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HEARSAY ETHNOGRAPHY: A METHOD FOR LEARNING ABOUT RESPONSES TO HEALTH INTERVENTIONS

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INTRODUCTION

How can we know how health interventions -- the dissemination of health knowledge and the promotion of behavior change -- are received by the people whom our interventions address? In this paper, we describe a practical methodology that contributes to the project of studying collective meaning making as it unfolds and changes. By fixing episodes of public discourse as texts, rather than directly interrogating respondents in interviews or focus groups, conversational journals convey a sense of spontaneous issues that comprise the dynamic world of publicly available, collectively constituted meanings. While several theoretical traditions, from the Durkheimian to the symbolic-interactionist, posit such a dynamic public realm, few methods capture its texture.

At one extreme of research on health behaviors is survey research, collecting systematic data from a large sample representative of a defined population. At the other extreme is classical ethnography--full immersion in a field site, learning a language, coming to understand practices and institutions that first appeared strange, and then returning with a career's worth of field notes (Geertz 1973; Lindenbaum and Lock 1993; Scheper-Hughes 1992; Clifford 1988). We introduce here a new research technique: asking members of local communities in rural Malawi to be our ears and eyes, observing, listening, and writing what they overheard in field journals that tell us about conversations in social networks from which outsiders are necessarily excluded. Our "hearsay ethnography" -- invented originally as much by accident as by design -- offers unique advantages over both traditional ethnography and over interview-based research approaches.

We focus on conversational interactions in order to capture more effectively the way meaning is produced and re-produced in everyday life, what the people health promoters aim to influence

say to each other rather than to an outsider with a clipboard or a tape recorder. These interactions are transformed by cultural insiders into texts of who said what to whom. In the Geertzian sense, then, these texts, or collections of publically available cultural meanings, can be 'read' to understand the manner in which health knowledge and behavior change discourses are taken up and incorporated into local systems of meaning. However, our approach views local Malawians, likely to be well enmeshed in Geertz' 'webs of meaning,' as active consumers and critics of these texts themselves. It also acknowledges that although meanings may be publically accessible, they are differentially accessible to insiders and outsiders, and differentially transmitted depending on, for example, whether the forum is an everyday conversation or a formal interview. Through hearsay ethnography, we can thus access health knowledge as it actually circulates: how the pro's and con's of behavior change are evaluated and debated, whether public health programs become part of the discussion, and what become authoritative resolutions.

The material here was gathered as part of a study of responses to the AIDS epidemic in Malawi, a very poor, largely rural country in southern Africa that is among those most ravaged by the epidemic. It is no accident that a new research approach emerged in a study of AIDS—both the epidemic and responses to it are shaped by social and cultural patterns that may be difficult for Western researchers to comprehend (Parker 2001). Through many journals, collected from multiple journalists in a wide variety of situations, we witness cultural understandings evolving, tacking back and forth, sometimes folding back on themselves or breaking down in confusion—but over time, even in the course of a single discussion, collective definitions have shifted. This observation is in agreement with the insights put forward by anthropologists and sociologists of science, who point out that knowledge is always partial, plural, and provisional, but that at any

given moment there is agreement about some things (Schutz 1964; Crick 1982; Lambek 1993; Schmaus 1984; Longino 2002). At least in our setting, rural Malawi, and about an important issue like AIDS, which is problematic, frightening, salient, and challenging, people are not passive. Collectively and publicly, they dwell on the problem they face, piece together practical knowledge, gossip and authoritative opinion, to try to bring clarity, to construct a conversational and situational universe and to map potential ways forward.

We argue that hearsay ethnography has three methodological advantages (as well as several practical ones): First, it provides data more authentically representative of local understandings than all other methods, including ethnography, that require the presence of an outsider.[1] This is especially valuable in places where people do not construct themselves as having "opinions" of the sort that pollsters ask about, and where their deference to those they see as more educated, urban, or cosmopolitan (or as potential sources of help) or their occasional desire to pull the leg of gullible outsiders may distort research interactions. Second, because our texts are records of ordinary conversation--including joking around, conversations on intimate issues among friends, and incidents from women's group meetings to barroom brawls—conversational journals show how culture is actually mobilized in natural social contexts (Swidler 2001; Eliasoph and Lichterman 2003). Third, and most important, hearsay ethnography makes visible what is *social* about social experience, thought, and culture.[2] Our method captures not what individuals think,

[1] We are not the first to recruit "insiders" as research collaborators in order to avoid the distortions that come from local participants' interactions with outsiders. Williams and Kornblum (1985) had high school students keep diaries of their everyday lives in order to capture the texture of their daily experience. These moving documents convey the interior sense of life as it is lived by youth in poor neighborhoods with great poignancy; they do not attempt to capture the flow of public discussion. Power (1994) and Elliott, Watson et al. (2002) provide examples of the use of "indigenous fieldworkers"—current or former members of "covert communities" such as commercial sex workers or injecting drug users—recruited as "temporary research staff."

[2] See (Noelle-Neumann 1993) who explores how survey questions can capture this public aspect of public opinion. Focus groups are also meant to capture this collective property of cultural meanings

even if one could, in principle, have complete, accurate access to their subjectivities (Wuthnow 1987). Rather it captures dynamic public discourse--the living reality of talk and dramatic incidents from the thick and thin of life—and thus tells us what goes on in the relational space between people. The practical advantages--that it takes in a much wider variety of people, places, and settings than even the most energetic ethnographer could do; that it records public dramas as well as casual conversation; that it permits local meta-commentary on public discourses instead of just documenting them ;that it puts meat on the bare-bones notion of social networks; that compared both to ethnography and surveys it is relatively "cheap"; that the journalists already have local language and cultural knowledge;--will be addressed below.

