Older adults' experiences of ageing, sex and HIV infection in rural Malawi

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Declaration

I certify that the thesis I have presented for examination for the PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

I warrant that this authorisation does not, to the best of my belief, infringe the rights of any third party.

I declare that my thesis consists of 97,035 words.

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Emily Freeman

Abstract

This thesis contributes to understanding two demographically important phenomena: African ageing, and the ageing of the African HIV epidemic. Building on the body of interpretivist demography that privileges context and meanings, it explores older adults' experiences of becoming old, sexuality and living with HIV in rural Malawi.

The research uses a constructivist grounded theory framework. It is based primarily on data produced using repeat dependent interviews (N=135) with older men and women (N=43). These are supplemented by fieldwork observations, as well as data from a three-month multi-site pilot study, interviews with HIV support groups (N=3), and key informant interviews (N=19) and policy documents.

The thesis identified sets of meanings surrounding old age and ways of discussing ageing that, taken together, formed an analytical framework. The framework is focused on the importance of maintaining an 'adult' identity and draws insights from sociological and psychological identity theories. The adult identity was aligned with personhood. It was situated within the body-centred livelihood system of rural Malawi, and associated with physical production. Old age was understood to limit productivity and thereby an individual's adult identity. This thesis argues that ostensibly contradictory narratives about ageing experiences can be understood as rhetorical strategies respondents employed to maintain their adult identities. A central tenet of the thesis is that the adult identity (and its childlike counter identity) influenced older adults' broader experiences and behaviours. This framework is used to explore ageing, as well as sex and HIV infection. The grounded understandings of older adults' experiences developed in the thesis are presented against dominant understandings of the situation of older adults documented by the academe and in policy and programmatic arena emerging in Malawi.

The findings highlight the centrality of wider experiences of ageing for older adults' experiences of sex and HIV, as well as the broader importance of identity for understanding demographic behaviours and processes. In addition, they demonstrate how grounded theory and repeat dependent interviewing can be used within demographic studies to produce nuanced analytical accounts of the experiences that are most salient for the population of interest.

For my parents, who have given me everything.

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Glossary, translations, acronyms and abbreviations

Africa	Used in this thesis to refer to sub-Saharan Africa
Agogo	Respectful address for an older adult (Chichewa)
AIDS/ Edzi	Used to refer to both the HIV and AIDS
Anganga	Respectful address for an older adult (Chiyao)
ART	Anti-retroviral therapy
Blood	Used to refer to a body's strength and vitality and any fluid in the body, including blood and ejaculate.
Borehole	Communal well or water pump
Bwana	Boss
Chatting	Having sex
Chibwenzi	Non-marital romantic relationship that typically involves sex
Chitenji	Cloth wrap used by women to cover their skirt or to carry things, including babies
Chiwerewere	Illicit sex
Dimba	A well-water plot used for growing fruits, vegetables and rice
Friend(ship)	Used to refer to sexual partner(ship), in addition to a platonic relationship
Isilisya	Soaked and dried reeds used to make mats
Kachilombo	Literally 'virus', used to refer to HIV
Let's Chat	The MLSFH survey team
Manpower	Herbal 'Viagra'
Matrilineal	Recognising kinship with and decent through females
Matrilocal	Marriage in which the couple resides in the same location as the wife's kin
MLSFH	Malawi Longitudinal Study of Families and Health

Movious	Promiscuous; moving from one sexual partner to another in quick succession
Mzungu	White foreigner
Nkhokwe	Maize store/granary
Nsima	The staple meal of maize flour mixed with water to form porridge or a stiff patty
Nyamakazi	Translated as rheumatism neuralgia or sciatica
Proposing	Requesting sex
Relish	Vegetables (pumpkin, pumpkin leaves, greens and sometimes tomatoes), meat (goat and chicken) and fish (typically dried) to eat with nsima.
Sing'anga	Herbalist and/or spiritual healer
Ufa woyera	Maize that has first had the outer kernel shell and seed germ pounded off before being milled
VCT	Voluntary counselling and testing
Zibwenzi	Plural of chibwenzi

Chapter 1 | Introduction

"Across the globe, demographers think population aging is the most important problem for the next 20 years, except for Africa where demographers view the HIV/AIDS pandemic the most important problem."

(Van Dalen and Henkens 2012, p. 369)

Population ageing, and increasing numbers of older adults, now take centre stage in demography as "unquestionably the most important demographic force of the first half of the twenty-first century" (Schoeni and Ofstedal 2010). In the global response to the HIV epidemic, the significant and rapidly increasing number of older adults with HIV is gaining recognition as one of the most important challenges for the coming years (Negin *et al.* 2012). The rate of growth in absolute size of the older population will be fastest in sub-Saharan Africa (Africa) (United Nations Population Division 2011), the region that also accounts for 67 per cent of all HIV prevalence (UNAIDS 2010). This thesis contributes to understanding both of these demographically important phenomena in Africa, by exploring older adults' experiences of ageing and of HIV infection in rural Malawi. The choice of Malawi as a case study is to an extent arbitrary: the questions asked in this thesis are pertinent for a number of east and southern African countries with high HIV prevalence.

1.1 African Ageing

Africa's population remains in the earlier stages of the demographic transition. Although its population is ageing, the rate of increase in the population share of older adults is occurring at a slower rate than in other world regions. However, high past and current fertility, along with some gains in life expectancy, mean that the rate of increase in the absolute number of older adults is growing faster in Africa than in any other world region. Between 2010 and 2100, the number of older adults is expected to increase by a factor of 14.9 in Africa, compared to just 3.6 in Asia and 4.0 in Latin America and the Caribbean (Aboderin 2012). Over the next fifteen years the number

of older adults will increase by more than 60 per cent, from around 43 million in 2012 to almost 70 million in 2027. The following fifteen years will see that figure reach 121 million (U.S. Census Bureau 2012).

However, life expectancies at birth for approximately 80 per cent of African countries are lower than 55 years (Velkoff and Kowal 2007). Further, while definitions of older age in the region are changing (e.g. Livingston 2002), they have typically not been centred on chronology (Glascock and Feinman 1980). In light of this, some scholars have suggested that considering the proportion and number of adults aged over 50 gives a more insightful picture of population ageing in Africa (Lightfoot 2010; World Health Organization 2001). Using this definition, the projected number of older adults in Africa in 2027 and 2045 is twice that estimated using a definition of 60 years (U.S. Census Bureau 2012).

Malawi has a youthful population: at the 2008 census 8.76 per cent of the population were aged 50 and older and 4.23 per cent were aged 60 and older (National Statistical Office of Malawi 2008). However the absolute size of the older population is set to rise rapidly. Closely mirroring the rate of increase across the region, the number of adults aged 50 and older and 60 and older are both projected to increase by 67 per cent between 2012 and 2027, and by 57 and 60 per cent respectively between 2027 and 2045 (U.S. Census Bureau 2012).

Researchers have associated these demographic changes, as well as AIDS morbidity and mortality among economically productive adults, with social changes that are expected to have negatively altered experiences of old age across Africa (Apt 2002; Cohen and Menken 2006). This understanding has explicitly and implicitly shaped the research on African ageing carried out in the social sciences since the late 1980s. There are effectively two, quite separate, bodies of writing: anthropological and 'other'. While anthropological attention to old age as part of an integrated life course perspective long pre-dates this period, much of the work carried out over the last 20-30 years has centred on problematic ageing in response to these macro-level changes (Stroeken 2002). The second body of 'other' research has been labelled African gerontology, although it includes the work of scholars who might first identify with alternative disciplines, such as demography. It was initiated explicitly in response to

these changes (Apt 2005, 2012), which have since formed the "building blocks" of the discipline (Ferreira 1999, p. 1).

Set against a background of macro-level causes of problematic ageing, both bodies of writing have typically addressed the health of older adults (e.g. Ainsworth and Dayton 2003; Dayton and Ainsworth 2004; Ferreira and Makoni 2002; Ice *et al.* 2008; Kimokoti and Hamer 2008; Wilson *et al.* 1991), transfers of formal and informal material and social support to and from older adults (e.g. Aboderin 2004a; Adamchak 1996; Apt 1995; Bohman *et al.* 2007; Cattell 1990; Cattell *et al.* 1997; Cliggett 2001, 2005; Darkwa and Mazibuko 2002; De Klerk 2008; Hosegood and Timaeus 2005; Ingstad *et al.* 1992; Lombard and Kruger 2009; Maffioli *et al.* 2007; Ogunmefun and Schatz 2007; Paradza 2009; Rosenberg 2009; Schatz 2007; Schatz and Ogunmefun 2007; Seeley *et al.* 2008b; Van der Geest 2002a, 2004; Williams and Tumwekwase 2001; Zimmer 2009), and the social position of older adults within their families and communities (e.g. Cattell 2002; Ferreira 2004; Kaler 2006; Moller and Sotshongaye 2002; Sagner 2002; Van der Geest 1997). This grouping certainly omits research. For example, Amy Kaler's research in rural Malawi collected data from older adults, but compared these with archival data to document social change itself, rather than older adults' experiences of and responses to it (Kaler 2001, 2006). More specifically on old age, work around the "grandmother hypothesis" (Hawkes 2003) does not fit into these groups and does not appear to be influenced by the broad demographic, social and health changes documented. However this crude grouping is telling of the weighting of research on African ageing being carried out across countries, disciplines and epistemological approaches.

Again, with some notable exceptions, particularly that carried out within a tradition of anthropological work on ageing (e.g. Cattell 2002; Van der Geest 2002b), this body of writing has argued that demographic and social changes in the region are responsible for altering the nature and structure of the rural family. The migration of younger adults to urban areas and the expansion of access to formal education are understood to have eroded "the value base of African traditional society" (Apt 2012, p. 95), depriving older adults of their respected leadership roles and the familial care and support they traditionally received. The death of younger adults from HIV/AIDS and orphaning of their children is understood to have further shifted the transfer

balance, as older adults' take on the care of young children and lose the care of young adults. These changes have left older Africans vulnerable to poor nutrition, worsening health and psycho-social problems. Evidence indicating the resilience of familial support for older adults in the face of demographic and social change has made little impact on the pervasiveness of these understandings (Aboderin 2004b). They continue to shape research and policy agendas (Chapter 7 and 8).

The understandings presented in these existing bodies of research are important aspects of ageing in Africa. However, despite the burgeoning interest in African ageing from anthropologists and gerontologists, very little empirical research focuses directly on the subject of being or becoming old itself (Makoni 2008; Sagner 2002). Instead, research has explicitly sought to elaborate older adults' experiences with regard to one or more of the dominant macro-level themes outlined, or it has omitted the 'voices' of older adults, presenting more inductive description of their experiences, but within an ethnographic narrative (e.g. Cliggett 2005; Howell 2010; Lee 1992). In response, Sinfree Makoni has argued that the relevance of much of this "lament discourse" on ageing in Africa is questionable without sufficient evidence on "how aging [*sic*] Africans themselves describe their own conditions in their own terms" (Makoni 2008, p. 201).

