

Treating the Government Disease: AIDS Conspiracy Rumors, the Government of Malawi, and the Rhetoric of Accountability

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Introduction

In 2004, a young man named Mkhoma witnessed an argument between several men on a bus headed toward a northern lake district in Malawi. In his research journal Mkhoma described one of the disputants as a pessimist who said that scientists were in no rush to formulate a cure because, unlike victims of SARS and Ebola who died quickly, AIDS victims died slowly and could therefore contribute to the country's development before their deaths.

“Scientists are also benefiting from the disease AIDS.¹ You can see the mushrooming of AIDS organizations that only sensitize people to dangers of indulging in sex (unprotected) and other AIDS related things. Can you expect scientists to come up with medicine for the so-called disease while they are benefiting from it?” asked the man as his friends answered No! in agreement.”

[Another] man came in with the news of ARVs [anti-retroviral drugs]. He said that scientists have brought medicine for AIDS. According to him he believed that ARVs do suppress the disease absolutely. (I knew that the man [didn't] know the actual use of ARVs that they only sustain the life of AIDS victims and not suppressing the disease absolutely). “Why do you criticize Government for not bringing medicine for AIDS. Look [at] ARVs—aren't they medicine for AIDS,” he quizzed.

His friends tried to tell him [the pessimist] the purpose of ARVs but to no avail. The man was so pessimistic and stubborn hence everything ended in suspense [because] the friends of his did not want wrangles because of the story. (Mkhoma, Journal, December 2004)²

Just as the Malawi's National AIDS Commission (NAC) began to vastly expand antiretroviral drug distribution, these men asked the questions that troubled many Malawians. How can you trust the government (or scientists with whom they are aligned) to provide a cure when they benefit from AIDS as part of a "booming industry"? What happens to donor funding if it is not used for treatment? Is the government living up to its responsibility to heal?

This article is an analysis of stories revolving around the treatment of AIDS in Malawi. More specifically, it examines rumors and conspiracy theories that seek to account for inadequate treatment of AIDS in an era of conspicuous donor largesse. The three conspiracy theories presented here are illustrative of Malawian beliefs about healing, antiretroviral drugs, government accountability, and a global health hierarchy. The upscaling of ARVs by the Government of Malawi (GOM) in 2004 and 2005 provides a focal point around which to situate the study of conspiracy theories. Conspiracy theories borrow from past collective narratives and experiences to account for complex, troubling phenomena and constitute a kind of folk theory that explains the way the world works. As theories based in observation and the authoritative weight of past traditional narratives of suspicion, conspiracy rumors often posit compelling interpretations of real events.

My qualitative research reveals that many Malawians looked upon the arrival of ARVs with cautious optimism. Yet persistent suspicions of government misspending, hypocrisy, and global inequalities undermine this tenuous trust. Conspiracy theories not only express mistrust but also constitute a call for a greater measure of healing and government accountability. They are an answer to the question: Why do you criticize the government for not bringing medicine for AIDS?

I begin by introducing key concepts in the study of conspiracy theory. Then I outline a pivotal moment for the treatment of people with AIDS (PWA) in Malawi: that is, the upscaling of antiretroviral medicines. Next I present three conspiracy theories. The first I call "ARVs are Only for the Rich People," the second is "The AIDS Industry," and the final I refer to as "The Two-Tier Drug System." Only for Rich People rumors prevailed before the advent of free ARVs and revolve around ARV drug availability to the poor and rural. This section highlights beliefs about local and global inequalities as well as beliefs about the efficacy of antiviral drugs. AIDS Industry rumors turn critical attention to institutional infrastructures built upon solving the problems associated with AIDS. The Two-Tier Drug System rumor states that antiretroviral medications provided by international donors and distributed by the government are second-rate drugs, inferior to those found in the developed world. The last section explores Malawian

calls for government accountability both before and after the arrival of free AIDS drugs.

Conspiracy Theory Scholarship

Conspiracy theory scholars describe conspiracy theories as historically contingent propositions formed in response to events or conditions that serve as explanations for disjunctures or gaps in information (Butt 2005; Fenster 1999; West and Sanders 2003; Keeley 1999; Briggs 2004). More specifically, conspiracy theories are a kind of rumor suggestive of a reality in which individuals or groups with extraordinary power operate in a secret manner to manipulate outcomes, especially in the realms of politics, public health, and the economy (see Ashforth 2005; Geschiere 1997; Comaroff and Comaroff 1993; Yamba 1997; Andersson 2002).

The use of the term “conspiracy theory” is somewhat controversial because its lay usage connotes narratives that are false or irrational in nature. In other words, it is a derogatory term used to discredit the validity of a certain narrative or proponents of certain narratives. Some scholars have suggested the use of the term “conspiracy thinking” (Zonis and Joseph 1994; Kitta 2011) to emphasize the fact that it is not inherent falsehood or irrational/pathological thinking that marks conspiracy thinking but instead certain generic features. My use of the terms “conspiracy theory” or “conspiracy narrative/rumor/story” are not meant to comment upon the truth value of these narratives but to convey their generic quality. Kitta, who analyzes narratives with strong conspiracy components related to vaccination campaigns in North America, cannily substitutes the problematic term “conspiracy theory” with “conspiracy narratives.” She further refers to the pattern of generic features of conspiracy narratives as “cognitive attributes” which she enumerates according to Campion-Vincent’s list of characteristics (Kitta 2011:82). Campion-Vincent’s list of attributes includes both generic features of the narratives (i.e. evil agent(s) conspire to direct/manipulate/control complex systems for their own ends in secret) and the grounds by which such narratives are deemed plausible in the communities in which they circulate (knowledge that conspiracies do sometimes happen and some authoritative or learned figures affirm the narratives) (Campion-Vincent 2005:104-105).