THE ETHNOGRAPHIC JOURNALS

In 1997 Watkins and several colleagues began a research project, the Malawi Diffusion and Ideational Change project (MDICP),[3] on the role of social networks in influencing responses to the AIDS epidemic in rural Malawi. Because the focus was demographic, the primary data they planned to collect would come from multiple waves of a survey, supplemented by semi-structured interviews. After the first round of the survey in 1998, the researchers had a great deal of data about the composition and structure of the social networks in which rural Malawians talked about AIDS. They had not however, learned much about the content of the social interactions—what people said to each other about AIDS or their strategies for avoiding infection and death—and semi-structured interviews conducted in 1999 were disappointing.

(Gamson 1992). Some ethnographers, such as (Eliasoph 1998) give explicit attention to the group contexts in which public discussion occurs.

[3] The MDICP has conducted four surveys in rural Malawi (1998, 2001, 2004, 2006). The initial sample consisted of approximately 1500 ever-married women and their husbands; in 2004, a sample of approximately 1500 adolescents (ages 15-24) was added. Semi-structured interviews with randomly selected sub-samples of the initial sample were also conducted. More detail is available at www.malawi.pop.upenn.edu.

Unable to locate an anthropology (or sociology) graduate student willing to hang out and just listen to what people actually said in their social networks, the researchers improvised.

The researchers adapted classical ethnography to new purposes. They asked several high school graduates living in or near their study sites to be participant observers as they went about their daily routines. If they overheard anything concerning AIDS, they were to make mental notes of what people said and did, and then write their recollections in commonplace school notebooks that evening or soon thereafter (some include the exact time the ethnographer started writing, time off for a bath and dinner, several more hours before bed, then breakfast and writing again). The ethnographers wrote their journals in English, a language learned in high school; the handwriting and repetitions suggest they often wrote rapidly. Their notebooks were given to a local intermediary who mailed them to the researchers.

This approach depends on hearsay evidence: we hear only secondhand, through the journalists' ears. Although the "journalists" are relatively well-educated,[4] in rural Malawi many such people cannot find jobs in the modern sector. Rather, they live in villages side-by-side with those who have no schooling, and engage in the same tasks as others—small-scale trading, tending their maize fields, attending their church, going to neighbors' funerals, and so forth. It will become obvious below that in places where only the fortunate few have battery-run television, where there is modest access to the radio, and where many are unemployed or spend long hours doing sometimes dull tasks—weaving palm mats, sitting all day in the market hoping to sell something,

[4] Few who go to school in rural Malawi attend high school, although men are more likely to do so than women. Those who complete high school hope for social mobility and thus try to leave the rural area for a city. Many who are unsuccessful in finding urban employment, like our journalists, remain in their village.

taking the bus from one town to another, washing clothes at the well—sociable conversation is a major source of interest in life.

What public health interview or survey could discover the myriad themes—revealed in the excerpt below—that roil the issue of condom use? The excerpt is long, in order to illustrate how one topic segues into another and how one argument is answered with another. As with the other excerpts in this paper, we use pseudonyms when proper names are mentioned and for the journalist; the journal is dated in year, month and day format. In this excerpt, the journalist is on a bus going to a meeting of her Smallholder Marketing Action Group along with three other members of the group; the rest of the speakers are strangers. The bus has a breakdown, irritating the passengers. After complaining to the conductor, they debate whether it is better to die in an accident or from AIDS.

> Someone who sat at the back seat added saying that the death by the Bus accident is the same as the death because of AIDS. The AIDS is better off because there are some things which one can use to protect himself or herself from being infected to it while an accident have no any protection. Once the accident has occurred, a person can die at the same spot. People began talking, everyone was speaking on what he or she wanted. Some people were speaking that the accident's death is better than the AIDS death…..
>
> Mrs. Hajiri was among the people who were saying that it is better to die of Accident than die of AIDS. She said that if one has died at the same spot that the accident has done, [one] do[es] not feel any pain. He/she just dies. If any pain is there, it is just for a short time, but if you have been infected to the AIDS, it takes a long time for you to die. …. Mr. Chabwera said … but as far as I know, there is no anything which one can use to protect himself/herself from death. If the day have come for you to die, then you cannot do otherwise there. You have to die and you die, Mr. Chabwera said. Though many people are cheating themselves [fooling themselves] to use condoms in order to prevent themselves from death which can come because of AIDS, they just waste their time. The death will still come through other way round. God is very clever and nobody can compete with him. God has not vice or Deputy. If you don't be faithful to your Spouse you will die of AIDS. If you don't want to abstain from sex, you will die of AIDS. If you shall receive the unsterilized injection, you shall die of AIDS. If you [are] found sick and receive blood from the hospital, you shall die of AIDS. Many ways which can make one to suffer from AIDS and one can use condoms always when having sex but long at last, you can find that he/she has AIDS: Why? He also added that though he never used

the condoms but he heard many people complaining that the condoms have some problems. When men use them they just see that the sores have come out and those sores itch and after some time, they began [to be] painful. Condoms cause other disease in addition to the AIDS disease. Those sores is also a disease because it causes itching and one feels painful. Unfortunately, nobody knows its kind of treatment unless you go to the hospital to explain about that problem.