1.2 Ageing of the African HIV epidemic

Estimates of HIV prevalence at older ages in Africa are limited by availability of data. Major sources of HIV statistics across the region, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS 2009) or the nationally representative household Demographic and Health Surveys (Measure DHS 2012), typically only present data for men and women aged between 15 and 49 years. However, extrapolating from these data, an estimated 3 million Africans aged 50 and older are infected with HIV - 14.3 per cent of the adult disease burden (Negin and Cumming 2010). This indication of considerable HIV prevalence in older ages is mirrored across the region in estimates derived from the very few HIV surveys to have included adults aged over 49 (National AIDS and STD Control Program MoH Kenya 2008; Shisana *et al.* 2009), and data from medical settings (Ibara *et al.* 2002; Mtei

and Pallangyo 2001), small communities (Kassu *et al.* 2004; Nyambi *et al.* 2002), and case reports and verbal autopsies (Knodel *et al.* 2002; Negin *et al.* 2010).

In Malawi, HIV prevalence after age 49 may be greater than at younger ages. Again extrapolating from data on younger adults, Negin and Cumming estimate older adults (50+) had an HIV prevalence of 12.7 per cent, compared to 11.9 per cent of adults aged 15-49. This accounts for 18.6 per cent the total adult HIV epidemic (Negin and Cumming 2010). Using more reliable population-based data for all-aged adults in a rural sample in Malawi, Freeman and Anglewicz differentiate between 'older old' and 'younger old' groups. They identify low HIV prevalence after age 64 (0.7 per cent among men and 1.3 per cent among women), but considerable prevalence at ages 50-64 (8.9 per cent among men and 5.4 per cent among women). For men, HIV prevalence between ages 50-64 was significantly higher than at younger ages (4.1 per cent). In their rural sample, HIV at older ages accounted for 43.5 per cent and 16.3 per cent of the total adult male and female HIV prevalence (Freeman and Anglewicz 2012).

One of the greatest successes of the global response to HIV is that prevalence of HIV in older adults is set to rise dramatically. Increasing access to anti-retroviral treatment (ART) across Africa will enable HIV-infected individuals to survive into old age. Studies in Malawi, Ethiopia and South Africa have shown declines in mortality at the population level following scale-up of ART coverage (Herbst *et al.* 2009; Jahn *et al.* 2008; Reniers *et al.* 2009). In Uganda, a prospective cohort study suggests life expectancy for adults with HIV after early initiation of ART is almost equal to that of non-infected adults (Mills *et al.* 2011). Across the region, Hontelez *et al.* use a microsimulation model to predict the impact of ART coverage in 43 countries. They estimate that at the current rate of increase, the number of adults aged 50 and older with HIV will almost triple in just 30 years: from 3.1 million in 2011 to 9.1 million in 2040. This changing age-composition of the epidemic would see one in four HIV-infected people aged over 49 (Hontelez *et al.* 2012).

HIV infection at older ages has important health implications. Data from high income countries indicate that HIV infected adults aged over 49 have poorer prognoses than their younger counterparts. HIV infection causes the immune system

to decline through the depletion of CD4+ T cells. However ageing itself is associated with declining functionality of the immune system (immunosenescence). Older individuals have fewer CD4+ cells and are less able to produce new CD4+ cells. There is evidence that immunosenescence is accelerated in HIV-infected individuals as they age, exacerbating HIV (Somarriba *et al.* 2010). CD4+ reconstitution in response to treatment in adults aged 55 years and older has been found to be significantly lower than in younger adults (Goetz *et al.* 2001). Even with highly active antiretroviral therapy, the time from HIV infection to AIDS or death is shorter in older individuals than younger adults (Schneider *et al.* 2005).

ART is most effective when started before CD4+ cell counts become very low (World Health Organization 2010). However, older adults in Europe are also typically diagnosed with HIV later and with lower CD4+ cell counts than younger adults (Health Protection Agency 2010; Longo *et al.* 2008; Mothe *et al.* 2009). Older adults who diagnose late are substantially more likely to die within a year of diagnosis than older adults who are not diagnosed late or younger adults who are diagnosed late (Smith *et al.* 2010). There is some evidence to suggest this pattern of late-diagnosis at older ages is likely to be mirrored in sub-Saharan African settings (Fylkesnes and Siziya 2004; HelpAge International 2004; Negin *et al.* 2011).

In addition, high income country data indicate a high prevalence of HIV-related illnesses among adults over 49 years. Studies have identified elevated cases of metabolic syndrome (Adeyemi *et al.* 2008) and reduced bone mass density (Arnsten *et al.* 2007) among older infected adults; and compared to younger infected adults, higher risks of extrapyramidal motor signs (Valcour *et al.* 2008), developing AIDS dementia complex (Larussa *et al.* 2006; Longo *et al.* 2008), wasting syndrome, and of presenting multiple AIDS-defining illnesses (Longo *et al.* 2008). Recent data from Uganda found older adults with HIV were more likely to have syphilis than younger adults with HIV (Mukasa *et al.* 2012). Older infected adults also experience higher rates of many non-AIDS-related illnesses than younger infected adults or older uninfected adults (Adeyemi *et al.* 2003; Goulet *et al.* 2007; Hughes *et al.* 2010; Magalhaes 2007; Mothe *et al.* 2009; Power *et al.* 2010; Stuart-Buttle *et al.* 2010; Ward *et al.* 2010). Further, increasing ART provision is likely to increase prevalence of non-communicable diseases (NCD) in the HIV-infected population, either through

association of drug regimens with NCD risk (Brown and Qaqish 2006; Valcour *et al.* 2005), or by increasing survival of adults into older ages in which NCD risk increases (Bendavid *et al.* 2012; Justice 2010; Negin *et al.* 2012).

The evidence base for the prognosis of older adults with HIV comes almost exclusively from high income countries. Recent data from Africa has presented a more complicated picture. On one hand, HIV infection is worse at old ages than at younger ages. Data on ART treatment outcomes in Uganda (Bakanda *et al.* 2011), South Africa (Mutevedzi *et al.* 2011), and a combination of data from seventeen ART programmes in nine African countries (Greig *et al.* 2012), all suggest that advanced age is associated with higher HIV-related mortality. On the other hand, given high prevalence of poor health in the older population, older adults with HIV appear to fair better or at least the same as older adults without HIV. Other data from Uganda (Scholten *et al.* 2011) and South Africa (Nyirenda *et al.* 2012) respectively suggest that HIV-infected older adults may have similar health and functional ability to other older adults, and better health and functional ability than adults who have been indirectly affected by HIV infection of family members. The two studies highlight the benefit of increased access to general health care related to HIV treatment programmes in settings where universal access to health care is poor.

It is unlikely that prevalence of HIV in older age is exclusively attributable to the survival of adults infected in younger age. Data from high income countries indicate considerable numbers of older adults acquire HIV later in life (Smith *et al.* 2010). While there have been few measures of HIV incidence after age 49 in Africa, estimates from rural South Africa suggest that incidence in older adults is likely to be high (Wallrauch *et al.* 2010). Zaba *et al.* identified secondary peaks in HIV incidence around age 40 in pooled data from five longitudinal community-based studies in Uganda, Tanzania, Zimbabwe and South Africa (Zaba *et al.* 2008).

Although an imagining of asexuality in later life is frequently referred to in the literature on HIV in older age in Africa (e.g. Bendavid *et al.* 2012), quantitative studies have consistently highlighted considerable sexual activity at older ages. For example, in five longitudinal studies in Tanzania, Uganda, Zimbabwe and South

Africa the majority of 'young older' adults aged 40-60 reported being sexually active (McGrath *et al.* 2009).

In rural Malawi, period data for 2010 indicate 50 per cent of women and almost 85 per cent of men aged between 50 and 64 reported being sexually active, as did three-quarters of 'older old' men and a quarter of 'older old' women aged 65 and older. While the 'old older' generally had fewer sexual partners than those aged 15-49, the likelihood of having more than one sexual partner did not significantly differ by age. Men's average number of recent sexual partners remained above one until around aged 80 (Freeman and Anglewicz 2012).

In the Malawian study, much of this reported sexual activity is expected to take place within marriage, where the majority of HIV transmission takes place. Given continued sexual activity and the likelihood of sexual networks in which HIV can be transmitted, the authors argue that HIV risk from multiple sexual partners is expected to remain at older ages in Malawi (Freeman and Anglewicz 2012). This situation is unlikely to be unique: data from 'older old' adults in south-western Nigeria indicate that around a quarter of adults aged 65-100 had extra-marital sex at least once as an older adult (King *et al.* 2010).

Several studies have shown that older adults are less likely to use condoms than younger age groups (King *et al.* 2010; McGrath *et al.* 2009). Using survey data collected across nine sites in west, east and southern Africa, Negin *et al.* identified lower awareness and knowledge of HIV prevention measures among adults over 50 than those aged 15-49 years (Negin *et al.* 2011), mirroring findings using Demographic and Health Survey data from 39 counties in the region (Negin and Cumming 2010), the findings of some earlier qualitative research among older men and women (HelpAge International 2004; Ingstad *et al.* 1997; Williams and Tumwekwase 2001), as well as more recent data collected in rural Kenya (Muturi and Mwangi 2011).

Nevertheless, recent data has suggested that older Africans do perceive a risk of HIV infection. Qualitative data collected in rural Uganda indicate some older adults were concerned about becoming infected through new sexual partnerships (Seeley *et al.* 2008a). In rural Malawi, quantitative data indicate a relatively high proportion of

older old men (16 per cent) and women (8 per cent) aged 65 and older report being "very worried" about their personal risk of infection (Freeman and Anglewicz 2012). In urban Kenya, almost 40 per cent of adults aged 50 and older recognised HIV infection as a general threat to the older population (Chepngeno-Langat *et al.* 2012). In addition, a number of studies have identified concern among older adults about becoming infected through providing care to younger adults with HIV (Agyarko *et al.* 2002; Munthree and Maharaj 2010).

Studies on HIV at old age are in their infancy globally, and in Africa in particular (Negin *et al.* 2012). Almost all research attention in Africa has focused on identifying HIV prevalence after age 49, understanding prognosis and treatment outcomes of infected older adults and exploring risk and risk perceptions. Across all of these indicators, older adults are expected to differ from younger adults, bringing unique challenges for HIV prevention, management and care (Bendavid *et al.* 2012, p. 87). There has been very little research published that considers the lived experiences of HIV infection at older age in these settings, nor how older Africans' experiences of 'being old' and having HIV - so widely understood to be linked - might map together.