Indeed, folklorists like Véronique Campion-Vincent, Patricia Turner, Diane Goldstein, and Andrea Kitta have approached the study of conspiracy rumors by establishing the grounds of plausibility for conspiracy narratives. Plausibility here refers not to whether the events as described in a narrative are likely to have occurred but instead to the ways in which collective memory of rumors and past events set the

stage for the propagation of new conspiracy narratives. A similar conclusion has been reached by anthropologists and sociologists. For example Pamela Feldman-Savelsberg, Flavien Ndonko, and Song Yang in “How rumor begets rumor: collective memory, ethnic conflict, and reproductive rumors in Cameroon” (2005) analyze the recurrence of rumors about government-sponsored sterilizing plots and reveal how sociopolitical crises reawaken old suspicions and spur the circulation of conspiracy tales. Rumors that government health campaigns sought to sterilize women to control the population returned again and again: during the colonial period in Cameroon, in the 1980s during a regime change, and again during the neoliberal turn of the 1990s. The insecurity of each era has a hint of the familiar and frightening, leading those people who lived through earlier ages of insecurity to share the conspiracy rumors circulating in decades past with younger generations, thereby giving new life to the stories (Feldman-Savelsberg, Ndonko, and Yang 2005:141).

By investigating research on older health campaigns in Malawi I was able to come to similar conclusions. Earlier problematic health campaigns, differential treatment of blacks and whites, and the complex, opaque international sourcing of drugs in Malawi set the stage for the re-emergence and reconstruction of public health-related conspiracy rumors (Feldman-Savelsberg, Ndonko, and Schmidt-Ehry 2000; Feldman-Savelsberg, Ndonko, and Yang 2005; Kitta 2011). Scholars of health beliefs have shown that rumor can have a significant impact on public health campaigns, making it important to determine the conceptual grounds for the growth and dispersion of conspiracy narratives.

Conspiracies are attributed to marginal subgroups within a society and to powerful figures operating in secret (Campion-Vincent 2005). Bill Ellis’ examination of panics over Satanism in the late 20th century includes coverage of how long-circulating anti-Semitic rumors blaming Jews (marginalized within European communities) for a variety of social ills became combined with rumors about the Illuminati (who were said to be a powerful anti-Christian organization covertly advancing their members into powerful political and social positions to undermine Christendom) (Ellis 2000). Folklorists have thoroughly explored how ethnically, racially, regionally, and socioeconomically marginalized populations respond to their chronic disadvantage by constructing conspiracy rumors of threats to their well-being perpetrated by elites. These rumors account for their systematic marginalization (Turner 1993; Goldstein 2004; Campion-Vincent 2005). Whether it is the marginal or the elite who serve as subject to conspiracy rumors, Campion-Vincent suggests that conspiratorial

narratives are on the rise due to a “pervading sense of being surrounded by uncontrollable forces” (2005:109). Though Campion-Vincent writes this with reference to rumors in Europe, a similar sense of being in the sway of force invasive, invisible forces pervades the rumors Malawians tell about HIV/AIDS and ARVs.

Narrative Sources

Many of the stories presented in this article are drawn from writings of Malawians taking part in a qualitative research study commissioned by the Malawi Diffusion and Ideational Change Project (MDICP).³ MDICP, a longitudinal demographic and sociological survey-based project primarily aimed at capturing quantitative measures of beliefs, practices, and attitudes related to family planning, marriage, sex, and AIDS (1998-2010), was supplemented by a qualitative journal writing project. The qualitative project involved 22 Malawian locals who were hired to write up reports of conversations they heard in everyday life that broadly related to sex, marriage, and AIDS. The conversations take place in vernacular (Chichewa, Chiyao, Chitumbuka, etc.) and conversational reports are translated and written in English by journalers in small booklets used by school children in Malawi. Susan Watkins and Amy Kaler, who have written extensively on the benefits and limitations of this type of research, emphasize the richness of these texts in providing insights into topics not explicitly covered in surveys, capturing attitudes that may otherwise be tinged with survey response biases, and representing the conversational emergence and debate of ideas in everyday life (Watkins 2004:674-679; Kaler 2004). Over the years hundreds of journals have been collected and typed as part of MDICP, primarily from the southern district of Balaka. I have supplemented these journals with the collection of similar journals from the northern district of Rumphi and refer to all those who wrote reports as “journalers.”⁴ These journals feature gossip, rumor, and conspiracy theory in great abundance as people swing from talking about their own daily observations and experiences to combining their firsthand knowledge with reports from the media and their acquaintances.⁵ By searching through and studying these journals for references to treatment and ARVs in particular I was able to identify several stable themes and attitudes that were expressed with frequency. The excerpts presented here are identified by pseudonyms of the journalers and the dates.

The sets of rumors under consideration in this article question the lack of cure or adequate treatment for people living with AIDS despite the amount of money funneled into Malawi. Conspiracy theories perform “leaps of scale,” contextualizing unaccounted-for grievances

by projecting local suffering into a national and global context (Briggs 2004; see also Masquelier 2000; Butt 2005; Farmer 1992). In his analysis of conspiracy theories told among Amerindians of Venezuela during the cholera epidemic of the early 1990s, Charles Briggs found that such rumors constitute “back talk” against official discourses that blame the culture of the poor and politically unrepresented for their disproportionate morbidity and mortality. Similarly, Paul Farmer asserts that AIDS origin theories in Haiti and Africa turn blame back on rich nations as part of a global “geography of blame” (1992).

This article shows that conspiracy rumors and accusations can be about more than blame across borders and ethnic groups. This study explores the discursive path from a geography of blame to a rhetoric of accountability. I define the rhetoric of accountability as a type of popular discourse in which suspicion, blame, and finger-pointing is augmented by highly articulated calls for transparency, accountability, and positive interventions. While both traditions of blame and calls for accountability have deep roots in southern African cultures, this current post-colonial era of “transparent” multiparty democracies and civil societies (ushered in during the 1990s) has created a new charter and vocabulary for these complaints and demands. The limited availability of AIDS treatment became one area around which suspicions and demands coalesced.

Upscaling Antiretroviral Therapy

Antiretroviral drug therapy (ART) transformed the experience of AIDS in the developed world when introduced in 1996. With the combination therapy of three types of drugs, AIDS became a manageable chronic disease in rich nations. However, poor or middle-income nations bearing a greater disease burden have had less access to health-enhancing, life-prolonging pharmaceuticals. In 2001 the Government of Malawi reported, “[s]o far, little attention has been paid to care and treatment of HIV itself because of the enormous expense of antiretroviral drugs. Only about 100 persons out of 800,000 HIV-positive individuals receive antiretroviral therapy” (GOM June 2001:11). In 2003 the World Health Organization (WHO) launched its “3-by-5” initiative, the goal of which was to have three million eligible AIDS patients in poor nations taking ARVs by 2005.