When Mr. Chabwera finished speaking, the Bus Conductor who put on [wore] the Khaki short trousers and a Green T-shirt answered that AIDS is the dangerous disease because the only common way of being infected is through sex yet our God knows that there is that AIDS dangerous disease which can kill his people. He is the same God who created people and AIDS too because there is nobody who can create anything apart from God the great. God has an aim with us and that is why he is just looking on what is happening. His many people are passing away every day and many of them are sick. But still he is doing nothing. He would like to punish us but since everyone likes life, that is why we are trying to use the condoms always for protection. Using a condom is not a bad thing because it is the only way which we can save our lives. Since there is no any treatment that one can receive and get recovered from AIDS, then it is better to use the condoms which can protect our lives for some days before death.

Edah also put her comments on what the conductor said. She said that there is no good death or the bad death in the world. Both deaths by making an accident or getting sick for a long time is also the bad death. Death is death and no better death is in the world. She continued by saying the difference between the death because of AIDS and the death through accident. If one is sick, his/her relative know that one day, they will cry for their relative if he/she has shown the signs, while the one who dies of an accident cannot show the signs of anything but he/she stays normal and maybe a happy life. After some minutes or hours, people just see that they have made an accident. About the use [of] the condoms, Edah said that it is the good idea to use the condoms because the AIDS disease is very dangerous and many people are passing away every day because of AIDS and it has no treatment. If all the people in the country are not using the condoms, all the people will die of AIDS at a short time because they lack the knowledge and the ~~lack of~~ money for daily life. Many women are not married therefore they want to depend on men as their husbands though they are not their husbands. She also said that the use of condoms are very good though they encourage people in doing sex unnecessary and no matter they are causing problems like the sores our father Mr. Chabwera has said. It is better to suffer from sores than die of AIDS. If you use the condom and have sores, you can go to the hospital to explain and you can be helped by the Doctors while if you just have sex without any protection like condoms and be infected to AIDS, just know that the hospital can help you but you cannot get recovered until you die. Therefore it is good to use the condoms [rather] than having sex plain.

She stopped there because we reached at the roadblock and nobody continued speaking. (Alice 021025)

<u>The Journals and the Journalists: How Good Are the Data?</u>

More than 700 journals have been written since 1999. The current collection of diaries covers hundreds of distinct conversations, some overheard or witnessed by the journalists, others relayed to them through gossip. Since there are frequently several people conversing, we overhear, at second hand, thousands of people. The journalists' close networks, the ones in which they routinely spend most time, are homophilous, as are close networks elsewhere (McPherson, Smith-Lovin et al. 2001), but many of the conversations they overhear have a very diverse cast of characters. For example, the most prolific of the female journalists is on many committees in her community and sometimes attends regional or national meetings of these groups, and many women, but also men, come to her for advice; the two most active male journalists spend much of their time hanging out in a nearby trading center, at the bus depot, or at a bar, where there may be friends of friends or strangers. The male journalists write primarily about men's conversations, the women about women's, reflecting the gendered interaction typical of the communities in which they live (Marshall 1970).

Twenty-two journalists (9 females, 13 males) have contributed to our corpus of texts, with three (two males, one female) contributing very frequently, 13 frequently, and six only occasionally. The diarists wrote in English, a language learned in school, and used parentheses or carets (< >) to set off their explanatory comments or untranslatable expressions in the local language. We have retained locutions that reflect local adaptations of English. English is taught in Malawian public schools starting in Standard 5, equivalent to U.S. fifth grade, and has become somewhat indigenized. For example, to be sexually promiscuous is to be "movious" and one who has multiple partners is said to be "moving around," an Anglicization of a Chichewa expression, *woyendayenda*, derived from the earlier association of multiple partners with migrant labor. The naturalness with which the journalists adapt English to Chichewa, chiYao, or chiTumbuka

linguistic forms means that their English is somewhat closer to local languages than is the standard English in which a Canadian, British or American ethnographer might translate local languages. We have retained most of the idiosyncrasies in grammar and spelling, although on occasion we insert obviously missing words in brackets for greater legibility and make minor grammatical changes in the interest of legibility.

The journalists were paid US$30 for an 80-page school notebook; a typical notebook is about 10-12 typed single-spaced pages. The amount was deliberately set high relative to incomes in rural Malawi, as an incentive to continue with the project. The incentives raise the possibility of fakery. The journalists had worked for the MDICP as interviewers and shown themselves the most reliable, honest, thorough, and intelligent. But of course there is no way to know with absolute certainty whether the journals are honest and accurate. We have evaluated the journals in the light of other information (e.g. from the survey and the semi-structured interviews). In addition, because some of the more notorious characters in the area, such as the prostitute Miss Baidon, appear in the journals of more than one journalist, and some actors appear in more than one journal, we can examine internal and cross-journalist consistency. Most convincing, however, are the internal qualities of the journals. Kaler (2003) notes recurring themes in the journals, but the relative absence of clichéd situations and characters. We (and other readers of the journals) are struck by their quality of verisimilitude. While only extended excerpts from many journals could make this point fully convincing, it is evident as one reads these journals that only a writer as gifted as Chekov could have manufactured such a variety of voices, situations, incidents, and viewpoints. In fact, the sheer diversity of stories, characters, and experiences of the AIDS epidemic in Malawi found in the journals challenges international

authoritative accounts of familiar figures such as the ‘grandparent-led family,’ the ‘orphan,’ or the ‘destitute widow’ that color the pages of documents and reports.

