

“Our families are killing us”: HIV/AIDS, witchcraft and social tensions in the Caprivi
Region, Namibia

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Abstract

The importance of exploring ‘indigenous’ constructions of illness is vital when explanatory models of ill health differ markedly from dominant biomedical paradigms. In the Caprivi Region of Namibia, an upsurge of witchcraft accusations can be seen as a direct reaction to increasing AIDS-related illness and deaths, and to changes in socio-economic attitudes and expectations. The mobilisation of witchcraft narratives provides a socially acceptable explanation for illness, and can positively influence decisions regarding the care and identity of the ill person. However, drawing upon data collected at kin and village level, this paper demonstrates that while witchcraft accusations can avert stigma and blame away from the ill person, they can also result in significant disruption to livelihoods, and place considerable tension upon key social capital networks at a time when the household is particularly vulnerable. Such findings have significant implications for the effectiveness of HIV prevention and AIDS mitigation initiatives, and for livelihood security.

Keywords: Namibia, illness narratives, HIV/AIDS, witchcraft, social capital

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Introduction

Focusing upon narratives of witchcraft in the Caprivi Region of Namibia, this paper demonstrates how HIV/AIDS has been assimilated into the existing cognitive and epistemological frameworks of order and disorder within which disease and illness are understood. While mobilisation of witchcraft narratives may impact positively upon the treatment, care and identity of the ill person, it is argued here that they can also exacerbate HIV/AIDS-related stigma and denial, result in significant disruption to livelihood security and place considerable tension upon social capital networks. Literature on HIV/AIDS-related stigma (cf. Aggleton & Parker 2002; Bond et al. 2002) has stressed the discourses of blame and denial that are played out through dominant notions of morality, acceptability and socio-economic expectation, and it is within such frameworks that witchcraft narratives are exercised within the Caprivi Region.¹

A range of qualitative and ethnographic methods were used in three rural settlements in the Caprivi Region, namely Sangwali, Masokotwane and Lusesse². A livelihoods survey undertaken with 100 households, and participatory methods at six community meetings initiated discussions of health issues and perceived impacts of HIV/AIDS. Repeat interviews with 18 case study households enabled in-depth investigation into livelihood and coping strategies, beliefs regarding illness aetiology and the impacts of illness and death. Twelve focus groups, solicited diary keeping and participant observation provided further insight into customs and norms, discourses of morality and acceptability and the mobilisation of illness narratives.

The changing context of the Caprivi Region

Located in the far north-east of Namibia, the Caprivi is the least developed region in the country (Mendelsohn et al. 2002). This location and the South African apartheid policy of ‘containment’ meant that the area experienced relatively little in the way of outside influences until Namibia gained Independence in 1990 (Fisch, 1999). Since this time however, the region has become strategically important for trade and transport, and a focal point of population movement across the southern African region. As well as opening up the region to new forms of economic opportunity and enabling people to migrate to seek employment, such changes have inevitably exposed the Caprivi to outside influences, many of which are deemed by the elderly and by customary and religious authorities as detrimental to traditional notions regarding the order, values and morality of society. In particular, it was widely reported that changes in economic and societal expectations had fundamentally altered the social obligations that had previously underpinned key support networks.

Settlements in the Caprivi encompass a number of ‘villages’ comprising paternal relatives, their spouse(s) and children. Although a key reason for this arrangement is to enable men to access usufruct land rights³ through their paternal line, it was reported that living in close proximity to other male relatives had also been important in facilitating livelihood activities and ensuring social security. However, at the same time as economic opportunities have expanded, reliance upon a cash-based economy to meet even subsistence needs has increased pressures on livelihood security. Under conditions of increasing economic heterogeneity, the welfare of the household is now considered primarily a household responsibility and household members are expected to ‘see for themselves’ i.e. be self sufficient, before

contemplating assistance from relatives or friends, thus challenging social hierarchies and making reciprocity a prerequisite for support as Martin explains.

In the past, people were working as farmers and things were easier....Now if you ask someone for something they can say no.....sometimes they look at status, they look to see if you are rich, the way you are dressed. They can help someone who looks smart – someone who can also help them. If I went to ask to borrow two oxen, I wouldn't get them, but someone who is smartly dressed would. (Martin, men's focus group, Masokotwane).