1.3 Situating the thesis

I began with what demographers think the most "important problem(s)" are for the coming decades. But what do older adults themselves think is important? As Makoni notes, "we cannot assume that because something constitutes a problem to scholars it inevitably does so to the subjects of enquiry" (Makoni 2008, p. 201). Research on both ageing and HIV at older age in Africa, from scholars working both within and outside of demography, has typically lacked emic perspectives about how older Africans' experience becoming old or having HIV, or what they themselves identify to be the salient elements of their experiences. The rapidly expanding body of work in these two areas has done little to answer how older adults themselves understand old age and how that might influence their behaviour, or how older adults themselves understand HIV at old age, and how those understandings might shape what it is like to grow old with HIV in Africa.

Demography's ability to quantify the extent, cause and consequences of African ageing and the ageing of the African HIV epidemic is incredibly powerful, and probably necessary for making either phenomenon a priority for policy and programme makers. But the discipline has more to contribute to understanding than simply "counting everything human" (Hardin 1991, p. 339). Understanding demographic behaviours and processes requires understanding the personal and social motivations for and meanings of these behaviours and processes in the context of people's lives.

In recognition of this need, there has been a rapid increase in the use of qualitative methods in demography since 1980 (Randall and Koppenhaver 2004). These methods have most frequently been deployed to studies of family dynamics, fertility, family planning, sexual health and HIV in particular (Coast *et al.* 2009).

Much of this research has been carried out within demography's traditional theoretical and epistemological home. Researchers have used qualitative methods – most frequently focus groups or semi-structured interviews (Coast *et al.* 2009) – but have not engaged with interpretive qualitative analysis that recognises the subjective meaning of social action (Coast 2003; Greenhalgh 1997; Randall and Koppenhaver 2004; Riley and McCarthy 2003). For example, in their review of the use of qualitative methods by demographers, Randall and Koppenhaver document the way analysts have treated research participants' translated words as face-value statements that reflect their singular experience of an objective reality (Randall and Koppenhaver 2004, pp. 64-65).

However, some research represents a more significant movement towards what Riley and McCarthy suggest might be called a "new demography" (Riley and McCarthy 2003, p. 12). This body of demographic work has sought to free the discipline from the uncritical and unquestioned application of positivist approaches to understanding the social world, and instead incorporate the critical theories and postmodern perspectives that have successfully transformed neighbouring social sciences such as geography, sociology and anthropology (Riley and McCarthy 2003; Williams 2010). This has involved a focus on emic perspectives that privilege local knowledge in the interpretation of demographic behaviour and processes; contextualising

understandings; greater reflexivity; attention to interpretation; and mirroring developments across the social sciences, natural sciences and humanities, the inclusion of a wider variety of models and conceptual strategies from other disciplines (Riley and McCarthy 2003, p. 162). Indeed, there is growing recognition that, while challenging, and while not the only way (Gannon 2005), intellectual progress towards identifying salient questions and solving complex problems is often made at the intersections between disciplines (Coast *et al.* 2007).

Much of the qualitative demography on African ageing and HIV infection at older age outlined here reflects the discipline's traditional epistemological and theoretical perspectives. However, work on ageing outside of Africa and work on HIV among younger Africans has embraced these 'new demographic' approaches. In doing so, these scholars have produced research that has challenged established understandings of demographic behaviours and processes.

For example, with regard to ageing, Schröder-Butterfill's research in three rural Indonesian communities draws on longitudinal qualitative and quantitative data that combines ethnographic and panel survey methods. In doing so, she produces nuanced understandings of heterogeneous inter-generational flows of familial support to and from older adults, as well as meanings of and motivation for these flows that contradict longstanding images of Asian family systems (Kreager and Schröder-Butterfill 2008; Kreager and Schröder-Butterfill 2012; Schröder-Butterfill 2004). With regard to sexuality and HIV, Coast's research among Maasai in rural northern Tanzania draws on ethno-demographic literature, survey and qualitative group interviews. She identifies contested language surrounding the identification of HIV and complex understandings about the importance of giving and receiving semen that challenge both the salience of language used in large-scale survey questionnaires such as the Demographic and Health Surveys, and the relevance of HIV prevention messages promoting abstinence, fidelity and condoms for their intended audience (Coast 2007).

This thesis fits within this body of 'new' demographic research. It builds on the existing research that has highlighted rapid demographic change that may increase the vulnerability of older adults in Africa, and a growing HIV epidemic among a

population that is both, at increased risk of HIV-related morbidity and mortality, and typically excluded from research and prevention efforts. It does this by aiming to create a framework for understanding how older adults living in rural African experience ageing and HIV infection. It presents research guided by two broad questions:

- How do older adults living in rural Malawi experience getting older?
- How do older adults with HIV living in rural Malawi experience their infection?

The thesis argues that understanding these experiences requires reflection on the meanings of and responses to HIV, sexuality and old age in the social, cultural and conceptual context of people's lives.

The study was designed within a constructivist paradigm, encompassing interconnected ontological, epistemological and methodological assumptions (Guba and Lincoln 1994, pp. 107-108). It started from a position of relative unknowing: while some specific experiences of older age in Africa had been investigated (for example, their health (Ice and Yogo 2005) or living arrangements (Hosegood and Timaeus 2005)), very little was published on experiences of old age and ageing more broadly. To the best of my knowledge, nothing had been published on older adults' lived experiences of HIV. Any investigation into these experiences therefore had to be explorative and allow for discovery. Grounded theory, with its broad emphasis on the inductive generation of substantive, middle-range theory based on simultaneous collection and close analysis of data "that show process, relationship, and social world connectedness" (Denzin 2010, p. 297), provides a well-suited methodological strategy. Central to the methodology is the construction of theory that is grounded in the particular issues within the area of interest that are most important to the population being studied (Glaser and Strauss 1967; Mills *et al.* 2006); this study is concerned with the experiences of ageing and HIV infection that were most salient to the older adults participating in the research.

Despite the 'cultural turn' in demography outlined, grounded theory has been little used by scholars working within the discipline. Reviewing research reported in the ten most-consulted demographic journals, I found only 12 applications of the methodology (Appendix A). This is surprising given the unified commitment from

those working across the discipline to empirical data. As Van Dalen and Henkens note: "The norm among demographers is to stay close to the data. This focus may be one of the strongholds of demography, and makes it stand out from other social sciences." (Van Dalen and Henkens 2012, p. 397). The value of empiricism is at the very heart of grounded theory, a methodology specifically focused on staying close to the data in developing our theories or descriptions.

Further, grounded theory consists of several distinct research strategies tied to contrasting epistemological allegiances that could therefore speak to both sides of demography's fence. (See (Charmaz 2008b) for discussion of the developments, challenges and revisions made to the method over 40 years, and (Mills *et al.* 2006) for conceptualisation of these revisions taking the form of a "spiral", rather than the set of binary oppositions as presented by Charmaz). In this thesis grounded theory was employed in its constructivist revision, rejecting the positivist underpinning of its earlier formulations (Glaser 1992; Glaser and Strauss 1967) but building on its relativist ontological foundations and symbolic interactionist theoretical perspective (Corbin and Strauss 2008; Strauss 1987; Strauss and Corbin 1998). It was applied conceptually as laid out most recently by Kathy Charmaz (Charmaz 2006, 2008a). However, following the tradition among proponents of grounded theory to reconstruct and reconfigure its process (Charmaz 2008b), I modified some of Charmaz's procedures for data analysis in light of the logistical and theoretical concerns of conducting research in Malawi (explored further in Chapter 2).

Constructivism holds that individuals intersubjectively develop meanings and understandings about the world based on their experiences, observations and interactions. These multiple, changing, complex and often contradictory meanings form an individual's reality, shaping how they see the world. Constructed meanings cannot be true or false in any absolute sense, only more or less informed or sophisticated (Guba and Lincoln 1994, p. 111). Understanding how older adults experience ageing and HIV infection requires explanation of the meanings that underpin older adults' realities, the contexts within which the meanings were created and an appreciation of how these meanings, and therefore realities, change over time in response to changing contexts. The ultimate goal of the research was therefore the analytical interpretation of the ways older adults in Malawi made sense of their

realties with regards to their experiences of ageing and HIV, at the same time recognising that any interpretation is problematic, relativistic, situational and partial (Charmaz 2008b, p. 470).

This thesis's constructivist ontology inspires an epistemology in which the research reality is also recognised as being a co-construction: a "site of performance" (Grenier 2007, p. 716). During the research process both respondents and researchers create and play out particular stories, negotiate and manage their identities, and construct meaning through interaction and interpersonal processes (Holstein and Gubrium 1995). The social reality the respondent experiences and the social reality that is disclosed during a research encounter are shaped by self-identity, the interpersonal relationship between the researcher and respondent, and the purpose of the encounter, as it is understood by researcher and respondent. Data are not discovered.

Throughout data collection and analysis I therefore sought to critically reflect on how the respondents', my research assistants' and my unfolding interests, personal biographies, interactions and power dynamics shaped what was recognised as data, the data then collected and how I interpreted them. The findings presented here are not offered as being based on themes emerging *from* the data, but from themes emerging from *my interpretation* of the data; what I present is the reconstruction of experiences and meanings (Mills *et al.* 2006, p. 26), which have first been reconstructed by respondents and research assistants. Further, in this study, these social interactions between researcher and researched are not only regarded as influences shaping the data that must be recognised and taken into account, but as data themselves. For example, that respondents sought to discursively manage their identities during research conversations was given the same weight in the analysis as the identities they sought to present.

This approach is intimately connected to the way the study's results were constructed and are presented in this thesis. Like other demographic work influenced by postmodern perspectives, the study incorporates theoretical and empirical insights from other disciplines; here, social psychology, sociology, gerontology and anthropology. Reflecting the grounded theory approach which privileges evidence from respondents over hypotheses or frameworks provided by these insights,

literature is incorporated alongside analyses of collected data within the following substantive chapters (Chapters 3-6), and in the concluding chapter (Chapter 8), rather than in a more traditional review chapter. In doing so, understanding of respondents' narratives is further developed and the relevance of the findings is extended.

1.4 Outline of the thesis

In Chapter 2 I further detail the research design used, and introduce the key method developed for accessing emic perspectives on ageing and HIV: repeat dependent interviews. I explore how this approach allowed for complex, sometimes contradictory, and confused narratives about ageing and HIV to be more fully understood than would have been possible using survey data, or the qualitative methods more regularly favoured by demographers. I outline how and when theoretical insights from other disciplines were incorporated into this demographic thesis. I discuss some of the limitations of the research design as well as the ethical challenges involved in conducting research in a resource poor setting.