A related concern is whether the pay motivates the journalists to seek out situations in which AIDS is likely to be discussed. No doubt this happens. Initially, the journalists produced journals at the rate of one or two a month, but their productivity increased, first after the poor harvest of 2001 and then dramatically with the famine of 2002 when grain prices rose by approximately 500% (Malawi National Vulnerability Assessment Committee 2002). The male journalists may indeed have begun going to the nearby trading center more often than they otherwise might, playing *bawo* or drinking at the local bar in hopes of hearing something for a journal. The female journalists tend mainly to report conversations that occur during their daily tasks—washing clothes at the borehole or walking to tend their gardens—or walking to or from the very frequent funerals. When journalists have sought to “pad” their journals, however, they have done things like report at numbing length on a village AIDS committee’s informational meeting or reproduce nearly verbatim a pastor’s sermon. We have not discouraged such tactics, feeling that it is better not to censor what the journalists write. But this increased output does not directly undermine the value of the evidence they give about where and when discussions of AIDS take place. In fact, these robust accounts may help us to better understand the complicated context rife with multiple circulating ideas and claims into which AIDS dialogue and debate enters.

Agency and Action

Neither of the two "gold standards," survey research nor ethnography, can adequately capture the drama, the joking, the contradictions and disagreements of everyday talk (Billig 1987; Swidler 2001). Surveys that ask about the characteristics of those with whom the respondents talk provide information that permits analyses of network structure, and inferences about the causal impact of variations in that structure (Kohler, Behrman et al. 2002). But even supplementing short-response survey questionnaires with semi-structured interviews provides only a very partial glimpse of what transpires in social interaction. For example, the excerpt below comes from the MDICP semi-structured interviews on informal conversations conducted in 1999. Although the area in which this interview took place is the same as one of the areas in which the conversational journals were produced, notice the inhibited, laconic answers and the repetition of standard safe-sex slogans:

> Interviewer: And right now there is this disease of AIDS, what do the people say about this disease?
>
> Respondent: Aaah, what people say is that you should be holding your heart without doing any sexual intercourse with other women. That's why they say on that AIDS. Only holding the heart, be sure of your wife only.
>
> Interviewer: And where did you hear this?
>
> Respondent: Also this I heard on the radio.
>
> Interviewer: Okey. Did you ever hear from your friends?
>
> Respondent: Yes, they do talk.
>
> Interviewer: What are they saying?
>
> Respondent: They were saying that we [i.e. husbands] should be holding our hearts from these women, just believe in your wife because if you keep on going with other women, you will catch AIDS. (M 6504) [5]

[5] This excerpt is identified by the survey identification number of the respondent.

This is far from the complex conversations we showed earlier, with the variety of gossip, detailed narrative and the varied moral and practical concerns in which the narrative of AIDS is framed.

Why the difference? As Wendy Griswold (Griswold 1987) has argued in a paper on methods for studying culture, cultural artifacts are produced by agents implementing their agendas in contexts that constrain what they can accomplish. In our case, those producing AIDS talk are evaluating and debating information, entertaining their friends, seeking advice, and assessing potential actions, in pursuit of their own agendas, both collective and personal. They do so in a variety of quotidian contexts that offer constraints and possibilities, both real and imagined. It is this sense of purposive agendas, social performance and evolving collective production that differentiates hearsay ethnography from the pallid interview above. In the semi-structured interviews conducted as part of the MDICP, even though the interviewers had unusual latitude in the order and wording of the questions, the interview setting itself elicited condensed and sanitized generalizations rather than the vivid, sometimes ribald, back and forth of actual talk. Focus groups are not much better. Rather than pursuing agendas that are part and parcel of everyday life, participants follow the agenda imposed by the researcher. These difficulties are exacerbated in Africa. Focus groups are meant to stimulate natural discussion and debate. But transcripts of focus groups, including our own, show that natural talk rarely happens. Rather, moderators and participants follow the model of classroom instruction in Malawi, with the moderator asking questions and the participants answering one at a time, deferring to rather than joking with the moderator. In addition, the focus groups produce, as do the semi-structured interviews, responses that conform to current messages of AIDS prevention distributed through the prevention bureaucracy. Finally, in a time when many rural Malawians are feeling the effects of

'research fatigue' or have grown tired of participating in multiple research projects, it is important that researchers adapt their previously mundane, tired methods to more effectively capture the meat of everyday life.

Classical ethnography permits an outsider to overhear everyday conversation, but it has several disadvantages when compared to the method of hearsay ethnography. One problem is that village talk is likely to take a different turn when the anthropologist joins the conversation. As Philip Salzman (1999:96) notes, ethnography "gives us a good idea of what people will say to anthropologists, what pronouncements it pleases them to make, which self-image they wish to present to us, [but] we have little way of knowing what people will actually do, how they will act in their encounters in the real world." Salzman may be too dismissive. A very good ethnographer, one who learns local slang and learns to relish eating grasshoppers, who observes and participates in at least some local settings, and who focuses on trying to retain and record the details of conversational exchanges would be able to capture some of the dynamics of everyday chatting. But it is significant that even in excellent ethnographies one almost never finds the back and forth of everyday talk. There is a further disadvantage of classical ethnography when compared to our journalists' conversational diaries, and that is simply the volume of material and the variety of situations on which our journalists report. An anthropologist might be in Malawi many months or years and hear relatively few spontaneous discussion of matters like the advantages and disadvantages of condoms, or gossip about which neighbor is "moving with" which girlfriend. These topics might be less likely to come up in the anthropologist's presence, or, more likely, she or he might only rarely be in the contexts where such matters are discussed. Only multiple ethnographers, of varying ages, gender, and lifestyle situations could have access to the varied contexts from which our journalists report.