In addition to these economic and social changes, the Caprivi Region has experienced an upsurge in illness and death, largely due to HIV prevalence rates of 43% amongst the adult population (MOHSS 2004). However, relatively few people attributed increases in illness and deaths in the region directly to HIV/AIDS. Less than a quarter of those interviewed in the regional Demographic and Health survey claimed to know of anyone with AIDS-related illness and even fewer claimed to have undergone an HIV test⁴ (MOHSS 2000). Such low figures are due, in part, to the extreme stigma associated with HIV/AIDS in the Caprivi, which, combined with a lack of treatment availability until late-2003, acted as a disincentive to present for an HIV test. However, it is also due to the existence of 'alternative' illness narratives, mobilised to enable people to make sense of, and respond to illness within more familiar cognitive and epistemological frameworks of understanding. In a situation in which increased economic heterogeneity has paralleled an unprecedented upsurge in illness and death, it is of little surprise that culturally embedded beliefs in witchcraft which draw upon the concepts of misfortune and jealousy have thrived.

Mobilising narratives of witchcraft in the Caprivi

Witchcraft has long been associated with misfortune across much of sub-Saharan Africa (e.g. Evans-Pritchard 1937), including failure to obtain employment or to marry, poor school grades, bad harvests, mishaps such as car accidents, and illness and death. Witchcraft accusations are commonly associated with major socio-economic changes as well as strained relations within a society (Mavhungu 2002; Ashforth 2001). Writing about the Caprivi Region during the 1960s, Kruger (1963, p. 11) explains, ‘the notion is that all people should grow old and die from old age: if anything happens to them before then it is the result of machinations of evilly disposed persons.’ Given the considerable socio-economic changes and the significant increase in illness and death amongst the economically productive age group of the Caprivi, it is understandable that witchcraft beliefs and accusations are common and widespread, and are overwhelmingly perceived to be increasing.

Although individual witchcraft cases in the Caprivi are not an overtly public issue, their discussion was not tabooed and it was common for incidents of witchcraft to be raised during focus groups and interviews. Witchcraft beliefs were not confined to those in rural areas, but were also common in the region’s only town, Katima, including amongst people working for Government Ministries and NGOs. Witchcraft beliefs are also upheld by the traditional authorities, who are periodically called upon to arbitrate local witchcraft disputes. In such cases, three traditional healers are called upon to question the accused and examine their witchcraft ‘tools’. If found guilty, the accused faces a fine of up to 20 cattle, a proportion of which are given to the *khuta* (traditional authority).

Illnesses ‘caused’ by witchcraft manifest in a variety of forms and both the symptoms of illness and the age groups affected are reported to correspond to those

associated with HIV/AIDS. Because illnesses thought to be caused by witchcraft are generally considered more difficult to cure than in previous times, witchcraft is thought to be becoming increasingly powerful. While some forms of witchcraft result in a relatively quick death (e.g. car accident or heart attack), others manifest in long-term illness lasting over several years. One commonly cited form of witchcraft for example, involves the sucking of blood by a chameleon, resulting in a slow, wasting illness. It is also believed that increasing use of '*thobolo ya kaliloze*', an imitation gun made from human body parts, is enabling 'long-distance' witchcraft in response to increased trends in mobility and dispersal of kin, since it can be used to transmit illness or death to a person living in other areas of Namibia or even abroad.

Focus group participants explained that while many people genuinely believed that they or their relatives had been witched⁵, for others it offered a form of hope that the illness was manageable and acted as a form of denial and a strategy to help prevent stigma and rejection. These beliefs were not however, mutually exclusive with some people holding strong beliefs in witchcraft at the same time as recognising its use in deflecting stigma and blame. While HIV/AIDS is seen by many, particularly older people and those with strong religious beliefs, to be self-inflicted through immoral behaviour, witchcraft is considered beyond the control of the individual, and blame for the illness can be externalised. In case study interviews, it was evident that the illness narratives employed were influenced by who was giving them, to whom and with what consequences. For example, in one household where the respondent's nephew had been diagnosed with AIDS-related illness, household members decided to publicly explain the illness as witchcraft. In this case, mobilising witchcraft narratives acted as an active coping strategy which enabled the ill person to receive continued care and sympathy, and enabled open discussion of the illness

without stigmatising the household. However, as Ashforth (2005, 18) argues, illness considered a result of witchcraft becomes “a product of malicious human action and not just the impersonal agency of a virus,” a point that has significant implications for social support networks and livelihood security in the Caprivi.⁶