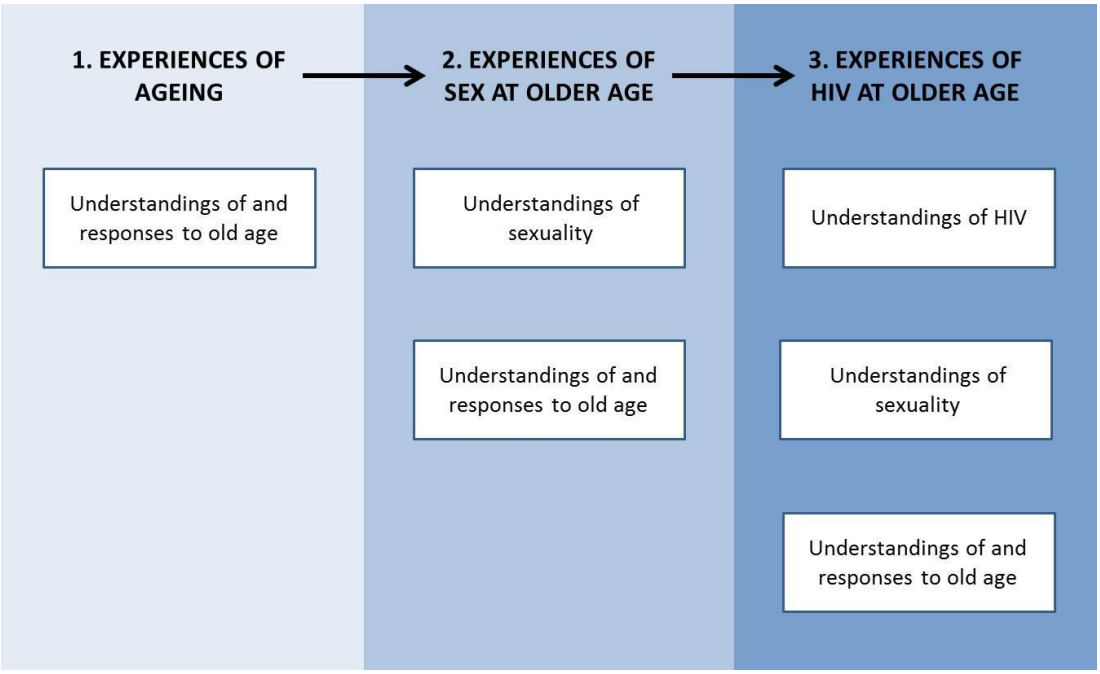
In the following four chapters (Chapters 3-6) I present the central substantive contribution of the thesis based on data collected from older adults over 11 months of fieldwork. It argues that lived experiences of ageing and HIV in this setting are dominated by older adults' understandings of becoming old, sexuality in later life, and HIV infection at older age, and their responses to these understandings. These three sets of understandings and responses are interconnected and cumulative (Figure 1).

How older adults understand and respond to HIV (that is, how they experience HIV) is shaped by their understandings of and responses to 'being old' more broadly. In addition, as at younger ages (Dixon-Mueller 1993; Oomman 1996), experiences of HIV at older age are shaped by meanings of sexuality in the social, cultural and conceptual context of people's lives. Meanings of sexuality at older age are in turn, also shaped by understandings of, and responses to, old age.

These understandings and responses underpinned the way older adults in Malawi discussed a wide variety of topics, for example, their relationships, health and food

security. Subsequently, a core tenet of this thesis is that they are also central to understanding the elements of experience set out in the existing literature, such as the position of older adults within society, care for HIV-infected and non-infected older adults and the risk of HIV infection.

Figure 1 Themes explored in this thesis



Chapters 3 and 4 introduce the two key themes on which the analytical framework of cumulative understandings and responses is built. The first is the centrality of the body in respondents' understandings of ageing, sex and HIV, and its importance for personhood, here represented by the 'adult' identity. The second is respondents' motivation and strategies to maintain positive 'adult' identities.

Chapter 3 focuses on understandings of ageing and old age in the study setting. Using social psychological and sociological identity theories, the chapter sets out how their body-centred understandings of old age challenged older adults' social and personal identities. Chapter 4 builds on this analytical account to explore how older adults responded to the threats to their identity, using social psychology's Identity Control Theory. The chapter identifies and accounts for competing narratives about ageing experiences by suggesting that they reflect discursive strategies to maintain positive identities in older age.

Chapter 5 presents a further step in the cumulating framework: older age sexuality. It begins by exploring how sex is understood in rural Malawi. It links ethnophysiological understandings of sex to meanings of old age identified in the preceding chapters. It then explores how these understandings shaped respondents' experiences of sexuality in older age.

Chapter 6 discusses older adults' experiences of HIV. It draws on understandings of and responses to ageing and sexuality at old age, as well as the changing understanding of the HIV epidemic over the last twenty years. It identifies understandings of HIV at older age that, like age discussed in Chapter 3, challenged older adults' sense of self. The chapter then explores how older adults with HIV made sense of and managed their identities in light of these challenges.

Taken together, the three sets understandings and responses provide a framework for interpreting how older adults experienced growing old and HIV in rural southern Malawi. Chapter 7 introduces ageing and HIV in the Malawian capital, Lilongwe. It is here that policies and programmes that could shape ageing and HIV in the field site in future are set. This thesis is not policy-focused and policy implications that can be drawn from the study's findings are restricted. The purpose of this chapter however is to set the experiences of ageing and HIV identified within the country-level setting. Using a quite different, more descriptive analytical approach from the previous chapters, I review documentary and key informant interview data to set out the broad policy landscape and identify the major discourses *about* older adults in rural Malawi. I note how these understandings reflect the international literature on African ageing.

In the final chapter, Chapter 8, I summarise the analytical framework for understanding ageing and HIV I present in this thesis. I discuss the contributions of my account to understandings of sexuality and HIV in later life and to understanding of demographic behaviours and events. I discuss the differences between my account and that which I identify in the academic and policy arenas and offer some tentative suggestions for policy in light of these. Finally, I present some limitations of the study and highlight directions for future research.

1.5 Significant contributions of the thesis

This thesis makes four major contributions to knowledge:

Firstly, it broadens the way experiences of growing old in Africa are understood and framed. It does this by exploring emic understandings of old age and responses to becoming old that underpin the experiences of changing demographic, social and economic contexts that have formed the core of writing on African ageing. Further, it extends academic understanding of old age in Africa based on the anthropological work discussed by privileging and presenting individuals' (albeit re-constructed) narratives about how they interpret and experience old age.

Secondly, it constitutes one of the first substantive studies of the lived experiences of older adults with HIV in Africa.

Thirdly, it is one of very few qualitative investigations into sex in older age in Africa, and the first in Malawi. It focuses on the meanings of sexuality in the social, cultural and conceptual context of people's lives, as well as on wider experiences and understandings of old age. In doing so it produces a nuanced analytical understanding that contributes to debates about sexuality in the gerontological literature, both within and outside of Africa, by moving the discussion beyond the presentation of continued sexual activity in later life as surprising or as an indicator of successful ageing (Scherrer 2009). Further, it provides a more sensitive framework for understanding sexual disinterest or inactivity than the emphasis on heavy social sanctioning of sex in old age described in both the academic and policy and programmatic literature.

Fourthly, it makes two methodological contributions. The first is to African gerontology (broadly speaking). This thesis demonstrates how the use of grounded theory can produce previously unexplored aspects of old age that develop academic focus beyond considering problematic ageing in the context of macro-level demographic and social change. The second is to demography. As well as adding to the body of 'postmodern' qualitative demography that has opened up new ways of viewing established demographic 'problems' (Riley and McCarthy 2003), this thesis presents and examines the use of repeat, dependent in-depth interviews. It offers

them as a useful tool for the collection of credible qualitative data and its grounded analysis in demography.

Chapter 2 | Methodology

The study aimed to create a framework for understanding how older adults living in rural Malawi experience ageing and HIV infection. This chapter sets out the study's methodology, designed using constructivist grounded theory (Charmaz 2006, 2008a). It describes how the data were constructed and analysed. Reflections on the quality of these data are highlighted throughout the chapter.

I refer to data construction rather than data collection to discuss the study's methodology and results in order to underline its epistemological contention that data about the social world do not exist 'out there' to be passively 'collected'. Instead, much like the analysis, they are produced - 'constructed' - by the researcher and the research process. Similarly, I use photographs and a first-person narrative to emphasise my presence in the field and role in shaping the data and their analysis. When referring to other research, I use the more familiar phrase 'data collection' in order to reflect quoted scholar's preferences.

2.1 Method choice: Why interviews are the main method

The research aimed to explore older Malawians' experiences of ageing and HIV infection in relation to their social worlds and from their perspectives. It has been argued that participant observation, the original tool of the anthropologist, is the ideal method for accessing such emic understandings (Bleek 1987; Denzin 1989). Although participant observation typically involves a range of data collection techniques, including document analysis and interviewing (Denzin 1989, p. 183), it is direct participation in the lives of the researched that is the method's distinguishing feature. By living with and as the people studied for extended periods of time, the method enables the researcher to access first-hand the complex social contexts of their participants' words and behaviours, increasing their ability to identify and understand the multiple realities of their participants (Matthews 2005). According to Bronislaw Malinowski, only 'I-witnessing' (Geertz 1989, pp. 73-101) can reveal either the processes of daily life too mundane for respondents to voice, or the

behaviours or beliefs respondents consider too improper or unbecoming to discuss with the outsider researcher (Malinowski 1932a, 1932b).

Is it possible to 'I-witness' the experiences and behaviours investigated here? Being old, having HIV, having sex with or as an older adult, and self-care while experiencing declining physical strength to name a few, do not lend themselves to easy observation, and participation would be ethically objectionable, were it not impossible. As a result, some have argued that demographic questions, concerned as they often are with intimate, significant behaviours and events carried out in bedrooms, in sensitive spaces or in secret, rule-out participant observation as a realistic research method (Lofland and Lofland 1995).

However, given the constructivist ontology and the privileging of context in this research design, and since older adults and those with HIV do not live in isolation of younger adults or those without HIV, I argue that full immersion in the public daily life of older adults, and asking questions about the private activities and feelings that are not open to participation or observation, would be possible and could yield high quality data (as used by (Hochschild and Machung 1989; Hukin 2012; Lareau 2011)). Nevertheless, three latent difficulties remain with the use of 'full' participant observation here (that is, participant observation methods which include the researcher living as part of the group being studied for a considerable period; Raymond Gold's "Participant-as-observer" (Gold 1958)).

The first two are concerned with my position as a demographer. It has been argued that demographers have neither training nor time available for participant observation (Coast *et al.* 2007; Knodel 1997; Matthews 2005). Indeed, my own skill-set reflects my training in non-anthropological qualitative approaches. While this would be surmountable, the second challenge I believe, should not be underestimated, and highlights considerable differences between disciplines in the type of research questions typically asked. The questions I ask here, at their core concerned with the effects of the rapidly changing epidemiology of a communicable and fatal illness, cannot wait the necessary years required to gain fluency in the respondents' languages and for long-term immersion in a community. As Sjaak Van

der Geest notes "anthropological reports often appear many years after the facts, post-post-mortem one could say" (Van der Geest 2010, p. 91).