Malawi’s application for funds from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) was approved, thereby establishing a major source of external funding for AIDS treatment. Following WHO Guidelines for drug therapy in “resource-poor” countries recommending simplified regimes and the use of generic drugs (Ministry of Health, Malawi 2003), Malawi developed a plan to

distribute free ARVs. In January 2004 only 4,000 people were receiving ART through public facilities. By September 2005 over 37,000 had started on a free antiviral medicine combination treatment in sixty facilities nationwide (Harries, Schouten, and Libamba 2006:1870).

“ARVs are Only for the Rich People” and Other Beliefs about ARVs

Before ARVs became widely available, Malawians were already talking about them. The inaccessibility of the drug and was uppermost on people’s minds.

One [man] said that the drugs are so expensive and are only for the rich people because they can afford to buy them every month because once you start taking it you have to make sure that you are taking it once every month and failing which then just know that you can’t stay longer before you die of it. (Bato, Journal, December 2003)

Helpful drugs existed, but they were not affordable for the average Malawian. Worse, the therapy requires adherents to take a daily dose for the rest of their lives, making treatment costs a constant burden rather than a one-time investment. Inequality in health care options, combined with the necessity of daily treatment, was enough to rouse suspicions of conspiracy. One man claimed that white countries had created the disease and now were making a profit by withholding a cure and in its place selling expensive drugs in need of constant replenishment. On the other hand, he said the poor African countries in which people could not afford the medications were decreasing in population due to AIDS-related deaths.

I think that if it was a heavy problem in the white countries they could have already found the cure for that disease at this point. And you can see that when they want to provide the life prolonging drugs they are selling them at a higher price so that it can be only bought by those people who are rich which means that there is no chance for the poor people to have something to help them try to overcome that disease... [I]f the life prolonging drug is going at more than MK10.000.00⁶ [per month] how much more money can be needed for the curing drug if they can find [one] and who can afford to buy that a curing drug among the poor people if it is already a problem for us to buy only the life prolonging drugs? (Geladi, Journal, December 2003)

In the above journal entry the inaccessibility of ARVs was framed as a deliberate act and linked to the popular understanding that white countries are determined to reduce the populations of African nations.

Since the advent of free antiretrovirals, a more hopeful tone has entered into conversations about treatment. Journaler Hastings Mkandawire noted a debate about the nature of ARVs that took place after a controversial church sermon. The preacher claimed that AIDS is a plague from God and this was the reason that there is been no cure for AIDS. Afterwards one congregation member responded in a conversation with friends with the statement below:

The truth is that [the] disease is not a punishment from God, this is just a disease like other diseases. Time will come when God will show somebody the real drug which will be going away with the disease. It was not easy for scientist to come up with ARVs, I feel like that is a step forward in the search for the drug to cure the disease. (Mkandawire, Journal, April 2006)

ARVs are “a step forward,” a hopeful development that nonetheless entails inconveniences. A female journaler, Nyadambo,⁷ was chatting with two friends on the way to the market. They passed a young woman with a baby on her back and the two friends told Nyadambo that the child had AIDS and was on ARVs. Nyadambo was astonished and began to ask her friends about his treatment.

I [Nyadambo] asked, “What? ARVs? So you mean that the child will be taking these medicines till the end of his life since those ARVs they don’t stop taking. Each day you need to take a single tablet till the end of your life on earth.”

Then Nyaunthali said, “Sometimes you might become okay and stop taking those medicines and live longer with your healthy life.”

“But AIDS has no cure,” came in Nyakaonga, she further added [...] “You could stop [taking ARVs] to become sick time and again but the virus won’t come out of you.” (Lilyan Dambo, Journal, December 2005).

Malawians praise ARVs for their ability to maintain health and prolong life but caution that they do not cure absolutely. They must be taken every day and thus constantly remind the patient of the disease that lives in his or her body—the threat of a health decline always possible.

Some people registered concerns about the possibility that ARVs can mask illness; other worried what would happen to a person if they failed to take the medicines as prescribed. Despite these reservations

and others the introduction of ARVs has done much to raise the government's reputation as healers of the people. One man told me that the government is doing a good job in "sensitizing" people about AIDS and the need to be tested but more importantly in providing ARVs stating, "...otherwise getting tested for the sake of getting tested is meaningless...but getting tested and given ARVs—now this is very positive" (Dec. 2, 2005). It would seem that ARVs and the government's distribution of them have been positively received by some Malawians. These positive responses to ARVs should be understood with relation to a more negative rumor cycle—The AIDS Industry.

Rumors about the government's central role in a thriving AIDS Industry comprise a considerable part of the conspiracy theories told about AIDS both before and after the advent of ARVs. As the government seeks hegemony over healing in the AIDS epidemic, it constantly points out its own internal weaknesses, culpabilities, and responsibilities. The public perceives inconsistencies between government claims to have control over the situation with its failure to cure in the midst of unprecedented donor largesse.

The AIDS Industry

The AIDS Industry conspiracy theory cycle links together a variety of activities, organizations, individuals, and material resources, imagining a profit-seeking motive for each element. The AIDS Industry is characterized as an infrastructure of organizations mobilized for a multilateral response to the epidemic, universalized discourses established at institutional centers distant from Malawi. From these ideological metropolises come a flow of resources across and through a variegated organizational network that includes government ministries, the non-governmental organizations (NGOs), and community-based organizations (Altman 1999; Butt 2005; Pigg 2001). AIDS Industry activities, from education seminars to food and drug distribution, and industry participants, from a village health surveillance assistant to a secretary working at an anti-AIDS NGO, are subject to scrutiny and suspicion by Malawians.

From where I found them the other man was saying that AIDS has been recognized in Malawi twenty years ago and all these years a lot of donors and well wishing organisations have been pumping in billions and billions of Kwachas towards the disease to assist people who are already infected in different ways the government itself might think it's the best way to assist them. Now they have come these Antiretroviral drugs in short ARVs the government is again

selling them where do you think the huge amount of money different organisations gave the government in fight against this disease have gone?