A major advantage of hearsay ethnography is that it reveals the natural contexts in which people discuss the issues that interest the researcher. AIDS comes up at the borehole where women draw water, at the market, in buses and jitneys, on the village path, in bars and *bawo* parlors, and in homes as well as more formal public settings like churches and village meetings. These places of sociability are, of course, far different from the artificial settings of survey interviews or focus groups. And whereas interviewers are trained to seek a private place where the respondents' views cannot be overheard by others, in the day-to-day life of rural Malawians, they both announce their views publicly and overhear the opinions of others, perhaps in turn relaying what they hear to yet others. Indeed, the Western emphasis on informed consent and privacy is puzzling: people are used to solving problems together and can't imagine why, for example, a son or daughter would be expected or permitted to chat with an interviewer out of their earshot. Our ethical concerns as well as our conventional methods limit what we can learn about how knowledge is made and evaluated locally. But more important than the physical location of conversations is that they are social activities that have a multiplicity of uses: scandalous stories provide entertainment; a chance meeting at the borehole offers an opportunity to seek advice for a deeply personal concern; gossip about other villagers, or those known to other villagers, provides narratives of moral instruction; and a chat at a funeral may turn into a philosophical discussion.

DIAGNOSING AIDS WITHOUT A BLOOD TEST

To illustrate what we learn from the journals about how knowledge circulates and is put to use, we examine a frequent activity in rural Malawi: speculating on the HIV status of relatives, friends and neighbors who are ill or who have died. In rural Malawi, it was difficult to get a

blood test for HIV until 2005, when the government expanded access to voluntary counseling and testing (VCT) to district hospitals and some smaller rural health facilities. Before that expansion, sick patients in a hospital or at an STD clinic might be tested for HIV for the benefit of the health care personnel, but VCT was available only in freestanding clinics in the two major cities (a long and expensive bus trip for most rural Malawians) or in special projects. Even now, most Malawians have not been tested for HIV. Whether or not a relative, friend or neighbor is sick from, or has died from, AIDS is, however, a topic of intense interest. Many conversations in the journals feature "social autopsies," where individuals discuss or debate the AIDS status of people around them, often apparently with a view towards learning lessons that might be helpful in their own efforts to prevent infection.

Usually, the participants begin by invoking a series of physical symptoms they have "seen with their own eyes." Speakers rarely debate the legitimacy of the constellation of the symptoms presented as evidence for infection with AIDS; rather, when they debate it is about whether they agree that an individual under discussion is infected. This usually involves moving away from an initial focus on visible, physical symptoms and moving toward discussions of the "movements" of that person, or his/her moral fiber. The main physical symptom of infection is weight loss, or becoming thinner. Thus, weight loss is given a certain primacy in the act of social diagnosis; in other words, it is usually present when people reflect publicly on a person's AIDS status. Variations on observations of weight loss include the notion of a "weak body" or "a body like a child's." Other times, people are sure that someone has AIDS because he/she is wealthy and eats a "well-balanced diet" but still loses weight. In addition, diagnoses of AIDS may be made based on the presence of other physical symptoms such as sores on the body, and particularly on the

face. An interesting physical symptom that recurs throughout the journals is change of the quality or coarseness of hair or hair loss. In the presence of weight loss, a person who has this kind of hair, or change in hair type is likely to be viewed as HIV-positive. This symptom is interesting because it is not one of the symptoms that health prevention experts use to diagnose AIDS. However, its repetition in conversation indicates that it has become a legitimate sign of AIDS locally.

Because rural Malawians know that the symptoms of AIDS may be symptomatic of other illnesses, they often proceed to pool what the participants in the conversation know about the medical history of the person: did he have a sexually transmitted infection? Was she treated for T.B.? Most significant, did he or she have an illness that was treated at the hospital, only to fall ill again within days or weeks. The pooled local knowledge can be quite detailed, including who saw the person at the STD clinic, or who paid for the trip to the hospital. Again, however, participants know that although those with TB or an STD are particularly likely to be HIV positive, some with TB or gonorrhea are not.

In addition, diagnoses of AIDS may be made based on the presence of other physical symptoms such as sores on the body, and particularly on the face, but especially when the physical symptoms are confirmed by elements of the moral biography.

> My friend Robert said that the man is extremely thin .... Beata said that the man is sick and that certainly he is dying, ... his coughing and sores are the signs of his dying. ... Robert said that the coughing started a long time ago and even his sores, but that not every person who suffers coughing and develops sores is dying. "Dying from what?", I asked. Beata said, "Dying of AIDS, I know the man's behavior very well". Robert said, "What kind of behavior?" Beata said that even though the man has two wives ... he goes with other extramarital partners, and that he had met him several times at night when he was going to his sexual partner at Nawangwa Village, and that the woman whom he is running with, her husband has died after a long illness, and people who know about the death of her husband are afraid to have an affair with her because ... her husband died of AIDS… (Simon 030918)

Following most discussions of the physical or bodily status of some individual, speakers usually move to speculate upon their sexual behaviors or movements. This social information is usually used to bolster the interpretations mobilized regarding the particular constellation of physical symptoms exhibited by an individual.