A third challenge concerns talk about older age sexuality and arises from the study's understanding of the research reality as a construction. Anthropologists working in other African settings had reported that older Kel Ewey Tuareg women acquired a culturally androgynous status in West Africa (Rasmussen 1987), that discussion of sex at old age with Akan women was limited by a degree of "prudishness" in Ghana (Van der Geest 2001, p. 1385), and that the ease of sexual presentation observed among 'younger older' female !Kung (aged 45-65) was diminished in later life and had not been included in research in Botswana (Lee 1992). Old age sexuality in Malawi was undocumented. Had it been understood in similar ways, it was unlikely that older adults' sexual behaviours and experiences would be visible to a researcher outside a formalised research environment. Further, if old age sexuality was socially circumscribed, it was unlikely that older adults would be confident talking about sex to a (albeit temporary) member of their social network, or that their sexual behaviours would be the subject of gossip – the "speaking and listening" that constitutes the majority of the participant observers' data (Van der Geest 1998c, p. 47) – in the way that say, HIV infection or illicit sex at younger ages might be.

To avoid these problems, but still maintain access to the rich, contextual data awarded by full participant observation, this study used repeat, dependent in-depth interviews with older adults as the central tool for generating data. Questioning in dependent interviews builds on data previously gathered from the respondent. In this study, which applied the method within a grounded theory framework, dependent interviews additionally built upon data constructed from interviews with other respondents, observational data gathered and themes identified from on-going literature review as the focus of the study was shaped and refined. The research conversations were regarded as "episodes of participant observation" (Matthews 2005, p. 801), aiming to encourage respondents to voice both the activities and behaviours that might have been observable to a co-resident participant-observer, as well as the complex and emotionally-charged behaviours, feelings and intensions that would not necessarily have been. In this way, the interviews generated detailed,

multi-layered data about both older adults' experiences of ageing and HIV infection and the contexts in which these experiences are based.

Fieldwork in rural Malawi was carried out over 11 months. During this time I lived in the small towns and trading centres neighbouring the rural field site. I spent time with respondents at their homes as a guest, observing and being observed, but only occasionally participating in everyday life (Section 2.5.7). Despite limited participation, being able to observe the most visible elements of older adults' contexts – the kinds of homes people live in, their kitchens and bathrooms, house work and leisure, who was present, who was absent, who visits, people's farms and people working on them, how people physically interact – helped to interpret what respondents said during interviews. These elements of daily living are often so ordinary respondents would not volunteer to describe them and an 'outsider' researcher would not know to ask about them. My observations on the "imponderabilia of actual life" (Malinowski 1932a, p. 18) fed into my construction and analysis of interview data[1].

2.2 The inductive research process

The questions we ask of the empirical world both reflect and frame what we know of it (Charmaz 2008a, p. 206). Therefore for the data we produce to tell us something meaningful, that is, if they are to have any relevance to respondents' experiences of their realities, we must first identify the right questions to ask. Following the identification of HIV and ageing in Malawi as a broad focus for the research, data construction and analysis aimed to maximise opportunities to discover the range of understandings and experiences I might investigate. This was achieved by beginning with broad research questions and an 'open mind' (that is distinct from an 'empty

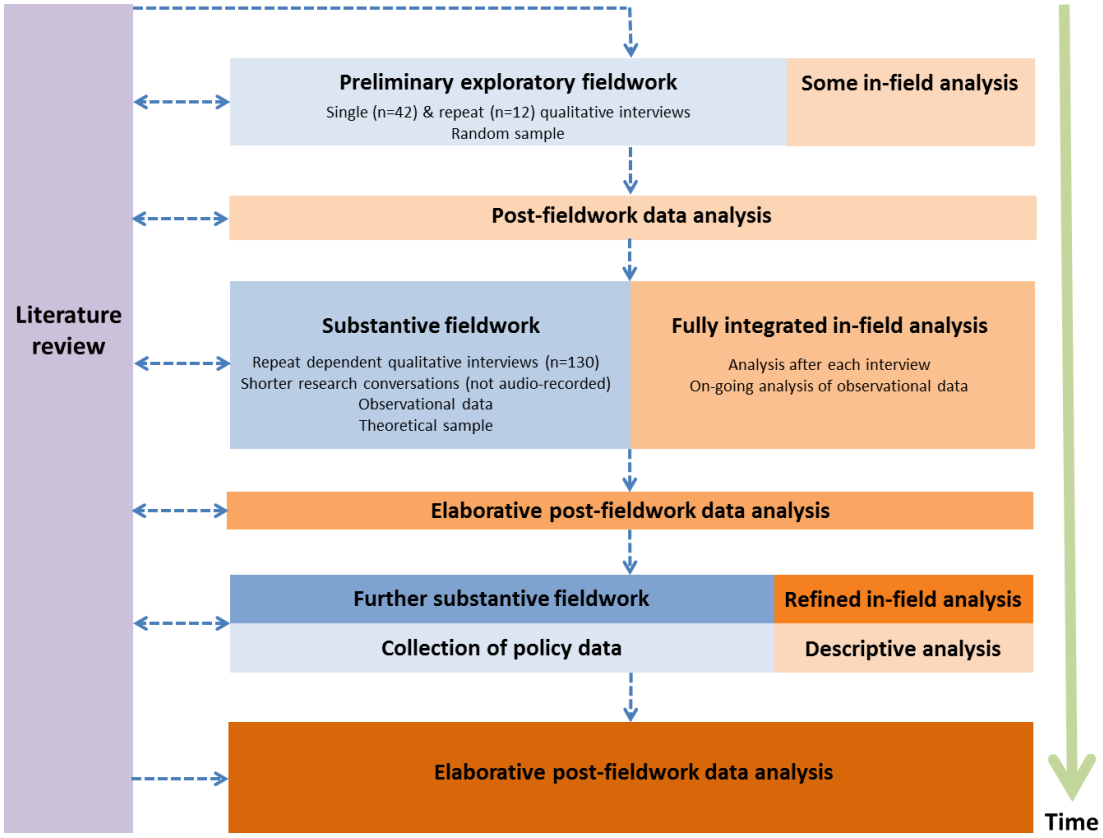
[1] As such, for some commentators, particularly those outside anthropology, the approach adopted here still constitutes participant observation, understood to involve a spectrum of roles and levels of participation. See for example Alan Bryman's reading of Gold's Roles in sociological field observations in his presentation of participant observation for (general) social scientists (Bryman 2008, p. 410-411) and Katy Bennett's introduction written for the cultural geographer (Bennett 2002).

head' (Dey 1993, p. 63)), and proceeded to continually develop, test and revise emergent questions and hypotheses based on the empirical data constructed.

At the macro-level, this inductive research design was played out in five components: constant review of available literature; preliminary exploratory fieldwork incorporating interviews with older adults and some in-field analysis (3 months, June-August 2008); an extended period of substantive fieldwork incorporating interviews with older adults and in-field analysis of interview transcripts (6 months, February-August 2009); a subsequent period of fieldwork incorporating key informant interviews in the Capital, Lilongwe and a small number of follow-up interviews with older adults (2 months, April-June 2010); and periods of further elaborative analysis of data conducted outside of the field site.

The macro-level process is illustrated in Figure 2. For readability the remaining chapter is broadly organised according to each of these phases, although follow-up interviews with older adults in 2010 are included within discussion of substantive in depth qualitative data construction in 2009. However, the grounded theory methodology used was emergent and the procedure described was one interlinked process, rather than a sequence of easily-separated linear steps. The final analytical account presented in this thesis was produced over the course of this process as I explored and consolidated ideas following construction and analyses of further data. This evolving process is highlighted in the figure by growing intensity of colour.

Figure 2 Inductive research process (macro-level)



2.3 Continuous literature review

Barney Glaser's original conception of grounded theory involved delaying review of relevant literature "so as not to contaminate…inhibit, stifle or otherwise impede" a researcher's ability to build an analysis that is really grounded in the data, rather than existing models of understanding. The approach aimed to place the researcher in position of objective neutrality (Glaser 1992, p. 31). This study's epistemology disavows the possibility of such a position. Instead, seeking out and drawing from other researchers' work was here treated as an on-going and essential part of the inductive research process.

In line with Corbin and Strauss' later grounded theory, themes identified from previous research were drawn upon to develop both the initial broad research questions and the subsequent areas for investigation during cyclical data construction and analysis (Corbin and Strauss 2008, pp. 36-38). Literature reviewed at the

beginning of the study identified the likelihood of considerable unexplored HIV prevalence among older populations in African and non-African settings, while research into HIV infection at younger ages identified the importance of considering wider social, cultural and sexual experiences and meanings. This, together with my general disciplinary perspectives (gained from formal training in geography post its cultural and critical turn, as well as from the interpretivist demographic research highlighted in the introduction), shaped the study's broad research topics, setting, conceptual emphases and research questions, and the methodological strategy. Subsequently, this literature, and that on ageing more broadly, was used to design the initial interview guide used in the first preliminary phase of exploratory fieldwork, and the theoretical sampling frame used in the substantive fieldwork outlined below.

Literature was also referred to during both phases of the analytic process: in- and post-fieldwork. During fieldwork themes arising in my interpretation of constructed data were investigated in, and compared to, the available literature in order to increase my theoretical sensitivity to issues (Corbin and Strauss 2008, p. 32), stimulate my thinking about the properties or dimensions of the theme, and help identify further questions to be asked in subsequent interviews. For example, when diarrhoea and the challenges presented by receiving or providing assistance with personal care began to reoccur during conversations about experiences of getting older, I searched for literature on these topics. Van der Geest's description of dealing with human faeces in Ghana (Van der Geest 1998a) resonated with the data already constructed and helped me shape further questions on the theme that were put to respondents during our next interviews. Subsequent questions for interview were shaped by the resulting discussions. Considerable care was taken to treat themes identified in the literature as general areas for investigation, rather than particular hypotheses for testing. This was to avoid narrowing data construction around research questions that might not be the most appropriate ones and to ensure that previously unconsidered interpretations, areas and themes were not missed.

In the second phase of elaborative analysis following data construction, literature was used to inspire questions I asked of the data, stimulate and enhance my construction of messages contained in the data, validate my interpretations by confirming findings, or to illustrate areas in which the literature is lacking (Corbin

and Strauss 2008, pp. 36-38). For example, the salience of identity management for understanding how older adults experienced ageing and HIV infection was identified from the way respondents presented themselves in contradictory ways during research conversations. This led me to the body of research on identity and in it, identity control theories. These theories were used to further refine and extend my analyses, and subsequently to frame my presentation of the analytical account in this thesis.

In line with the influence of scholarship contributing to a postmodern turn in demography (outlined in Chapter 1) and the study's grounded theory approach in which literature is consulted primarily by virtue of its content (that is, being on the same topic as an analytical theme), literature was identified using on-line and library catalogues that were not discipline-limited. Following the specific themes emerging in my analyses of constructed data, the literature consulted was more often from outside demography. Perspectives used in the construction, analyses and presentation of data in this thesis are drawn from sociology, social-psychology and anthropology, as well as demography.