The other person was just nodding his head in agreement to what his friend was saying. He continued saying we hear in the radios [and] television that the National AIDS Commission of Malawi has received such billions to help those who are infected but we don't even see any change as far as we see the patients. What they know is just using the money on their daily needs like going to Resort, Clubs, motels, Hotels etc with their families leaving the patients out there in agony. (Balalika, Journal, March 2005)

A rhetoric of accountability develops as a response to a “politics of the belly” (Bayart 1993) and displaces the discursive primacy of the “geography of blame” (Farmer 1992) at this stage of the epidemic. In the mid-1980s and early 1990s the epidemic was characterized by finger pointing among groups marked as different by nationality, ethnicity, and sexual orientation. A geography of blame held sway; when American scientists and the media talked about risk groups, Haitians, hemophiliacs, intravenous drug users, and homosexuals were their focus. Meanwhile, origin theories of the western biomedical community and media consistently pinpointed Africa as the source of the disease. Paul Farmer says the scapegoat narratives provoked the development of conspiracy theories, first in Haiti and later in African communities (Farmer 1992).

One major theory to come out of the fracas stated that AIDS was created purposefully by the U.S. military as a biological weapon. Renée Sabatier, author of *Blaming Others: Prejudice, Race, and Worldwide AIDS*, writes that assertions of the American origins of AIDS were appealing because pronouncements of African origins seemed to arise out of a racist determination to blame Africans (Sabatier 1988). Conspiracy theories implicating the global North in producing AIDS can thus be seen as a rhetorical counterattack (Farmer 1992).

But by the middle of the first decade of the 21st century some Malawians were impressed by efforts of non-governmental organizations and foreign aid, calling them “well wishers” and praising them for “pumping in billions and billions of kwachas towards the disease to assist people who are already infected.” The focus here is not on blaming the North but on holding the local government officials accountable for the use of donor funds. In the following journal entry, an old man explains to an audience of young men the way government officials draw donor funds into the country and then benefit from them.

And he [the old man] said that [in a] country like Malawi which depends on asking an assistance from other countries, it becomes rich when it gets supports/funds from other countries in terms of AIDS crisis ... by having the high report of people suffering from AIDS and the reports [are sent] to the donor countries and people, the rich people especially those in government and the Malawi leaders like the Presidents becomes richer and richer from the money they hide sent from donor countries to be used in caring the patient suffering AIDS. (Bato, Journal, March 18, 2004)

In this rumor, foreign agencies arouse less suspicion than domestic governing bodies; the national government is perceived as swallowing billions of kwacha and neither producing results nor publicly accounting for the use of the funds. More specifically, those in high positions in the government and people who are already rich seize and hoard AIDS donations. The speaker in the excerpt insinuates that government reports of Malawi's AIDS burden may be manipulated in ways to draw money from donors. The government is thus accused of manufacturing AIDS as a means for elite enrichment and participation in politics of the belly. Government has even been suspected of covertly gathering health information through unjustified routine blood tests or lying about the real reasons for blood tests at government clinics (Geladi, Journal, January 2003).

Not only is blood taken for reasons other than those explicitly expressed by health officers, but even the results of the blood tests are hidden from those who might benefit from knowing their HIV status. The benefits of the testing are all for the health officials. A journal writer described one man's reluctance to have an HIV test.

[T]he man who sat opposite us ... spoke very loudly and said: "*UNE AMWENE NGATENDA YELE!* (Yao) meaning: "I can't do that!" We laughed and then I asked him why? He begun saying that he can not do that because he knows that the government are recording rather keeps the records and names of the people who goes there to have their blood tested and they use the number of people plus names of them who were/ are found positive and be sending to other rich countries like America and other countries so that they may be sending assistance or rather any aid to them and just leaving you in frustrations and worries because you are found positive while they become rich in the name of the positive ones cheating the donor countries that they are assisting the patients suffering from Aids or people found

with the virus which causes Aids. We laughed and he continued saying that he can't do that that his name should give some people money and be rich while him becoming poorer and poorer and we were laughing. (Bato, Journal, December 2003)

In this estimation each datum representing an HIV positive individual corresponds to donor funds, yet persons represented by the datum are being cheated. The information they provide by giving blood becomes the means for elite or government consumption.

In the article "‘AIDS is Money’: How Donor Preferences Reconfigure Local Realities," Simon Morfit shows that "AIDS exceptionalism," that is the rigorous and sustained organizational focus and high levels of financial resources directed toward HIV/AIDS-related programming, has drawn non-governmental organizations to redefine their missions to include AIDS. Morfit says the salaries and benefits of being part of an AIDS NGO tend to be greater than for other agencies, thus feeding speculation that elites involved on the local level are merely feeding their own appetites and eschewing their mandate to heal (Morfit 2011).

The politics of the belly, or "extraversion," as described by Bayart, is a style of governance arising in the African post-independence states in which politicians aspire for positions in order to gain access to resources and influence for the purpose of hoarding and consuming at the expense of the poor meant to benefit. Wealth becomes concentrated in the hands of the ruling elite while impoverished communities wait for the benefits of foreign aid to reach them, and find themselves disappointed (Bayart 1993). The natural outgrowth of such conditions is the proliferation of conspiracy theories. Conspiracy rumors thrive when people suspect significant actions of powerful institutions are hidden from the public's view. Yet these days development community calls for transparency in the intertwined areas of governance and economics. "The notion of transparency similarly lies central to the everyday operation of myriad transnational institutions like the United Nations, the European Union, the World Bank, the World Trade Organization, the International Monetary Fund, and various nongovernmental organizations. ... A modern world must be a transparent world" (Sanders 2003:149). In Malawi the transparency gospel has found city dweller and villager alike fomenting an imperative for government action and accountability.

While the development agenda has given Malawians a new vocabulary for "good governance," in public health the mandate for government accountability in healing can be traced back more than a century. According to Ranger's study of nineteenth century chiefs,

prophets, and cult leaders, systems of governance and healing have long been intertwined in eastern and southern Africa (1992). Ranger quotes Feierman in saying, ““Authority for the control of health was in the hands of a set of leaders which included chiefs, healers and local patriarchs. These controlled the conditions of health in several different ways”” (1992:247-8). Broad public health measures included controlling deviance that threatened the health of the community, forcefully isolating the ill, and calling upon the advice of diviners to identify and eliminate witches. Chiefs and elders also provided for the health of the public by regulating land use for optimal output. With the help of specialists, they buried the dead, created irrigation systems, and organized communal rites. This broad concept of health and the government’s responsibility to provide for public health is echoed in calls for government responsibility in the AIDS crisis. In the public’s perspective the government has both the mandate as well as the resources to significantly reduce the impact of AIDS.

