. This is necessary partly because of the urgent nature of the problem at hand, which requires being able to get a foot in the door of the community as fast as possible. That is also what we did in Chiawa; our easy reception in the village was facilitated by the Chieftainess and her Headmen. Whenever we arrived in the village we first paid a courtesy visit to the Chieftainess Chiawa, or to the village Headmen. And yet, as I indicated, she and the Headmen epitomised those who exploited others.

The Chieftainess and her Headmen are regarded locally as having more in common with the *musungus*, Europeans, than with ordinary Chiawa people. It is to the Europeans she had given – some claim sold – tribal land. A local expression often employed to describe this category of people regarded as exploiters was ‘they do not live like people’. Informants describe ‘those who do not live like [the common] people’ as those who have turned their backs on tradition. They would not contribute to funerals or feel compelled to practise local rituals like ordinary people.

That a traditional leader should have been described in this manner is very serious indeed. The anthropologist who works with HIV/AIDS prevention, with the connivance of such local rulers, is certainly guilty at least by association. There must be better ways to make a difference when one is applying one's academic training to the solving of social problems. The jury is still out, but it won't be long before the verdict comes in.

Notes

1. The paper was presented at the Arusha conference while I was a Research Fellow at the Nordic Africa Institute. It was revised after I left the Institute for Diakonhjemmet International College, Oslo, where I am currently based. I thank the participants from the conference in Arusha for many interesting and lively discussions, some which proved to be very important when I was revising the paper.
2. The pre-research workshops were sponsored by the ODA, UK (Overseas Development Agency) and Sida/SAREC (Swedish Agency for Research Co-operation with Developing Countries), Sweden. I recall the lively discussions between scholars and policy makers, such as Brooke G. Schoepf, Elisabeth Ngugi, Beth Maina Ahlberg, Virginia A. Bond, Eric van Praag, Katele Kalumba, and many others, who in their own way became prominent in the field of public health and HIV/AIDS work.
3. The project was funded by Sarec, Swedish Agency for Research Co-operation with Developing Countries, now SAREC and the research department of Sida, Swedish International Development Cooperation Agency. Sandra Wallman, Lisbeth Sachs and Katele Kalumba produced the methodological and theoretical framework of the project, while Ginny Bond, Paul Dover and Phillimon Ndubani, and many others too numerous to name, carried out the burden of field research. They all deserve my thanks for sharing the data with me; none of them is responsible for the interpretation I have made.
4. Feedback from one of the unconvinced reviewers of the project proposal (Wallman et al. 1990) that was passed on to us by SAREC.
5. We need not belabour this point, but it is perhaps necessary to point out that the discourse of capacity building and sustainability is one that runs across the documents and mission statements of most donors. This is true of Sweden, Canada, the Netherlands, and Norway, to name a few of the countries that belong to the group of Like-Minded Donors.
6. From an interview with Clement Chela, a medical doctor who was then Director of the Chikankata, Home Based Care Programme (See also Siankanga et al. 1991).
7. Thus, for example, our vehicle was labelled, 'IAS/UNZA and IHCAR Health Promotion project', IAS standing for the Institute of African Studies, University of Zambia, the present name for the famous Rhodes-Livingstone Institute, IHCAR, the Division of International Health, Karolinska Institutet.
8. Yet another factor may well be the fact that most men move to other parts of Zambia to look for work. Lancaster (1981), Leavey (1989), and Dover (1995) cover transformations in Goba residential patterns.

9. Data collected by Mr David Matesama, research assistant, Chiawa, Zambia.
10. This is the position of my colleague, Dr Solveig Freudenthal, Sida, Sweden.
11. I am grateful to Mr Peter Katiyo, Chief Advisor to Chieftainess Chiawa for this information.
12. UNIP was the party of Dr Kenneth Kaunda that led the country out of colonial rule, to be replaced by MMD, which holds power at present in Zambia.
13. I tried to point out the flaw in the system to the NGOs in charge of the food distribution. They said they had already anticipated the problem, and usually made the headman of each village identify 'vulnerable' households for assistance. Such households, they were proud to point out, did not need to provide labour for food. Unfortunately, some village Headmen see this as a way to get even with intractable and difficult members of their communities. At present, it is the two hundred households who are fighting eviction that are being punished in this manner. To get their share of food aid, they must obey their Chieftainess and leave their land.
14. This fanciful notion of putting the researcher on trial for the alleged consequence of her or his work is borrowed here from Professor Joseph Agassi, who turned one of his lectures on the philosophy of science into a trial of Paul Feyerabend. In his 'trial', Agassi was both the prosecuting attorney as well as the defender, and surprisingly does a brilliant job with both sides of the whole thing, so that, at the end of the 'trial', the student, and I should expect, the reader, too, is not quite sure whether to vote guilty or not guilty.
15. For some sophisticated views on these issues see Wallman (1985).

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