2.4 Preliminary exploratory fieldwork

I carried out preliminary exploratory fieldwork in 2008 with four aims. First, I aimed to orient myself to elements of daily life in rural Malawi - the immediate context to older adults' experiences. These data would be used in the final design of data construction methods and for beginning to build an understanding of older adults' experiences. Secondly, I aimed to ascertain which broad issues older adults identify as being important in shaping their experiences of ageing, and as a key part of that, check that HIV, identified as being important in the literature reviewed, also reflected a salient concern for older adults in Malawi. These issues would be used as the starting position for substantive data construction and further literature review. Thirdly, I aimed to test the chosen methods for eliciting data on these topics, and finally, to select an appropriate field site in Malawi to investigate them.

2.4.1 Introduction to rural Malawi and the context of older adults' lives

Access to the study population was secured through the Malawi Longitudinal Study of Families and Health (MLSFH) (previously known as the Malawi Diffusion and Ideational Change Project), a longitudinal panel survey in rural Malawi. Although carrying out data construction within the auspices of an established research project may introduce certain biases (Section 2.5.11), the benefits offered for this study were numerous. The MLSFH negotiated permission for conducting the study from Malawian national, regional and local authorities, provided an introduction to the practicalities and logistics of conducting research in this setting, and made data available that could be used as a frame for drawing a theoretical sample for qualitative data construction. In addition, access to quantitative and qualitative data collected by the MLSFH, as well as studies detailing aspects of life in rural Malawi by researchers using these data, provided a rich introduction to the contexts in which older adults are ageing in this setting. In line with the study's ontological and epistemological approach, knowledge of this context is central to constructing an understanding of older adults' situational experiences of ageing and HIV infection, and to interpreting respondents' interview performances.

Preliminary fieldwork was timed to coincide with the MLSFH's biennial data construction. Since 1998 the MLSFH has constructed quantitative social, demographic and health data from a sample of 1,541 ever-married women, then aged 15-49, and 1,065 of their typically-older spouses. Their sample is drawn from villages in three districts, one in each region of Malawi (Figure 3). In 2008 the MLSFH added a sample of approximately 800 parents of MLSFH respondents, selected based on their residence within a MLSFH sample district. This extended the upper age of the MLSFH's female sample from 57 to 92 years old.

The MLSFH also collects qualitative data using observational field journals. These journals have been kept by "cultural insiders" (Watkins and Swidler 2009, p. 162): Malawians living in the MLSFH sample districts. They document translated conversations about HIV/AIDS overheard by journalists in natural settings. The conversations captured are immersed within journalists' day-to-day experiences and

provide rich data on the dominant discourses about a wide range of issues beside HIV/AIDS. More detailed description of the MLSFH quantitative and qualitative data and samples are presented elsewhere (Anglewicz *et al.* 2009; Invest in Knowledge 2011; Watkins and Swidler 2009; Watkins *et al.* 2003).

During preliminary fieldwork I became a member of the MLSFH research team, traveling with them to each of their sample sites. I coordinated collection of data from the new sample of older parents and assisted with administration of the main survey. Observational data I constructed during this time focused on the most easily observable elements of survey respondents' lives: How compounds and villages are arranged, people's homes, bore holes, farms, trading centres, and importantly, where older adults typically spent their days. Further introduction to the cultural and social context of the field site, along with dominant discourses and way language is used, came from close reading of the MLSFH observational field journals. As part of the MLSFH project to prepare these data for wider analysis, I undertook line-by-line coding of a series of journals (n=c.20) using a set of MLSFH predefined codes.

Working with the MLSFH also introduced me to a network of international researchers working on rural Malawian livelihoods. Informal discussions and sharing ideas with these researchers stimulated my theoretical sensitivity and thinking about the experiences of older and younger adults in rural Malawi. In addition, on-going conversations with the MLSFH's local survey fieldworkers about their understanding of the strengths and limitations of quantitative data collection provided useful insight into how respondents (and their neighbours) discussed and understood international researchers and research activities, the topics covered in the MLSFH questionnaire and the wording of the questions. The contextual data constructed and accessed during this period represented essential building blocks for both understanding older adults' experiences, and the final design of my substantive fieldwork.

Figure 3 Map of Malawi showing MLSFH sample districts

Source: Adapted from (Benson *et al.* 2002)

2.4.2 Identification of salient issues for understanding ageing in rural Malawi

Parallel to my work with the MLSFH, I conducted exploratory in-depth interviews with older adults living within each of the MLSFH field sites. Interviews aimed to elicit data that would allow me to identify salient topics for building an understanding of older adults' ageing experiences, confirm the relevance of HIV for older adults' ageing experiences in the field sites, and begin to explore how older adults made sense of and understood these topics. Data were constructed using both conventional single interviews and the chosen method of repeat dependent interviews. Single interviews were used to enable data on salient issues to be constructed for a larger number of older adults in the sample sites, while repeat interviews, used towards the end of this period of fieldwork, were used to elicit more in-depth data on the meanings and understanding of these issues.

An initial interview guide for single interviews was developed prior to fieldwork based on the literature reviewed. This was revised on several occasions during preliminary fieldwork as new themes and questions emerged from my reading of data being constructed in qualitative interviews, my own observations in the field sites and those documented in the MLSFH journals, and my daily conversations with MLSFH researchers and fieldworkers. Interview guides for repeat dependent interviews were developed during fieldwork.

Single interview guides contained broad prompts intended to encourage respondents to discuss the issues most salient to them with regards to getting old in rural Malawi. Concerned to reflect the lived (un)importance of HIV for respondents, initial guides did not ask about HIV directly. Instead, prompts about experience of problems, changes respondents had witnessed in their lives and communities, and sex and relationships in older age, aimed to consider respondents' indirect experiences of HIV infection (e.g. caregiving, loss of familial support), identified as the epidemic's most significant impact on older adults in previous research (Agyarko *et al.* 2002; HelpAge International 2004; Williams and Tumwekwase 2001), and their direct experiences of HIV (e.g. risk of HIV infection), less explored in the existing literature but identified as a possible concern from my review of the few estimates

available (e.g. Shisana *et al.* 2005). Reflecting the dominance of the topic in the literature published during the planning of the study (Chapter 1), the guides also included questions specifically about familial support networks. Although conscious that these questions might overly direct research conversations, the importance of the issue for respondents quickly became evident and questions about these topics remained in all revisions of the interview guide.

Repeat dependent interview guides covered a wider number of topics than single interview guides, identified from review of the literature as well as data constructed in single interviews. They included more targeted prompts and specific questions (including about HIV), and were designed to elicit more in-depth data regarding the way respondents understood these topics.

Data analysis began during exploratory fieldwork. This was much less intensive than the cyclical process of data construction and analysis carried out during the later period of substantive fieldwork (explored below). Interviews were transcribed and translated by research assistants every few days. I read these transcripts and noted general themes and areas for further investigation. These were added to the interview guide.

Following this period of fieldwork, I carried out line-by-line descriptive coding on about half of the interview transcripts (25 of 54, representing all regions and by all of the interviewers employed) to more closely scrutinise the data. Data within each code were compared to develop the properties of the code. These explorations formed the starting position for further inductive data construction during the substantive fieldwork phase. They were used to identify salient areas for investigation and the respondent characteristics on which to draw an initial theoretical sample.

Reflecting the breadth of exploratory questions asked during interviews, initial findings were numerous. The most significant for the direction of further fieldwork were that:

- Filial support was frequently discussed and particularly salient for respondents' experiences of ageing. This support was multi-directional and based on shifting

resource availability rather than predetermined roles. Men and women had different caregiving roles.

- However, filial support with regard to the indirect impact of HIV did not appear to be as salient. Although respondents cared for orphaned and non-orphaned children this was not associated with HIV/AIDS particularly.
- Respondents discussed facing a number of problems, often related to loss of physical strength in older age. These included food insecurity, ill health, a lack of money and resources, the absence or inadequacy of material support and widowhood. No respondents discussed their care of children as being a challenge, in sharp contrast to the dominant discourses in the literature reviewed at that time.
- Initial literature review had additionally indicated the importance of focusing on witchcraft accusations for older adults as an indirect impact of HIV, particularly women. Respondents confirmed that witchcraft accusations occur but these were rare, not especially associated with HIV and less of a concern than being bewitched. Moreover, respondents did not appear to regard witchcraft as a salient feature of their ageing experiences.
- Similarly, although identified as a key concern in the literature reviewed, no respondents discussed instances of violence towards older adults.
- Data constructed about respondents' understandings of older age were heterogeneous and ostensibly contradictory.
- Most respondents reported having sex and that sex at older age was different from sex at younger age. While the majority of respondents identified a decline in sexual desire with old age, some respondents reported that sex had improved as they learnt techniques for increasing sexual pleasure.
- None of the randomly sampled respondents discussed having HIV and were not asked to report on their HIV status directly. However, in contrast to findings of previous studies in Africa that found older adults were less informed about HIV, respondents understood the sexual transmission of HIV, some considered themselves to be at risk of HIV and most recognised abstinence and fidelity as effective prevention strategies.

Based on these initial findings, the decision was made to:

- Begin substantive fieldwork by investigating the importance of the ageing body and familial support for older adults' experiences.
- Remain vigilant for, but not focus data construction on, issues of witchcraft and elderly abuse.
- Focus the study on experiences of HIV infection at older age, moving away from the broader consideration of the indirect impacts of HIV that had been researched in other African settings. These latter impacts could be investigated using the MLSFH's observational journals and would arise in research conversations that prioritised discussion of context and familial support in particular.
- Draw a theoretical sample for further data construction based on age (to explore the concept of loss of physical strength), HIV status (to explore experience of HIV infection) and sex (to ensure equal representation).

2.4.3 Testing method choices

The third aim of preliminary fieldwork was to evaluate the use of in-depth qualitative interviews with older adults to elicit data on experiences of ageing and HIV infection, as well as the logistics of fieldwork in this setting, such as the practicalities and implications of interviewing in respondents' homes, response rates I might expect, working with research assistants and the level and type of training they were likely to require. Since repeat dependent interviews have rarely been evaluated, testing the feasibility, acceptability and usefulness of the method was considered to be especially important. Using both single and repeat interviewing enabled comparison of the techniques.

Fourteen adults aged over 49 years were randomly selected for single interviews from the MLSFH respondent listing in each sample site, Mcjinji, Rumphi and Balaka (N=42). In the final site, Balaka, three dependent interviews were carried out with an additional 4 older adults (N=12). They were selected for interview by a Malawian research assistant from the villages surrounding his home in Liwonde, about 18 miles

from the sample site[2]. Both single and repeat dependent interviews elicited narratives on a broad variety of topics and were acceptable to respondents. However data constructed using repeat interviews were considerably richer than data constructed using single interviews. They elicited discussion of a larger number of topics than single interviews as might be expected, but also encouraged better rapport to develop and more in-depth discussion. The selection of the repeat, dependent interviewing method for subsequent data construction was therefore confirmed. A fuller evaluation of the method, incorporating lessons learnt from substantive data construction, is offered below (Section 2.5.5).