Malawian conspiracy discourses surrounding HIV and AIDS treatment may constitute what Diane Goldstein describes as “vernacular theory” which “provides an experientially based, alternative construction of illness which while subjugated in terms of medical authority, is likely to address the actual daily concerns, experiences and worldview of those coping with illness.” (Goldstein 2000:315) Although this definition of vernacular theory presupposes that the theory derives from those who physically suffer a disease, I argue that it can also be extended to communities suffering a disease together. During my fieldwork stints in Malawi it was common for AIDS educators in public health campaigns to remind the public that everyone in the country is either infected or affected by AIDS. People bear witness to AIDS victims, care for them, pay for their treatment, watch them die. In a country with a high HIV prevalence rate like Malawi, the vernacular theory represented by conspiracy narratives seeks to hold some agent(s) accountable for all the suffering they experience or bear witness to.

Billions and Billions of Kwacha

Malawian suspicions of government misspending and belly politics is promoted by frequent media coverage of donor giving. I submit several examples of such reporting that took place within a short span of time. Newspapers report on the amount of money that the government and NGOs receive due to the AIDS burden. A report on the ARV scaleup in the *Malawi News* included the estimated cost of the drug consignment:

The ARVs are part of the K1.4 billion worth consignment, which includes drugs for opportunistic

infections, gloves and CD4 count equipment.” National AIDS Commission (NAC) executive director Biswick Mwale said, “We expect 50, 000 people to be on ARVs by December this year.” (*Malawi News*, June 18-24, 2005)

Another newspaper article quoted the figure for funds donated to a Malawian family planning NGO called Banja La Mstogolo (BLM):

BLM Programme Director Walker Jiyan said this in an interview during the official launch of the NGO’s voluntary counselling and testing (VCT) centre in Nkhata Bay on Thursday. Japan International Cooperation Agency (Jica) funded the project to the tune of K38 million. (*The Daily Times*, July 4, 2005)

In an article titled “Clinton takes cheap drugs to African children,” *The Daily Times* reports on the munificence of former U.S. President Bill Clinton’s foundation:

The former president said in April his foundation would spend some \$10 million this year on treating 10,000 children afflicted by HIV/Aids in poor countries, particularly in rural Africa. “We hope to add another 50,000 children next year. We think that at the end of next year we will about 60 countries buying medicines through my contract and we are negotiating to try add more producers to it,” Clinton said on Sunday. (*The Daily Times*, July 19, 2005)

The fight against AIDS is linked to the conspicuous importation of money and distribution of resources to those who are involved in the industry from central government to district level participants. An article titled “Nac intensifies Aids fight” begins:

The National Aids Commission (Nac) on Friday presented 31 vehicles, 28 motor cycles, 28 computers and printers valued at almost K 107 million to all district assemblies in an effort to intensify the fight against HIV and Aids. (*The Nation*, Feb. 28, 2006)

Such reports, hailing the arrival and distribution of funds and medicine, could reasonably create an expectation of plenty. Yet reporting of supply chain problems along with lack of funds for medicine temper the optimism. In an article published in *Malawi News* on July 9, 2005, a government health official tells the reporter that Malawi will not be able to meet the WHO “3 by 5” target for a slew of reasons.

Makombe said Malawi has just received a consignment of drugs it ordered last December. “As at [*sic*] now, Malawi has distributed the drugs to 22,000 people which represents 14 percent of her target,” he said.

Health Minister Heatherwick Ntaba said Malawi is not the only country in southern Africa that has missed the 3 by 5 target.

“The major reason for this is lack of money for buying drugs. We budgeted drugs that would cater for 80,000 people using money from the global fund,” said Ntaba. Ntaba further said his ministry is mobilizing resources for training of personnel and procurement of more drugs (*Malawi News*, July 9, 2005).

In the face of reported donor generosity, the failure to meet the ARV distribution target appears strange. The numbers don’t add up. Why can’t billions of kwacha purchase enough drugs for 80,000 people? In conspiracy theories Malawians react against the apparent discrepancy between the money given and experience of healing on the ground. Because the course of donor funds is not transparent, Malawians look for signs of illicit, unnecessary, or conspicuous consumption. Some people say that the money is used for partying at hotels where AIDS conferences are held. When someone complained that his friend could not afford ARVs and was sent home, another man offered an explanation for the situation, linking a lack of treatment directly to misspent funds.

After that he continued on the very same issue that sometimes the responsible people under the Ministry of Health organize fake seminars intending to discuss about HIV/AIDS in different motels and clubs only to spend time there doing nonsense things like drinking beer and womanizing, that is not good at all. Now you are saying that your friend was sent back from the hospital where he went to buy the ARV drugs just because he had not enough money to meet the cost of the drugs, that was very unfair. He lamented. (Balalika, *Journal*, March 2005).

Even after the ARV scale up made the drugs more available, the hypocritical behavior of government officials and continuing inequality in health care access bear witness to the government’s consuming habits in the midst of a high AIDS death rate.

“[S]ometime[s] when you go to workshops you find— maybe there’s a workshop on way to Intensify the fight

against HIV/AIDS—the bosses would come to their rooms with prostitutes to warm their beds and you wonder if the pandemic would really end. I think most of the bosses know that AIDS is somehow good to have been here because it has provided jobs for those who are helping in the fight against. You can imagine one being paid half a million kwacha per month working with an organization which is there trying to eliminate AIDS! That's more like killing one's self. That's more like drying a well from where you depend on water.” Nyagondwe with her eyes sparkling with truths. (Botha, Journal, Dec 2, 2005)

The benefits of involvement in the AIDS Industry seems obvious to the Malawi public: access to workshops, salaries, motorcycles, bikes, computers, and trips to the city paid for on the NAC budget. The incentives for such AIDS Industry affiliates (either on the national, district, or village level) to truly exert themselves toward eradicating AIDS seems less obvious in a country of stark rural poverty.