Strains on support networks

Community and inter-household trust and cooperation can be undermined by increasing social and economic heterogeneity (Moser 1998), and research in South Africa has found that witchcraft accusations are intrinsically linked to widening economic inequalities as increasing opportunities for advancement and promotion arise (Niehaus 2001). Rather than being considered as ‘backward’ or as a misunderstanding of the ‘true’ situation therefore, witchcraft beliefs in the Caprivi are ‘thoroughly modern manifestations of uncertainties, moral disquiet and unequal rewards and aspirations in the contemporary moment’ (Moore & Sanders 2001, p. 3). Instead of directing accusations at the macro or ‘impersonal levels of misfortune’ (Ashforth 2001, p. 216), allegations are directed at those thought to have a personal motive for malice. As reported elsewhere in southern Africa (cf. Ashforth 2001; Colson 2000; Bond 1998), the overwhelming explanation for witchcraft in the Caprivi is jealousy, thus as one focus group participant put it, ‘jealousy is the mother of witchcraft – they go together’.

Witchcraft is said to afflict people of all ages, but is considered a particular problem amongst the economically productive age group who are most likely to be educated and own assets which generate jealousy. The following example stresses the kind of situation that can arise in which a person may become jealous of another, resulting in accusations of witchcraft.

If my brother buys a car and I don't have one, I will be jealous of him. Or if I never went to school – we were given the same opportunity but when we are called to class, I squeeze out [don't attend], then you see after four or five years my brother has completed his education and is buying his own car and is having his own shop. I will be jealous of this and I will kill the brother, to take all his possessions. (Simon, Sangwali community meeting).

Simon stresses that tangible assets, as well as the ability to invest in livelihood security, are reasons which may incite jealousy. Witchcraft accusations are almost always directed at a person close to the victim such as a relative or occasionally a work colleague, because these are the people thought most likely to benefit from their death through inheritance or promotion. In the past, older male relatives were considered the most likely perpetrators of witchcraft, having the strongest witchcraft powers and being most likely to benefit from inheritance. However, it was frequently commented that increasing economic heterogeneity and changing social hierarchies mean that witchcraft is now perpetrated by people of all ages. Younger people, particularly men, are now able to obtain cash to either purchase witchcraft powers, or pay a witchdoctor to act on their behalf. Given the increase in illness and death and the decreasing social and economic obligations to assist all but the closest family members, commonly heard claims that 'our families are killing us', reflected the strained relations between households in a number of villages in the study sites.

'Diagnosing' witchcraft

Witchcraft is considered a possible cause and explanation of illness in cases when ill health can not otherwise be readily accounted for, or when strategically mobilised to

help prevent HIV/AIDS-related stigma and rejection. Even amongst individuals claiming not to believe in witchcraft, the fact that so few people actually know their HIV status, external pressures from relatives, and a determination to explore all possible avenues of treatment may result in witchcraft becoming a credible explanation.

That large-scale social upheaval has led to upsurges of witchfinding in parts of sub-Saharan Africa is well documented within the anthropological literature (e.g. Colson 2000; Marwick 1950; Richards 1935). Although there was no evidence of public witchfinding events on the scale documented by Yamba (1997) in Zambia, witchfinding activities were clearly evident in the Caprivi, with witchdoctors being consulted to identify the perpetrator of the crime and to assist in the healing process.⁷ Identifying the perpetrator of witchcraft is influenced by several factors. In some cases, a witchdoctor contacted by the family involved directly names the person responsible, or makes hints as to the perpetrator's identity. In other cases, the witchdoctor may verify the already held suspicions of the family, or may simply confirm that witchcraft is present, leaving it to the family to determine the person responsible. A commonly cited experience was for the witch to appear in a person's dream, undertaking suspect or harmful behaviour. Such suspicions may be influenced by existing tensions between individuals and households, or may be aroused when behaviour that previously seemed innocent is perceived as less harmless after close scrutiny. The following case study demonstrates how explanations are sought to understand illness and death thought to be caused by witchcraft.