> On the 13th June 2003, I went to Vingula to attend a funeral at the village of my friend Qualida. The man who died, Mr. Tingo, was the older brother of her aunt, her mother's older sister. ... He worked in South Africa[6] but his sister Qualida did not know the type of job that he'd had.
>
> Mr. Tingo stayed there for about five years without coming home to see his parents and his wife. ... When his friends came back from South Africa to see their parents, they told his parents and relatives that he had got married in South Africa and also had other partners apart from his wife and that what he was doing was very bad. ....
>
> Now this fifth year, Mr. Tingo came back from South Africa because he was very ill. ... he was very thin, he could not walk or sit down by himself. At that time he was opening his bowels and he was also coughing very much. He was sometimes vomiting if he started to cough. ... he died in the third week after he arrived. (Alice 030618)

In another excerpt from a different journalist, the moral biography is decisive:

> A lady was walking on the other side of the road. One of the men greeted her, saying "God is great for keeping us alive so that we should meet again today", and the lady replied, "God is wonderful, and the time has not yet come for us to die".
>
> Then a man told his friend who sat with him, "That lady is found everywhere. I used to see her at Mzuzu, Salima, Mchinji, Kasungu, Zomba, Mangochi, Blantyre, everywhere she was going to these places with different men. Those days she was fat. She had to fight off the men. But now she is becoming sick, and I am sure that she has taken this HIV because her body talks". But his friend said that he was wrong to say that she had got this HIV because nowadays everyone has it.
>
> But his friend said, "... I say that the lady has got AIDS because of how she moved, I have seen her. If someone wishes to sleep with her he should know that he is making his grave". (Anna 050330)

On other occasions, AIDS is inferred from a person's appearance in combination with whatever is known of his or her past, even if that does not include knowledge of sexual behavior.

> Today, Monday, I was at the trading centre and saw a man, he wore shorts and a dirty ragged shirt. He was about 28 years of age and was very thin indeed and had sores all over his body. His legs were so thin ... I wished that he had hidden them ... with long

[6] Malawian men have long traveled to South Africa to work in the mines.

> trousers. ... I stood at Mr. Zex's Tomato Bench. I was not buying anything, but was just chatting with Mr. Zex who sells tomatoes, onions, cabbage, ground nuts, pepper, eggplants, rice and other sorts of vegetables. ...
>
> Then I asked, "Where was he living before?". Mr. Zex answered, "The man used to live in Thyolo district where he was working on the tea estates, he migrated there a long time ago, probably when he was young, ... and I heard that he had married there and when his spouse died he only stayed a short period of time and then came back here. He came here last year in December and when he arrived his body was not healthy and I believe it's the same disease which he is suffering from".
>
> I asked, "What do you think the man is suffering from?". He said, "I think I already said that the man is suffering from nothing apart from AIDS".
>
> Then I asked, "Where did he contract it?" Mr. Zex said that where he contracted this AIDS nobody knows but himself. ... He said that probably it was on the tea estates ... He said that on the Thyolo estates ... the trees are always high and leafy and what often happens is that a man and a woman go far away from their fellow laborers for sexual intercourse and in these estates a lot of fornication happens. I exclaimed, "Indeed?" (Simon 030224)

As we can see, in most cases informal diagnoses of AIDS rest on tacit knowledge, the now taken-for-granted association of HIV and AIDS with promiscuous sexual behavior and a corresponding set of physical symptoms. In some cases, however, people rely less on the tacit nature of the knowledge they share and attribute its legitimacy or authority to some source. Usually, these sources include: the radio, gossip, and stories. For example, when one of the journalists asks his wife how she came to know that a male secondary school student is suffering from what she calls, "an unknown disease," she responds by citing the social chain through which she became privy to the information. Though this social chain may amount to little more than gossip or rumor, it grounds the piece of knowledge (that the school boy is infected with AIDS) in embodied individuals who know or live near to the boy:

> My wife said she learnt from her mother, who is the best friend of Mrs. Nkolokosa and she has been going to visit him to see him when he was sick. She went on saying that the patient was nearly about to die because (the wife went on saying that) her mother said that she heard from her friend Mrs. Nkolokosa saying that a patient was to die because one day the patient called/summoned his Father. (Simon 030129)

In another case, a friend of the journalist asks a man how he came to know for sure that some members of a family died of AIDS. The excerpt highlighting this exchange is below. It is notable that Tingo legitimizes the knowledge by suggesting that it is something that is taken for granted or well known in Dausi village where he stays:

> Kili asked him from where he learned this information. Tingo said that he knows about this since the late [parents] were living in Dausi village and he also stays in Dausi village and the rumor is well known to many people within the village and outside the village and everyone knows that the man and his wife had died of AIDS in the way he was suffering together with his wife he said that anyone contracted AIDS is well noticed because of his or her health status becomes very unpleasant and he said that even you can see the way the young girl is looking. (Simon 030707)

THE "DOMESTICATION" OF OFFICAL AIDS INFORMATION

Malawians are very aware that they have been bombarded by official information about HIV and AIDS. Sometimes—as in the early years with condom messages–they remain skeptical, but they also often express the view that anyone who does not understand what AIDS is, how one contracts it, and how one could prevent it, is a fool, or as they often say, intentionally courted death.