AIDS Industry stories not only dwell upon consumption and failure to heal by “AIDS industrialists” but take the next logical step to suggest that a cure is available that AIDS industrialists are hiding from the public. With all the research conducted and all the money donated, it seems inconceivable that no cure has yet been found. Many marvel at the difference between the “nowadays disease” and diseases of the past, particularly STDs for which cures have been found. Rumor journalist Hastings Mkandawire of northern Malawi reported a conversation in which an elder man named Mr. Silungwe (whom he described as “educated”) claimed that there was local traditional healer who had a cure for AIDS. Some of those with whom Mr. Silungwe was speaking rejected his claim saying that it was a bad thing for traditional healers to provide false hope and take people's money. They insisted that if there was a cure or treatment beyond ARVs that the government would provide it and announced its availability through a media campaign. Mr. Silungwe disagreed saying that the government would not advertise the traditional cure for AIDS because the government (1) doesn't want to dry up their fund from rich countries and (2) they do not want people to have sex carelessly after hearing about a cure (Mkandawire, Journal, March 2006).

ARVs, as powerful as they are, are not a cure for AIDS. The government medicine has ultimately failed the mandate of the sacred leaders to heal the people. Schoffeleers argues that traditional healers such as Billy Chisupe (who in the mid-1990s claimed to have a cure for AIDS in the form of a red drink) rise in popularity because of the failure of the government to heal. The government's failure is attributed

in part to a loss of connection with sacred power, to which traditional healers claim to be linked. Sacred power is derived from ancestors and the spirits that rest in places. Malawi's modern leaders, however, gather foreign aid and take a biomedical approach to healing. Chisupe criticized the Ministry of Health, telling them that if they wanted to treat AIDS, they should "dig for medicine in the bush," that is, search for a cure in local resources of nature, healers, and ancestral spirits (Schoffeleers 1999:411).

The government's proffered treatment, ARVs, while not a cure is viewed as effective. Yet the long-anticipated arrival of the drugs in Malawi, as well as other "resource-poor" nations, was preceded by a debate by stakeholders over the feasibility of treating AIDS with antiviral medicines in poor countries (Harries, Schouten, and Libamba 2006; Creese et al. 2002). Did they have the infrastructure to deliver such drugs? Would funds be available to sustain the daily dosages for millions of AIDS sufferers? Would Africans really adhere to treatment regimes in such a way as to prevent the development of drug-resistant strains of HIV? The rhetoric of "medical futility," a discourse preoccupied with "sustainability" and "appropriate technologies" for poor countries (Farmer 1999:21) characterizes the debate taking place among public health researchers, policy makers, and drug companies. This rhetoric may help to explain emergence of the next rumor under consideration.

The Two-Tier Drug System

After interviews one January evening, Catherine (my research assistant) and I stopped by the market on the way home and came upon our next door neighbor, Mike. As we three walked toward home together, we spoke generally of the difficulties village women faced in marriage including AIDS. Mike said the disease is called "Matenda a boma,"⁸ because the disease has come from the government. When I mentioned that the government was now giving medicine he replied:

"You know they say there are two kinds of ARVs. One for the rich countries and another for the poor countries like Malawi. They say they give a strong medicine in the rich countries but they give a weak one to the poor countries like Malawi" (Author's unpublished fieldnotes, January 2006).

The Two-Tier Drug System rumor recognizes a world order in which Malawi and other poor African countries must receive whatever imports of aid and ideology are offered. According to Altman the arrival of ARVs accentuated the gulf between the rich and poor "with a minority of people with HIV now seemingly able to live for long

periods without major disease, while the majority of the infected people face a series of debilitating and painful illness en route to a reasonably rapid death.” (1999:572) The upscaling of ARVs provided greater access to life-prolonging pharmaceuticals in “resource poor” Malawi but failed to eliminate the sense that all is not equal between the rich of the global North and the poorer South.

In mid-December 2005 Simon Nyirenda, a young journalist, ran into an older man outside of a motel in Rumphu *boma*, a small town in northern Malawi. The old man said he had just seen a woman begging for money to help her care for a son who was suffering from AIDS. He did not blame her, since the AIDS situation is so bad due to youth careless with their lives. He himself had tried to help his son. He said:

“I cannot cheat here that my son was bewitched as other people say.

Because I openly know that my son died because he was very careless with his life. I tried very much to save his life but things did not work. I remember I was sent to South Africa to buy the ARVs for my son so that maybe he could be saved—but the ARVs did not help at all.

And from that day I have developed a negative attitude towards the ARVs—because I believe these drugs are just meant to kill the people who said [that they] have got HIV—fast. Why am I saying all this? Most of the people who are now dying just because of HIV, you will find out that they were taking ARVs.

And what I believe is that the western countr[ies] are producing these drugs in two forms : The better ones are put in their countries and they really cost a lot of money for one to have them.

Then there is another type of these ARVs which are just dropped in African countries, which are added with some poisonous particles which help to take the life of a person little by little.

In fact as you can see for yourself a lot of people here in Africa are given free ARVs yet you will find out that in western countries you will not hear of any country providing free ARVs.” (Nyirenda, Journal, December 2005)

How can a cure that is free and “dropped” into Africa measure up to the drugs that are being use in the rich, white countries or in South Africa? Medicines that had been extraordinarily expensive are suddenly being given away for free. The local experience of public health freebies hinted at sly coercion, and some have expressed the fear that the cure

may be worse than the disease. Are Africans being offered a treatment that could hurt more than heal, or are they being offered an inferior product? The old man quoted above could not decide whether the pills were tainted or simply low quality. He is not alone in his fears. Concerns about the hidden qualities of imported medications and food products are not new and fluctuate between identifying imports as toxic or inadequate. Often conspiracy theories about foods or injected substances focus on the harmful effects of those materials and the malice of those who distribute the products (see Langlois 1991; Turner 1993; White 1995, 2000). Rumors about ARVs in Malawi incorporated these types of fears and have an antecedent in the colonial era.

In the colonial period similar concerns about government provided medicines arose in Malawi (then Nyasaland) during the syphilis and smallpox campaigns. In 1936, a local health care worker employed by the colonial government reported his experience when trying to vaccinate people against smallpox infection. When he rode into villages on a decrepit bike offering residents vaccines (sometimes inactive), he was often rejected. One chief told the health worker that “no one was sick and besides when someone came before for smallpox more people got sick and suffered very much.” (Vaughan 1994:185-86) The vaccine meant to protect against the disease had brought illness.