Background to Bernard and Bernard (75) and Mary (43) married in 2001. Mary was Bernard's third wife. In 2002, Bernard's second wife became ill, and died aged 46.

Mary Bernard was Mary's second husband. Her first husband had died aged 43. Verbal autopsy revealed that both the deceased had suffered AIDS-related symptoms. However, witchcraft was given as the explanation for their deaths.

Initial illness and suspicions In February 2004, Bernard became very ill. His eldest children suspected witchcraft, so rather than go to the clinic they consulted a traditional healer. The prime suspect was Bernard's brother from the neighbouring village, who had been seen by Bernard's family 'acting suspiciously' in their courtyard. Bernard also recalled a dream in which this brother had chased him on an elephant whilst collecting witchcraft 'medicines'.

Suspicious confirmed – jealousy seen as explanation of illness The suspicions were confirmed by the healer who told them that Bernard had been witched by his brother due to jealousy. The reasons for his jealousy were clear to the family – Bernard had a salaried job, was highly respected and was asked to read prayers when important visitors came to Sangwali, and he had recently been given some building materials free of charge.

Breakdown of a social support network As the perpetrator of the illness, the brother was considered the only one able to heal Bernard. He did not deny the accusations but came to Bernard's courtyard to perform 'kuperu' – a healing ritual involving the spitting of water on to Bernard's body. After several days, Bernard felt well again. However, when he related this incident to me in March 2004, he believed that his brother was still trying to witch him. He was angry with him and stated that he would never trust him or help him again. Before this incident, Bernard and his brother had provided regular help to each other, assisting one another with ploughing, and providing food in times of difficulty.

Death caused by witchcraft In the week following this interview, Bernard became very ill and after four days he died. Bernard's brother was immediately suspected of causing the death, despite the fact that he had visited Bernard while he was sick. At this point, accusations were not confined to Bernard's family, but became grounds for gossip and blame amongst many people in Sangwali.

Understanding death – exploring social tensions While most considered the brother the prime suspect, a number of women who were friends with Mary had a different theory. Rumours circulated that Bernard had been witched by his second wife's family. By the time the second wife had died, Bernard had already married his third wife – Mary. The women claimed that when the second wife died, she was covered in sores, including genital sores. The second wife's family believed she had been witched by Mary, who wanted Bernard to herself. Thus they had witched Bernard to get revenge on Mary. Had this ultimately been the accepted theory, the repercussions would have had significant consequences for the second wife's young child, who had remained with Bernard and Mary after his mother's death. The women felt that Mary would reject the child, forcing him to uproot and move away.

Confirmation of the cause of illness and death Despite this alternative theory, Bernard's brother remained the prime suspect. For fear of retribution, he did not attend Bernard's funeral but sought refuge at the local police camp. Early the following morning as we drove through the village, Bernard's brother ran out to stop us and requested a lift to Katima. We were not able to help him, as we were not returning to town. A few minutes later, we saw him running up the road out of the village with his suitcase, to try and get a lift from the main road. A number of other people also saw him – for most, the sight of him

fleeing the village was evidence enough that he was guilty of witching Bernard. When I left in June 2004, he had still not returned to the village.

As is illustrated in this case study, witchcraft was considered a plausible explanation for Bernard's death since he had a variety of assets that were deemed to generate jealousy. In addition, being elderly, well respected and religious, AIDS was not explicitly suspected despite the fact that Bernard's previous wife and third wife's former husband had died in their forties with AIDS-related symptoms. It was plausible to Bernard and his family that the brother was the likely suspect, suggesting a pre-existing tension existed between them. Despite this possibility however, Bernard and his brother had contributed to an important reciprocal support network, helping each other to plough and providing food for each others' households. Following the allegations of witchcraft, both Bernard and Mary claimed they would never help the brother again, thus the support network was broken, a scenario that was repeated frequently by people in all three study sites. The breakdown of support networks can therefore affect the household at a time during which assistance is particularly necessary as caring and treatment seeking takes its toll on household assets.

As a school principal explained, it is considered extremely difficult to forgive a person accused of witchcraft, particularly when it results in chronic illness or death.