People attribute knowledge they have about AIDS to sources like billboards, or the radio, and the MDICP project itself. Certainly, many reflect on their bombardment with AIDS messages and information. In a conversation among young men who speculate about their chances with a group of young women, one youth says, "but you guys we are receiving HIV / AIDS messages almost, every day through radios, newspapers, drama groups, political leaders, medical personnel, chiefs and the like even research teams like LET'S CHAT team yearly they come in Black T-shirts but you can not take a lesson." (Daniel 050305) He cites this as one justification for the claim that anyone who does not know about AIDS or change his behavior is an idiot.

> Rafiyasi said that when one comes to suffer diseases like *chizonono, chindoko, mabomu* just know that its likely the person has also AIDS, because even the radio also announces about this. (Simon 030206)

Also notable are the instances in which individuals compare one kind of knowledge to another, or note possible discrepancies between two epistemologies for recognizing AIDS. For example, persons frequently use the phrase, "I am not a doctor" before making a claim about the serostatus of some individual. Below, a man acknowledges that because he is not a doctor, he may not be able to conclusively state that a man under question is infected, but he suggests that the knowledge he has regarding this matter is sufficient for him. He has heard the man refer to the large number of women he slept with "plain":

> And that he has AIDS, I believe he has indeed, even though I am not a doctor. But you heard yourself that even a Zasintha Bus can be filled by the ladies with whom he has slept plain [no condom] always. (Simon 020613)

Another example, in a discussion of a group of prostitutes:

> What do you think is the purpose or reason why their body status has greatly and completely changed as you say?" Lawrence answered saying, "Nothing, apart from AIDS, definitely. Even though I am not a doctor that has examined them, but I absolutely believe that it's AIDS. They have this disease in their bodies because indeed they were the sex lovers and great prostitutes. They used to have several sexual partners and the partners were only the rich and not the poor. (Simon 020730)

In short, then, the kind of diagnosis we see in the journals is a social process. Part of the ability to make a diagnosis of AIDS rests on convincing those around you that the foundation for your diagnosis is a good one. In the series of excerpts presented here, we note a few ways in which speakers legitimatize or make their knowledge authoritative: attribution to sources such as radio, attribution to social chains or familiarity with local context, and a generalized tacit knowledge, or reference to facts or information that is so prevalent that it need not be elaborated upon. In this way, speakers are able to make diagnoses of individuals' serostatus without a blood test. Nonetheless, despite the absence of scientific evidence of infection, much of the speculation in

the journals suggest that rural Malawians find their way of diagnosing those around them to be useful, generally correct and reliable regarding AIDS.

AIDS IN MALAWI: MISCONCEPTIONS THAT MATTER

The international AIDS prevention community has identified several knowledge questions that it considers important that those at risk of HIV infection be able to answer correctly (WHO 2004:38). Those who claim that people need more correct information typically point to relatively high proportions of survey respondents who, when asked whether HIV can be transmitted by mosquitoes or by sharing plates, say Yes. The other indicators are not believing that condom use and fidelity can reduce HIV risk and that a healthy-looking person can still be infected. These are then considered "misconceptions" that need the attention of programs. The contrast between what respondents say on a survey and what they say to each other is illuminating: in the hundreds of social autopsies in our journals, it is extremely rare that mosquitoes or sharing plates are mentioned as a source of infection. Perhaps in their role as respondents, people think that it is theoretically possible that HIV can be transmitted by mosquitoes or sharing plates, but when they are in their natural settings and engaged in trying to figure out why a particular person they know has died of AIDS, these "misconceptions" are never used as an explanation. The social autopsies, as well as other types of conversations in the journals, do, however, expose fundamental misconceptions about the epidemiology of HIV, misconceptions that are not tracked b y the WHO or used as Millennium Development Goals. In particular, rural Malawians vastly overestimate the transmission probabilities of HIV and they drastically underestimate the time from infection with HIV to the appearance of the symptoms of AIDS. These misconceptions matter for local strategies of HIV prevention.

A critical misconception (partly created by the deluge of public health warnings) concerns how easily HIV is transmitted through sex. While the actual risk of infection from a single act of sexual intercourse is 1/1000 or less (Gray, Wawer, Brookmeyer et al. 2001),[7] most Malawians have been led to believe that HIV is easily transmitted. In several MDICP surveys, respondents were asked how likely it was that one act of sexual intercourse with an HIV infected person would lead to infection for the other partner. Over 95% said the probability of transmission was either certain or highly likely. Since husbands and wives are expected to be having intercourse, it is not surprising that Malawians strongly believe that if a husband is infected than so must his wife be, and vice versa.

> She said, "Yes, indeed, people say that lying together is dying together. If he has HIV/AIDS, I have HIV/AIDS, but I know that we don't have it."
>
> And I asked, "How do you know? Did you go for a blood test?"
>
> She said, "I know myself and he told me one day that he doesn't have HIV/AIDS. He went for a blood test and found that he doesn't have it." (Simon 020319)

The belief that if one spouse is infected it is inevitable that the other is as well leads to considerable puzzlement when one dies, supposedly of AIDS, but the other survives.

> Miss Tinenenji said that she does not believe that her husband died of AIDS.
>
> During the time that Mr. Eliasi was ill, many people said that he had AIDS since he had several sexual partners. Women did not refuse Mr. Eliasi because he had money and when people said he was suffering from AIDS, she believed them. When his illness became serious, she took him to the hospital where VCT was done on him and the results were that he was HIV positive.