In the smallpox campaign of the 1960s, a rumor circulated claiming that the vaccine was really meant to cause sterility or death. The external plot to sterilize Africans is a particularly persistent motif in public health rumors (For example Feldman-Savelsberg, Ndonko, and Schmidt-Ehry 2000; Kaler 2003; Sabatier 1988; Turner 1993; Vaughan 1994). During this latter smallpox eradication campaign in Malawi, mothers were so worried about the possibility of forced sterility that they hid their daughters when health officials swept through the villages (Feldman-Savelsberg, Ndonko, and Schmidt-Ehry 2000). Throughout the twentieth century rumors circulating in southern Africa have pointed to imported pharmaceuticals as the means by which foreign nations carry out population control plots (Feldman-Savelsberg, Ndonko, and Schmidt-Ehry 2000; Vaughan 1994). The fear of population control plots was echoed in conversations reported in the journals. More specifically, the acceptability of condoms as a means of birth control and protection against STDs has been compromised by the never-dying sterility rumors (Kaler 2004). These rumors suggest that powerful multinational organizations, aided by the Malawian government, have set a course to control the fate of African nations.⁹

In early 2000s Malawians were telling stories of condoms, sold at a low cost by the high-profile United States NGO Population Services International (PSI), that are defective in many ways. Some say that

condoms have holes that allow the passage of germs or that they are coated with a lubricant that is contaminated with HIV. It was said that when Malawians were not overwhelmingly persuaded to adopt the family planning philosophies and practices of industrialized nations, NGOs and multilateral organizations had to deploy more covert means of manipulation. In this conspiratorial equation, foreign aid is not a gift but a means of control. Malawians complain about or reject condoms for a variety of reasons well-documented by researchers (Kaler 2003, 2004; Watkins 2004); one reason that researchers consistently overlook is the complaint that there are two types of condoms. A journalist wrote about a bus driver who told his passengers that there were several types of condoms.

AIDS can only be prevented by these condoms. And I don't use the condoms which we the Black People use but durable ones which the Europeans use. Look, he showed us again. (Bato, Journal, June 2001)

Here we can discern the theme of Europeans dumping inferior health products in Africa while keeping the best for themselves. A similar charge was made in the syphilis treatments given to blacks in the 1920s; even though a better drug had been found to replace arsenical treatments, officials decided to continue with the older ones because of financial constraints. Yet it became generally known that there was a newer drug being used outside the borders of Nyasaland; this made people angry and wary. They wanted the newer drug, not a lower tier drug (Vaughan 1992:275-6).

That people receive ARVs with suspicion of inferior quality should be no surprise given the history of Malawi with international health campaigns. The distribution of expensive drugs at no cost resurrected old suspicions. Most Malawians could not afford the ARVs before the government received Global Fund aid. After the scaleup some have suspected the rich or those involved in the international AIDS Industry of secreting quality ARVs from rich nations for their own benefit or for sale on the black market. One respondent told us of a local health worker on antiviral treatment.

“...[T]he ARVs from England he is taking are the ones loving his life. We normally say ‘A-a-a! this one is already dead.’” (Anonymous, 2 December 2005)

In telling ARV rumors, people draw attention to both global inequalities and to the elite within Malawi who stand to profit from their involvement in the AIDS Industry. Some complaints suggest alternatives to government distribution of AIDS funds and ask the

government to be more transparent and accountable for spending. At the root this is a call for government responsibility to restore health to the nation.

“You, NAC, Is this Your Responsibility?”

One of my informants reported a Malawi Broadcasting Company (MBC) radio broadcast at the end of 2005, the year of the major ARV scaleup. During the evening News Bulletin a reporter, Joshua Kambwiri, summed up the activities of NAC, noting successes and posing explanations for failures and demanding more openness from the government in detailing the progress (or lack thereof) in fighting AIDS.¹⁰

...At the day of commemorating AIDS in the country, it is the responsibility of the commission to tell the nation of Malawi if it is necessary to continue with methods which it follows or to change certain approach[es] in the fight against the pandemic.

NAC has released a report on some of the strategies to fight the disease which organizations must follow. Truly speaking, they don't look at the disease as a major threat to the lives of people. The commission must find good facts and follow ways which in the end would materialize. Maybe Malawians should start asking themselves if messages which are given to the masses carry important information.

Do people use condoms [when] they buy them? Will the vaccination assist in future where do the donations go? You, NAC, is this your responsibility? (Mhango, Journal, Dec. 8, 2005)

We can interpret the announcer's request for NAC to “come in the open” and explain to the public what progress has been made as a call for transparency. More specifically, the reporter asks for financial accountability. Not only does the announcer ask these questions on his own behalf, but he puts himself in league with the public he imagines saying, “Maybe *we* can find a chance to ask the National Aids Commission (NAC) to give *us* the current statistics on the state of the disease in the country.”

It is not only the responsibility of the government to heal the nation, but it is their responsibility to tell the nation what they have been doing. Have their current programs yielded fruit? He urges Malawians to ask questions of the government. The public does indeed desire to know what the government has done, and this includes knowing what AIDS organizations know about Malawian communities that is not being

shared or made public. When I arrived in my field site in November 2005, I was approached by a young man at the market. He assumed correctly that I had worked with an AIDS survey project conducted in that area the summer previous. He asked me, "When will you people come and share with us what you have learned from the survey? We want to know how our community is doing." Malawians desire national statistics and progress reports as well as feedback from research conducted locally.

People perceive ARVs as an important way in which the government can fulfill its mandate to heal, but ARVs are not enough. They do not singlehandedly eliminate all the ways in which suffering from AIDS in the poverty of rural Malawi differs from suffering from AIDS in the rich north.

The talkative man...went on saying that Malawi's government receives a lot of money also with regards to the epidemic disease AIDS so that the money should be used in caring for those people affected by this disease both in town and villages, in homes and in hospitals by buying food like maize flour beans, soya beans, cooking oil and be distributing to them so that they should be living in a happy life even [though] they know that they have the *kachilombo* (chichewa language—the virus, literally "little beast," causing AIDS). (Bato, Journal, February 2004)

The money that the government receives for AIDS should not only be used for purchasing lifesaving drugs but also for the food that is needed for ARVs to work properly. Such provisions would also ease the burdens of families caring for relatives with AIDS. This is the kind of care some say the government should be giving. Others have suggested that AIDS money should be used to create jobs for young people so that they would be occupied and gainfully employed. Some reason that employed young women would not seek rich boyfriends and employed young men would be too occupied in wage labor to spend all their time sleeping with many women.