Principal: If my child dies while I am staying with my grandparents, then I'll leave them and make my own village somewhere else, so that they won't go there and see my child again.

Interviewer: With so many people getting sick though, isn't it very important to have all your relatives there to help you?

Principal: What I'm thinking is that it *should* be like that. But when your child passes away, you'll be very, very sad, and when you go to the witchdoctor, he will tell you that it is that person in your family [who has witched your child]. When you come to him [the relative] he will be cross – he will talk rubbish, saying that you are just imposing things that do not concern him. The end result is then you will just separate, you'll go and make your own village and just leave them there....deep inside you don't like them and you wish they had just died long back.

In all reported witchcraft cases encountered during the research, it was clear that once an accusation had been made, it was extremely difficult for the accused to prove their innocence. In no case study related to me had the accused admitted their guilt. However, several had reportedly failed to deny the accusation against them, and those who had denied their involvement were generally deemed (by the victim's relatives) to be lying.

That the relatives of Bernard's second wife became suspects is understandable since revenge is considered an accepted response to witchcraft, despite the time and costs involved. Fearing revenge, the brother did not attend Bernard's funeral, and felt unable to stay in the village, thus reducing the labour base available to his own household. As the case study also demonstrates, accusations can become a public issue, particularly when community members are themselves related to the individuals involved. Under circumstances in which witchcraft is increasingly cited as the cause of rising illness and death, it was frequently commented that community relations and previously important social support networks are becoming strained as trust between individuals and households breaks down.

An accusation of witchcraft may result in the accused, and sometimes their household, being shunned by other relatives and community members as long term

trust is damaged. However, it was reported that in cases, the household afflicted by the illness may also become isolated from support networks as people perceive that their misfortunes will in turn result in them witching others, either in revenge or due to jealousy as their own assets are depleted. When asked if witchcraft accusations have always resulted in families dividing, it was explained that prior to Independence, local *indunas* (chiefs) would have played an active role in arbitrating family disputes to prevent long-term divisions within the community. However, societal changes since Independence have led to a blurring of authority claims, and it was felt that those who were educated would not listen to such advice but would instead decide on a solution, however extreme, for themselves.

Witchcraft narratives and livelihood security

It was explained that accusations of witchcraft accounted, in part at least, for the dispersed geographical layout of many villages within the study settlements, since once an accusation had been made against a relative it was common for families to divide and establish separate villages. Besides the emotional aspect of such an upheaval, considerable cost in time and livelihood resources is also likely to be incurred. As the following case study demonstrates, witchcraft beliefs can result in major disruptions to livelihood activities as well as a strain on resource assets.

When I first visited Mate village in Old Masokotwane, the residents of all four households were in the process of moving to establish a new village approximately 100 metres away from the existing site. Rather than using materials from the existing village, new resources were being used to build houses and compounds. Although building was initiated during the quiet time of year, the ploughing season was already underway before the new village was habitable, placing increased pressure on village

residents to perform livelihood activities at the optimum time. Because of the move, the women had been unable to produce as many baskets for sale as in previous years. When asked why they were establishing an entirely new village, it was explained that their existing village was '*nakabolelwa*' – a place where people were dying from witchcraft.

In 2001, the village had experienced the deaths of three men – one aged 80, and his two sons, aged 28 and 45. The hospital told their relatives that they had died from tuberculosis, and verbal autopsy suggested that the sons' symptoms were AIDS-related⁸. However, the residents of Mate believed that rather than having a biomedical aetiology, the illnesses had a social/spiritual cause, and that they had been witched by their late grandfather. As well as considerable emotional impacts, the illness and deaths of the three men had extremely costly impacts upon the asset base of the villagers. Treatment and funeral costs had resulted in the sale of nine cattle. The villagers had also suffered a poor harvest after cattle destroyed crops while the women were caring for the men in Katima, and because they were busy caring, they were unable to raise cash from selling baskets and cakes. Fearing further deaths, the villagers decided that they would all move together to establish a new village away from the witched area. It is intended that the old village will be burnt down. In the meantime, several of the villagers are afraid to pass through it.