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[7] Following a study of monogamous, heterosexual discordant couples in Rakai, Uganda, Gray et al. (2001) estimate the overall probability of transmission per coital act was 0.0011. It is important to remember the transmission rate of HIV varies; some factors proposed to effect the variance in rate of transmission include: presence of sexually transmitted infections, male circumcision, and viral load of the HIV-positive individual. For example, a study of men who had acquired a sexually transmitted disease from a group of prostitutes with a prevalence of HIV infection of 85% found an overall cumulative HIV transmission rate of 0.03 (Cameron et al.,1989). Still, the estimated rate from the Cameron et al. (1989) study is much lower than that estimated by respondents in the MDICP.

> The doctors at the hospital tried to save his life but failed. It is now almost seven years since Mr. Eliasi died but Miss Tinenenji does not show any signs that she has HIV. She said that if her husband was HIV positive she should be HIV positive as well because they slept together, having sex without ever using a condom(Alice 041124)

Kaler (2004) has written of the "fatalism" that, especially earlier in the epidemic, often entered conversations about AIDS. A terrible plague (*mlili* in Chichewa, the term for the Biblical plagues), AIDS was sometimes seen as inevitable: "AIDS is for people not for chickens," or as one man said, "Everyone will dies of AIDS because no one can resist sex either with a wife or other sexual partners" (Simon 030125). It turns out that actual fatalism is rare and becoming rarer, and people are actively trying to find ways to avoid infection with AIDS (Watkins 2004). On the other hand, their attempts to avoid infection are hampered by their belief in the perfect transmissibility of HIV. As one young man says when his friends urge him to break up with an unfaithful girlfriend:

> He went on speaking that since he had been sleeping with her for a long time and moreover plain sex, then there is no need that he can divorce her for if it is the matter of AIDS disease then he had already contracted it and how can he avoid AIDS and if she has it it means he had it…. (Simon 040130)

Malawians tend to assume that if one has had sex even once with someone who is already infected, then one is infected as well: "Lie together, die together." Thus, when a young man says, after his first sexual encounter with a young woman who he hopes will be his "real girlfriend," that "Indeed, friend, if Grace has AIDS, she has given it to me, I couldn't resist her attractions." (Simon July 8-10 2001), he is spontaneously offering a serious AIDS "misconception."

The second consequential misconception, seen frequently in the social autopsies, is a telescoping of the time between risky sexual behavior and the visible symptoms of AIDS. Hence, although

people know and sometimes say spontaneously that a person can be infected with the AIDS virus and still look healthy, they often also attribute the illness to behavior that happened only a year or two before, or they insist that if someone really looks fat, she or he cannot be infected.

The central message of HIV prevention programs has been to practice the ABCs: abstinence before marriage, behave faithfully after, and, when that is not possible, use condoms consistently. The journals show that virtually all in rural Malawians know that these are effective measures of prevention. They also show, however, that for many the ABCs are considered unattainable or undesirable. They are unattainable because humans naturally want sex. They are undesirable because strictly following the ABCs would take away much of the pleasure of life. Thus, in conversations in their social networks, participants rework the strict ABCs into more flexible rules for sexual behavior, as well as discussing other strategies of prevention that are not on the international prevention agenda. Currently, local Malawian modifications of the ABCs are to reduce the number of partners, both pre-marital and extra-marital, and to select these fewer partners with greater care by drawing on local knowledge of a prospective partner's medical history and sexual biography. The journals also expose local strategies of prevention that are not mentioned among the recommendations of the international prevention community. One of these is to divorce a spouse whose behavior threatens "to bring AIDS into the family"; a second is to turn to religion for support in resisting the temptations of multiple sexual partners.

Although these strategies of prevention are not perfect, when practiced by many they could reduce the incidence of new infections. It is surely better to avoid selecting a partner whose husband died of AIDS than to select a partner in ignorance of that local knowledge; similarly, a

woman who is uninfected but worried because her husband is promiscuous might avoid infection by divorcing him. Yet these strategies, we believe, are likely to be more effective if rural Malawians have correct knowledge of the transmission probabilities of HIV and the duration from infection to symptoms. If joint testing were to become a routine precursor to initiating a sexual relationship, there might be no need to speculate about a potential partner's HIV status.[8] Since it is not, it would be better were the speculation grounded in what is scientifically known about the epidemiology of HIV. As it is, their misconceptions also put Malawians at risk as they try to navigate the epidemic (Watkins 2004) by deciding who might be a safe sexual partner, and when to break off a relationship or divorce as a way to avoid infection (Reniers 2008). Additionally, a key current prevention approach, the promotion of VCT to learn one's status, is hindered by the misconception that "to lie together is to die together": in conversations about the advantages and disadvantages of VCT, a major reason given for not seeking testing is "There is no need, I know I must be infected." The apparent discordance between the kinds of misconceptions organizations like WHO are trying to address and those we found circulating in everyday conversation is clear, and we suggest that hearsay ethnography is one method by which researchers may be more likely to come across the actual motivations, ideas, and claims that affect AIDS-related behaviors in local Malawian settings.

CONCLUSIONS: As a method, conversational journals allow sociologists and health researchers access to spontaneous uses of health information by real people, on the ground, trying to harness their own understandings to protect themselves from a terrible disease. This method shows how health information can be integrated with local knowledge through local

[8] The "window period" after a person is first infected, when viral load is very high but antibodies have not yet developed, makes even joint HIV testing less-than-perfect protection. See Epstein (2007).

social processes and relations to become real in people's everyday decisions about their lives; and it can also reveal misunderstandings—often created by the international public health community itself—that can actually hinder local people's ability to take effective steps to avoid illness and death.

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