Two research assistants were recruited and trained to conduct, transcribe and translate the interviews in each of the three sample sites. All were introduced by the MLSFH and had worked for the project previously as survey interviewers. Reflecting the MLSFH selection criteria (Watkins *et al.* 2003), research assistants were local, young (ranging from around 20 to 39 years old), less-educated, gender-matched and shared the mother-tongue of the respondents (Chichewa, Chitumuka or Chiyao).

The potential influence of interviewers' residence in the sample sites, education, gender, ethnicity, and language on data construction had all been explored and clearly articulated in the literature in Malawi, and with regard to sexual health research in Africa more broadly (Huygens *et al.* 1996; Watkins *et al.* 2003). However, literature on the influence of interviewer age and generation for interviewing older adults in Malawi was not available, and reflections on research conducted elsewhere was ambiguous.

The more abundant literature on interviewing older adults in high income countries suggested that older, age-matched interviewers may be more sensitive to pick up on nuanced and complex understandings and experiences, but also that such interviewers may develop over-rapport, experience difficulty separating respondents'

[2] The selected respondents were identified by village heads in four villages surrounding the town of Liwonde and were not known previously to my research assistant. The topics and tone of these interviews are not significantly different from those carried out with randomly sampled MLSFH respondents suggesting that future use of repeat dependent interviews with MLSFH respondents could be reasonably tested on this sample.

specific experiences from their own, or limit respondents' willingness to share experiences that may highlight their weakness in comparison to the interviewer (Grenier 2007; Pratt and Norris 1994; Williams and Nussbaum 2001). Empirical evidence from Uganda demonstrated similarly contradictory effects. In a comparison of methods used to study sexual behaviour across six studies, (Huygens *et al.* 1996) describe how in one study, understandings of age norms and socially-appropriate conversations prevented both older respondents (aged 50+) and their younger interviewers (aged 25 and younger) from being able to discuss sex with each other, but in another study, 54 per cent of respondents said they would not feel able to report their sexual behaviour to an age-matched interviewer. During the preliminary fieldwork, I reflected on the influence of research assistants' ages, and, with my research assistants, developed interviewing techniques that built upon the age-differences.

In the course of data construction and analysis, I became aware of a culture of intergenerational knowledge transfer in the field sites. I encouraged interviewers to draw on this during the research conversations. By using prompts that emphasised the learned position of the experienced older respondent in contrast to the inexperienced young interviewer, interviewers mirrored socially sanctioned reasons for asking questions and enabled rich and detailed discussion. For example, in one interview carried out in Rumphi, the interviewer asked the respondent to advise her about what constitutes good sex and the techniques the respondent uses now and in the past to achieve it, noting that she was young, unmarried, and had no grandparents of her own to advise her. The interviewer's genuine enthusiasm for learning, explained to me following their interview, is clearly visible in the transcript of their conversation. That this was appreciated by the respondent is evidenced in her frank account of sexual preparations and pleasure-giving practices. Over the course of data construction, interviewers yielded higher quality data as this strategy became more developed and successful.

In other interviews the importance of age differences faded as other "social locations" (Grenier 2007, p. 714), such as being married or a parent, took precedence. Discussion of the interviewers' experiences established group-membership on these grounds and interviewers reported that respondents conversed

with them as an age-mate, demonstrated in their language and greetings. Group-membership served to increase rapport with some respondents and resulted in freer discussion and more empathetic probing (as observed by (as observed by Randall and Koppenhaver 2004, p. 80)). However with other respondents, group-membership acted as a barrier to discussion of topics connected to these positions (for example sex or care for children). Respondents reported that they had nothing to contribute to the discussion that the interviewer would not already know from their own experiences. In these instances, interviewers stressed the importance of their unique opinions for the research and were eventually successful in encouraging the respondent to share their experiences.

Preliminary data construction therefore confirmed that identities connected to age are multiple, shifting and experienced differently (Grenier 2007). Sharing a social location does not imply homogeneity in group members. The influence of age differences on interviews differed by respondent and interviewer. Subsequently, neither age-matched nor intergenerational interviewers would appear to be better. Instead preliminary fieldwork indicated the need for reflection about age-related dynamics and the development of strategies for connecting with respondents that are unique to the interaction between a particular interviewer and respondent.

Of course, the age of interviewer and respondent also involves more practical considerations: pace of the interview, volume of the conversation, physical location and generational differences in the way language is used all required thought and planning. In this regard, the use of younger interviewers, trained to be sensitive to such issues, was especially beneficial. Their functional ability enabled them to adapt their approaches (e.g. speaking louder, angling their bodies differently), and do so in ways that were entirely motivated by making research conversations accessible and comfortable for the respondent, their own accessibility and comfort being less of a priority. My reflections on the influences of research assistants' biographies and social locations on the data constructed were incorporated into my selection of interviewers for the main period of substantive fieldwork and are discussed below (Section 2.5.3.2).

2.4.4 Selecting a field site

Finally, the process of conducting preliminary fieldwork and the exploratory data constructed informed the choice of field site for the main fieldwork. Each of the MLSFH sample sites visited differs considerably in residents' dominant ethnicity, kinship, lineage and religious systems practiced, and in HIV prevalence (Kaler 2006; Watkins *et al.* 2003). Data constructed confirmed the importance of these differing contexts for older adults' situated experiences of ageing and HIV. However it also confirmed the complexity of these contexts and the need for in-depth and nuanced understanding of them. In addition, the preliminary fieldwork indicated that travel between the MLSFH sample sites and arranging accommodation and recruiting and training research assistants in each was time consuming. Subsequently, one sample district was selected so that the 6-9 months available for data construction could be concentrated on gaining in-depth understanding of experiences.

Balaka District in the south of Malawi was selected as the field site since HIV prevalence among adults aged 15-49 is higher here than in the northern and central regions. This was expected to be mirrored in a larger population of adults over age 49 with HIV from which to sample for qualitative interview. Secondary to this, I had established a good relationship with one of my research assistants in Balaka, Jonathan Kandodo. His appreciation of the research and methods was particularly good, perhaps reflecting his better fluency in English. As an (unpaid) HIV testing counsellor at the local hospital, he was familiar with the broader context of the epidemic in Malawi. Over the course of the preliminary fieldwork he had begun to act as a key informant, introducing me to broader issues for residents of the field site (e.g. government fertiliser subsidies and timing of maize and cotton harvests) and events happening in the villages during data construction that as a new outsider, I could not recognise (e.g. funerals and initiation ceremonies).

Balaka District is one of the poorest regions of Malawi, one of the poorest countries in the world (United Nations Development Programme 2010). Almost 85 per cent of Malawi's population and over 90 per cent of Balaka's population live in rural areas (National Statistical Office of Malawi 2008; National Statistical Office of Malawi (NSO) 2008). The proportion of older adults living in rural areas is even higher

(National Statistical Office of Malawi 2008). A similar proportion of the total and Balaka populations are small-holder subsistence farmers (Chintsanya *et al.* 2010). Levels of food insecurity are high (Devereux *et al.* 2006; Sahley *et al.* 2005) and food shortage during the annual hunger season is common (Verheijen 2011). Under-nutrition is a significant problem for older adults in rural Malawi (Chilima and Ismail 1998). As I will explore in the following chapters, food insecurity dominated life in the field site. Older adults' experiences were typical of the widespread experience of poverty and food shortage.

Respondents' homes typically consisted of one room containing a mat woven from reeds for sleeping on, a blanket, sometimes a mosquito net, limited clothes and few other possessions. They were constructed of burnt mud bricks and thatched with grasses or when possible, metal sheets, and set within bounded compounds. Other adult family members living within the compound would have their own single room building. With the exception of sleeping and sex, life happens outside of these buildings. Buildings had covered "verandas": ledges of roughly a metre on which to sit. Kitchens – sometimes covered, sometimes not - were arranged around a fireplace somewhere in the compound. Clay pots and plastic cups were stored here. Bathrooms were towards the edge of a compound, screened off by a reed-woven door or a mud-brick wall. Here, water collected from the borehole or well was heated over a fire for bathing. Compounds that had a toilet usually had a separated pit latrine within this area. An *nkhokwe* stored the residents' maize, the staple food, within the compound. A few compounds contained mango trees. If chickens or goats were owned, these too were stored close as valuable commodities eaten only for special occasions (see Figures 4-6).

Compounds were typically, though not exclusively, arranged in villages. Respondents' fields were usually to the edges of the villages, but could be some distance away. Where they existed, roads between villages were dirt and often difficult to pass, especially during and following the rainy season (see Figure 7).

The district is predominantly composed of people of Yao, Lomwe, Ngoni and Chewa ethnic groups (Malawi Longitudinal Study of Families and Health 2008; National Statistical Office of Malawi (NSO) 2008) living alongside each other. Ethnicity was

not obvious to an outsider, and intermarriage is common. Most of the sample is matrilineal and practiced matrilocal residence. Divorce, remarriage and associated mobility are typical in the field site (Kaler 2001; Reniers 2003). Many respondents had had numerous relationships and remarriage in later life was not uncommon.

The role of religion in the field site has been well documented (Adams and Trinitapoli 2009; Trinitapoli 2007; Yeatman and Trinitapoli 2008). Respondents in this study were all Christian or Muslim. Affiliation between religions and across denominations was typically fluid, and many respondents had changed religion more than once over their life. More generalised statements about God and religious teachings featured sporadically but consistently throughout respondents' narratives and were used in similar ways between and within religions.

Figure 4 A compound in the field site

Figure 5 A kitchen

Figure 6 Two full *nkhokwe* in the village head's compound

Figure 7 My research assistant and I walk the remaining mile down the road to Yotamu and Ruth's home after the rainy season

2.5 Substantive fieldwork

The study's main period of fieldwork was carried out in 2009. Analysis began after the first day of interviewing and led to the development of analytical ideas. These

ideas generated new questions. Further data were constructed to answer them. These data were analysed and the analytical ideas were 'fleshed out' and new analytical ideas emerged. More questions were generated and more interviews were conducted to answer them, and so on. The original research questions were modified over and over again in light of my analysis of the data constructed. The circular process continued until sufficient data were constructed to describe each analytical idea in terms of its properties, dimensions, and variations, to the extent that they reflected respondents' experiences and could be used to develop the coherent explanatory story described in the following chapters (Corbin and Strauss 2008).

2.5.1 Repeat dependent interviewing

Data were constructed using repeated in-depth dependent interviews with men (N=20) and women (N=23) aged between 50 and around 90 (N=130). They were conducted between March 2009 and August 2009, with a median gap of 1 week between interviews. Intervals between interviews allowed time to reflect on data constructed and develop a further interview guide, while the date and time of subsequent interviews was selected by respondents. Conducted over six months, these interviews do not reflect a longitudinal design. Repeated interviews were used to elicit in depth understanding rather than temporality in older adults' experiences. Between April 2010 and June 2010 further interviews (N=5) were carried out with five respondents interviewed in 2009. These interviews were used to explore how respondents' experiences had developed, and to verify the on-going analyses in the intervening period. Respondents were selected based on our conversations in 2009; some had discussed situations that I wanted to follow-up, such as plans to remarry or HIV diagnosis during 2009 fieldwork, while others were particularly lucid and appropriate 'sounding boards' for my analytical ideas.