The case study illustrates how the intense fear of witchcraft may not only disrupt one household, but can affect the livelihood activities of a number of households. In this example, the entire village was pressured to uproot for their individual and collective security, incurring losses in cash income, and risking the success of the harvest through late ploughing. Even though one woman heading a household in Mate claimed not to believe the witchcraft allegations, she too moved to the new village, not only because she did not want to be left alone, but because refusal to move would

have been deemed irresponsible by other village members. Beyond the household, immediate support networks in Caprivi tend to lie within the village, thus, as a communal action, the upheaval in Mate may be particularly hazardous to livelihood security since each household is facing similar risks at the same time. The possible failure by all the households to produce a good harvest due to late ploughing therefore risks reliance upon wider, less secure social support networks.

Studies have found that household dissolution has occurred as a result of AIDS-related deaths and redistribution of surviving members (e.g. Rugalema 1999) and this phenomenon was evident in the Caprivi. However, there was also evidence that entire villages were disbanding and even disappearing due to witchcraft beliefs. In another village in Masokotwane for example, it was reported that following the deaths of three brothers within the same year, their wives and children had ‘run away’, fearing witchcraft. The livelihood implications of such actions cannot be under-estimated. Uprooting from one village to resettle elsewhere, usually means leaving behind fields that have been cultivated and regularly maintained. It may take considerable time and labour to clear weeds and prepare a new field for cultivation, during which time, dependency upon others will be high in all but the most asset secure households.

Discussion

There are clear connections between the upsurge in accusations of witchcraft and the increase in HIV/AIDS in the Caprivi. However, the extent to which they are perceived as related or separate issues varied widely within the study sites, and did not appear to be strongly linked to factors such as age, gender, or even education. Even amongst Home Based Care workers, there were still beliefs – at least publicly – that witchcraft

accounted for many of the illnesses in existence. When asked whether witchcraft or HIV/AIDS was the biggest problem in the area, most focus group participants felt it was not possible to distinguish between them, since the symptoms were similar. However, a number of people stated that while they were aware of HIV/AIDS prevention campaigns, they felt that more information on dealing with witchcraft was necessary. Even amongst those who openly recognised that witchcraft accusations were counter-productive to social networks and to the effective management of HIV/AIDS, there was still reluctance to acknowledge that their own ill relatives may have suffered from AIDS-related illness. Such views are understandable when interviews with representatives from government ministries and NGOs found that despite realising the potential impacts of witchcraft accusations, little was actively being done to directly address such issues.

The persistence of witchcraft narratives in the Caprivi Region perpetuates HIV/AIDS-related stigma and denial and acts as an obstacle to HIV prevention initiatives through upholding a false sense of security that the illness can be effectively dealt with if traditional medicines are sought in time (Bond et al. 2002). While traditional medicines were reported to alleviate many of the opportunistic infections associated with AIDS-related illness, these medicines tend to be more expensive than those available through 'modern' health facilities in the Caprivi, thus hastening depletion of the household asset base and increasing dependence on remaining social support networks at a time in which the household is particularly vulnerable. Since the introduction of anti-retroviral treatment drugs in late 2003, hospital staff reported a further worrying implication of witchcraft narratives - namely that people were delaying attending the hospital until they were already critically ill

and their immune system so severely damaged that it was too late to register them for effective anti-retroviral treatment.

While witchcraft is considered a more socially 'acceptable' illness narrative than HIV/AIDS, and externalises blame away from the ill person, it has been demonstrated that accusations of witchcraft can exacerbate fear and result in asset expenditure, long-term divisions within families, and subsequent loss of key social support networks with adverse implications for livelihood security. Levels of insecurity and feelings of injustice brought about by AIDS deaths and witchcraft accusations are not yet as ubiquitous in the Caprivi as that documented in South Africa (cf. Ashforth 2005). However, given that there is no sign that levels of HIV/AIDS will decrease in the Caprivi in the near future, and that availability of anti-retrovirals is extremely limited, witchcraft accusations have significant potential to further break down social capital networks and exacerbate the adverse responses brought about by community tensions and fear.