That AIDS funds should be distributed in a variety of programs is an idea not alien to the government's official agenda. The aim of NAC's AIDS "mainstreaming" initiative is to develop and support AIDS programming across a variety of government ministries and in the private sector as well. Cries for alternative uses of AIDS funding may be seen not as a radical request on the part of the Malawian public but as a call for the government to do as it has already promised to do. The government promised to deliver ARVs, but missed its 2005 target. It promised to mainstream AIDS interventions but the efforts (read

resources) have not flowed much beyond the central level or materialized in forms other than workshops. NAC has said it will be responsible in all matters pertaining to AIDS. Conspiracy theories are a reminder of those promises, a reminder of a responsibility to heal the nation.

Conclusion

Studies of conspiracy narratives, especially those conducted by political scientists, often have an air of patronizing disbelief. Conspiracy beliefs are seen as the products of overactive and paranoid imaginations or as a response to alienation engendered by modernizing states and economic systems (West and Sanders 2003). The danger in conspiracy theories is believed to lie in their ability to create a distrusting public that disengages from government or institutional programming. For public health programs involving broad-based drug treatment, a lack of mass participation can doom a project to failure, causing drug-resistant disease strains. In the case of ARV conspiracy rumors in Malawi, distrust of the government is not equivalent with a rejection of medical technologies. Instead, the rumors constitute a critique of the delivery of those technologies and a call for ever greater availability.

The conspiracy narratives related above should not be thought of as free-floating narratives but as narratives anchored in experience and folk belief. Just as Malawians in the past were not incorrect in their belief that there was an international alliance to control African populations (Kaler 2004:109), they are also correct in surmising inefficiency in the delivery of AIDS treatment through AIDS organizations. An independent review of Malawi's National AIDS Commission conducted by the Health Research for Action (Hera) group stated, "The limited financial, technical and administrative capacity of many CBOs [Community Based Organizations] to fulfill the requirements for funding through the Umbrella Organizations, has considerably affected the pace of programme implementation" (2005:35-36). Bureaucratic red tape has "considerably affected" delivery of AIDS services. The additional observation of hypocrisy within their own communities feeds the sense that funds are misspent and industry insiders are involved for their own benefit.

The sense that ARVs are only for rich people can be linked to the experience of long inaccessibility of the drugs in Malawi. In 2004, only 7.7 percent of Malawians with advanced HIV infection were receiving ARVs (Department of Nutrition, HIV and AIDS 2005:vii). Even as funds for treatment were increasing on the global health stage some international public health discourse continued to question the

feasibility of treating the very poor. An article published in the *Lancet* analyzing the relative cost effectiveness of prevention programs versus treatment programs recommended that cost-wise it did not make sense to invest in treatment at the time (Marseille, Hofman, and Kahn 2002). Similarly, the Two-Tier-Drug-System may be rooted in the varied therapeutic strategies recommended by the World Health Organization (WHO) and implemented by the Malawian government. Antiretroviral therapy does look different in Malawi and “resource-limited” settings than it does in industrialized nations.

The availability and use of ARVs in Malawi has increased dramatically since the 2004 roll out of the national program: from the 4,000 patients in 2004, to more than 37,000 in 2005, to an estimated 250,000 Malawians in ART in December 2010 (Libamba et al. 2007:156; Schouten et al. 2011:1). ARVs have become a part of an ever-increasingly “normalized” life with AIDS (Peters, Kambewa, and Walker 2010). As time passes new rumors surface. Indeed, in 2008 a rumor briefly flourished claiming there was a new sexually transmitted disease (*mphutsi* meaning “maggots”) more heinous and deadly than AIDS. The comparisons made between the “new disease” and AIDS highlight the ever-evolving attitudes towards AIDS brought about in part by the passage of time and in part by a changing experience with AIDS made possible by access to ARVs (Wilson 2013).

While ARV rumors such as The Two-Tier Drug System may question the efficacy of the drug combination, they more pointedly comment upon apparent global hierarchies in which African bodies are valued below that of white bodies in rich nations. They draw attention to the decade gap between the delivery of ARVs to the rich and to sub-Saharan Africa. They note differences between the simplified one-pill-a-day regime they receive and the complicated, individualized drug regimes of the rich. Yet suspicion need not be viewed as an opting out of participation in biomedical regimes such ART. Instead it might be seen as a way of engaging with it. The habit of suspicion, suggests that for many in sub-Saharan Africa, functioning in an atmosphere of suspicion is the norm, not the exception. Though the government is perceived as having done a good service in making the drugs available, many Malawians perceived all too clearly the signs of AIDS Industry waste and hypocrisy.

Notes

¹ HIV and AIDS are often elided in everyday discourse. Because I am reflecting on texts which elide these terms my own usage in related discussions sometimes follows suit.

² The square brackets inserted into the text were added by me for clarification, whereas the parenthetical comments in the excerpt were part of the original research report. This convention is used throughout this article for all such research reports.

³ The Malawi Diffusion and Ideational Change Project has been funded by the National Institute of Child Health and Human Development (NICHD), grants R01-HD37276, R01-HD044228-01, R01-HD050142, R01-HD/MH-41713-0. The MDICP has also been funded by the Rockefeller Foundation, grant RF-99009#199. The MDICP received ethical approval from institutional review boards at the University of Pennsylvania and the University of Malawi.

⁴ Readers of earlier drafts said that “diarists” connotes private writing and “journalists” sounds too much like professional journalists.

⁵ I have made small changes to the journal texts for the sake of ease of reading. These changes include modifying punctuation, syntax, and spellings. These changes are aimed at providing clarity for readers without compromising the original meaning.

⁶ About 135 USD.

⁷ “Nya” is a female honorific suffixed to surnames.

⁸ “Boma” refers to a township that is a local seat for government operations within an area. A “boma” tends to be a center for markets as well as governmental activities. Rumphu *boma*, is the administrative seat of the Rumphu District. “Matenda” means “disease.”

⁹ In rumors about plots to import poisonous or inferior drugs. The target of the plot is not Malawi specifically but rather African countries as a whole category.

¹⁰ MBC informed me that they do not generate transcripts of their shows and they keep audio recordings of their broadcasts for a short time before re-recording over the cassettes. The above quoted passage was written by a project journaler who took notes from radio broadcasts relating to AIDS.

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