There are however, also signs that the regularity with which people draw upon witchcraft to explain illness is actually leading people to start questioning these claims. As Bond et al. (2003) note in Zambia, a witchcraft diagnosis may now also be stigmatised because of the strong associations between witchcraft and HIV/AIDS. In the Caprivi, it was evident that while the household may portray the illness as witchcraft, other community members may assess the illness by the social standing and perceived moral integrity of the ill person. For example, while a married, respected and religious man such as Bernard was publicly thought to have been witched, the death of a young, unmarried woman in the same village was rumoured to have been caused by HIV/AIDS (despite her household making witchcraft allegations) because she was known to have 'moved around'⁹ and had few assets to

generate jealousy. Such findings have serious implications for the treatment and care of the ill person and imply that those who are already disadvantaged by a weak asset base are also the most likely to be stigmatised for their HIV status.

The mobilisation of witchcraft narratives clearly has significant implications for the success of any HIV prevention or AIDS mitigation initiatives in the Caprivi. At present, extremely little is being done in response to these matters. This is largely due to the difficulties inherent in providing practical responses to address such complex and unconventional issues. However, it is also influenced by the fact that many people in positions of authority either themselves hold such beliefs, or continue to be influenced by beliefs of family members. The role of traditional authorities in adjudicating witchcraft cases and the role of traditional healers in identifying the perpetrators of witchcraft and providing treatment are two obvious ways in which such beliefs are perpetuated, thus it is imperative that initiatives developed to respond to the issues caused by witchcraft accusations involve close collaboration with these groups.

Acknowledgements

The author would like to thank the many people of the Caprivi Region who participated in this research and the helpful comments of three anonymous referees.

The research was made possible with funding from the ESRC, Royal Society, Slawson Award and the Developing Areas Research Group.

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¹ Drawing off deep-rooted fears and anxieties, stigma is defined by Goffman (1964:3) as a “process of devaluation”, in which certain attributes are defined by others as discreditable or unworthy, resulting in the person stigmatised becoming ‘discounted’ or ‘tainted’. Stigma may involve gossip, verbal abuse and distancing from the person with HIV/AIDS, and can range from subtle actions to extreme degradation, rejection and abandonment.

² All ethnic groups in the Caprivi are descended from the Lozi. Colonial occupation in the twentieth century divided identities and allegiances into three broad ethnic groups (Shiyei, Subia, Sifwe), the latter of which is further subdivided. Five main languages are spoken in the region, with Silozi being widely used. While the study sites constituted people from different ethnic groups, they did not differ markedly in socio-cultural practices, witchcraft beliefs or interpretations of HIV/AIDS. Ethnographic literature on the Caprivi prior to Independence is extremely limited and what does exist (cf. Pretorius 1975; Kruger 1963) has little in-depth discussion of witchcraft. It is not therefore possible to provide detailed comparison of witchcraft discourses or practice over time.

³ The Namibian State administers communal lands in trust for the use of traditional communities. Usufruct land rights enable an individual to use and enjoy the benefits of communal land for residence, cultivation and grazing.

⁴ Demographic and Health Survey findings show that only 22% of men and 8% of women in the Caprivi Region knew of anyone with AIDS-related illness. Only 5% of women and 8% of men surveyed claimed to have undergone an HIV test (MOHSS 2000).

⁵ ‘Witched’, is used in this paper (rather than ‘bewitched’) because this was the term used by people in the Caprivi.

⁶ Ashforth (2005) argues that death considered the result of witchcraft has radically different implications than a death caused by a biological disease since the former will be construed as murder. In cases, households interviewed claimed they had sought revenge through trying to kill the accused or someone close to them. However, in others, household members stated that they had not tried to inflict physical harm upon the accused but would no longer maintain contact or support networks with them. Factors influencing decisions on retribution included the level of belief in the witchcraft accusation, religious belief and the availability of capital assets.

⁷ The term ‘witchdoctor’ was commonly used to describe a person involved in witchcraft, usually thought to be harmful, while a ‘traditional healer’ treats and cures. Most healers interviewed claimed to be diviner herbalists’ who use *taula* (a ‘traditional x-ray’) or divination to diagnose illness. However, many who claimed to be ‘healers’ were also involved in witchfinding and in the protection and treatment of the ‘witched’ person.

⁸ TB is the most common AIDS-related opportunistic infection in Namibia. In the Caprivi, co-infection with HIV is thought to account for 70-80% of cases (National Planning Commission 2004).

⁹ ‘Moving around’ is a term used to describe promiscuity