Each respondent was visited between one (3 respondents) and six times (1 respondent), depending on their consent and availability, fieldwork logistics, and the research questions generated during our conversations. Respondents were visited until we had fully explored the most salient topics. Most respondents were visited 3 (18 respondents) or 4 (13 respondents) times for interview (Table 1). Interviews

typically lasted between 60 and 180 minutes. Respondents and their families were additionally visited when passing their compounds. These greetings, short conversations and observations, contributed to rapport building and provided further context to the recorded conversations. Shorter interviews with other respondents, such as two respondents' family members following their deaths, were analysed as the in-depth interviews but are not included in the table below. Similarly, two short non-audio-recorded interviews with older old adults just diagnosed with HIV, carried out by Jonathan after the period of fieldwork (and sent to me in the UK as a "Christmas gift"), are not included below but fed into my analysis.

Table 1 Repeat dependent interviews conducted in 2009 and 2010

	N
Interviewed respondents	**43**
In-depth interviews	**135**
Respondents interviewed once	***3***
Respondents interviewed twice	***5***
Respondents interviewed 3 times	***18***
Respondents interviewed 4 times	***13***
Respondents interviewed 5 times	***2***
Respondents interviewed 6 times	***1***

The aim of the interviews was to elicit as much narrative as possible about respondents' perceptions, attitudes and beliefs about ageing and HIV infection, and how they relate to the local cultural, social and structural context. Respondents were asked their understandings, thoughts and experiences of older age, family, support and work, problems, illness, relationships, pleasure and sexuality among other topics. Although conversations were not 'life history interviews', increasing attention was paid to past experiences as fieldwork proceeded. The social identities men and women constructed in later life, and the understandings, meanings and actions associated with those identities, built upon and were a continuation of experiences and understandings developed throughout their lives. Eliciting narratives on past experiences (such as past marriages and work) provided insights into their present experiences and how they shaped their behaviour in older age. For example, having

discussed her previous abusive marriage, battle with alcohol addiction, and religious conversion, I was in a better position to explore and subsequently understand one respondents' discussion of her recent marriage to the village head and her presentation as a socially-productive and highly respected member of her community.

Data construction and analysis was aimed at developing theory as inductively and data-driven as possible, guided by the principles of grounded theory. At the start of fieldwork a lengthy 'general' interview guide was used with all respondents across repeated interviews. This was written based on findings from my preliminary fieldwork and a review of the literature. These ideas and themes were treated as "sensitising concepts" (Charmaz 2008a, p. 210) to be explored in the interviews and observations. Concepts were treated as problematic and alternative explanations and experiences were investigated.

Interviews were audio-recorded and immediately transcribed and translated into English. Following each interview, transcripts were read in detail and further questions about issues discussed in the interview and in a respondent's previous interviews, or raised in the accompanying notes, were recorded in a personal interview guide to be used during the next interview with that respondent. The initial 'general' interview guide was discarded. Memos were written about emergent perspectives, experiences and themes identified in the interviews and observational data gathered. These were discussed with my research assistants and investigated in subsequent interviews with all respondents until other themes replaced them in the investigations. Interviewing continued until these themes were sufficiently explored. As a result, interviews focused on, and the study itself became about, the issues that were most salient to respondents with regard to the broad topic of ageing and HIV. The research questions therefore became meaningful. This process is illustrated in Figure 8. As in Figure 2, the development of analytical ideas is highlighted by increasing intensity of colour.

Figure 8 Repeat Dependent Interviewing

2.5.2 Asking questions

A selection of interview guides is shown in Appendix B. Interviewers studied these guides before the interviews and were trained to use them as a set of rough prompts,

rather than a list of questions to be read out. I tailored interview guides to the interviewer, as well as the respondent. While the strongest interviewers were able to add their own questions and follow-up on respondents' comments, the weakest interviewers benefited from having a more extended list of prompts.

Questions reflected the study's ontological grounding emphasising the expert position of the respondent, and focusing on respondents' opinions, understandings and personal experiences of events and actions (Charmaz 2006, p. 29). Interviews started with broad, open questions that aimed to give respondents an opportunity to direct the research conversation and therefore increase the possibilities of discovery in the data construction process. However, such questions rarely elicited the free-flowing narratives that were hoped for, particularly with MLSFH respondents who were familiar with the fast-paced, closed questions of a survey and, according to some respondents, the feeling that the interviewer is not interested in their stories, only short answers to their question (as also found by Poulin 2010, p. 267).

Instead, explicit prompts explaining to the respondent how interesting their stories were and how much we were learning, combined with more specific questions about particular events and relationships were used to encourage respondents to discuss their personal experiences. Leading questions were avoided and more directed questions were phrased in the opposite of social expectation to lessen the chance of social desirability bias. For example, rather than ask "Do you have a *chibwenzi* [lover]?" or "When did you stop having *zibwenzi* [lovers]?", interviewers asked "A man I was chatting to last week told me about his *chibwenzi*, do you have one?" or "Do you think you will always have *zibwenzi*?".

In addition to the technique employed by younger interviewers during preliminary fieldwork described, one particularly successful technique was for interviewers to explain that they were asking so many questions about a topic because for their ignorant foreign employer, everything was different, new and interesting. This worked especially well for topics that respondents understood required no elaboration given the respondent and interviewer's shared culture. For example:

> *You told me, as other people have, that your mother cared for your children in the way you now care for your grandchildren and so on. This*

has always been the way I know too, but when I chatted to Emily, the mzungu *[white foreigner] who is doing this research, she was saying that it is not that way in the UK – it's usually the parents who care for the children - and it has made me think more about why we do it our way. Why do you think we do it that way?*

Do you think it is for the benefit of the older adults or for the benefit of the children? Or both?

[Interviewer speaking with Loveness, female, late 70s, widowed]

In some instances, this had the additional benefit of facilitating reciprocal knowledge exchange. By encouraging the respondent to also ask questions about my culture and experiences, the power dynamic of the research conversation was subtly altered and discussion was fuller. Framing questions so that respondents directed conversation and elaborated on answers took practice and improved over the course of each interview sequence as questions could be tailored to a specific respondent, and over the course of fieldwork as a whole.

While increased respondent-control over the research conversation is a benefit of qualitative research, it also implicates silence on subjects the respondent is not confident talking about, even if they are important to them (Randall and Koppenhaver 2004, p. 74). Sexuality is widely regarded as a "sensitive" topic in the literature that is unlikely to be broached by the respondent and requires appropriate questioning to avoid such silences. Preliminary exploratory fieldwork had confirmed that referencing socially-appropriate and familiar patterns of knowledge exchange within interviews could facilitate general conversation about sex. As fieldwork progressed, two further, inter-related, techniques were developed to encourage fuller discussions that centred on respondents' personal sexual experiences. Firstly, questions about sex were embedded within discussions about related topics rather than being addressed as stand-alone topics. Sex was situated within discussion of topics such as successful marriage, familial transfers and physical strength. Secondly, interviewers were encouraged to translate my interview guides into "safe" language (Huygens *et al.* 1996, p. 226) that reflected emic understandings. These seemingly vague terms were given clear meaning by their context. So for example, sex was referred to by interviewers (taking their prompt from respondents) as "work

that you do in the house" in the context of a conversation about marriage. Comparison with transcripts of exploratory interviews that did not use these techniques indicates that respondents – and indeed interviewers – were more comfortable and subsequent discussions (not just about sex) were fuller when the techniques were used.

2.5.3 In the field: Respondents, research assistants and me

As an outsider, unfamiliar with the research setting and the languages spoken in the field site, I sought the assistance of interpreters and informants who would help me negotiate access to respondents, conduct interviews, transcribe and translate them and facilitate my learning the ways of an alien culture. The subsequent fieldwork and the data I left with are a product of the complex web of interactions between the three parties. What respondents thought of the research assistants and the foreign white researcher, and what the research assistants thought of the respondents and the foreign white researcher and the relationships they developed with each, determined the shape of my time in the field.

2.5.3.1 Research assistants

Over the period of substantive fieldwork, I employed six research assistants at various times. Research assistants were employed in part to smooth research by guiding me with reference to their local knowledge. This knowledge was essential for planning fieldwork and locating villages, village heads (for seeking permission to visit a village) and respondents, at least during the first months of data construction. All research assistants spoke both dominant languages spoken in the area, Chichewa and Chiyao, and English. Their familiarity with the sample site, local vernacular and social and cultural context aided their establishment of rapport with respondents by reducing social distance more than I or fluent Chichewa and Chiyao speakers from other areas could have done (Bourdieu 1996; Huygens *et al.* 1996; Weinreb 2006).

I trained research assistants in qualitative research, reflexivity, the study's aims and background, interviewing, transcription, translation and the role of the key informant,

reflecting their central role in the construction of the manuscripts that became "data" (see Figure 9). Individualised refresher training was carried out regularly throughout the whole period of fieldwork as interview transcripts were analysed and areas for improvement were identified. Positioning the respondent as the expert, developing good rapport with respondents and sensitivity in interviewing were given particular emphasis during training. Observational data and interview transcripts indicate that research assistants successfully applied these techniques.

Figure 9 Research assistants at a refresher training day in Balaka Town

2.5.3.2 Relationship between the research assistant and the respondent

Interviewer-respondent interaction is mediated by the biographies and social locations of the research assistant (Grenier 2007). Based on my review of research literature, and lessons from preliminary fieldwork outlined above, much thought was given to selecting the right research assistants for the main substantive fieldwork in Balaka. A long list of preferred characteristics was drawn up. I wanted both male and female assistants, of different ages, who spoke Chichewa and Chiyao as well as

fluent English, who were not considerably wealthier than respondents, and who preferably lived in a village or were at least familiar with life in rural areas, to name just a few.

The list was soon shown to be naïve in this setting. If a potential research assistant had the significant skills required for the job, were resident in the sample district and were looking for work, they were unlikely to be very old. If a potential assistant lived in a village they were unlikely to have had access to the privileged formal education that could have taught them to speak English fluently. Similarly, if a potential assistant was a woman she was also less likely to have had access to English education. I was particularly concerned to avoid obviously wealthy research assistants because I thought social expectations about knowledge-exchange between uneducated poor respondents and ostensibly knowledgeable richer interviewers would distort interview dynamics. But in the subsistence economy of the field site, the very fact of my employment – regardless of education – meant that research assistants were, and were regarded as, wealthy, different and privileged.

Subsequently, two women and four men were employed over the course of this period of fieldwork. All were aged between 19 and 41. The oldest three - two men and one woman - were married and had young children. The youngest three were unmarried and childless, although one man cared for his younger brother and the youngest woman (19) married towards the end of fieldwork.

I initially recruited Jonathan, who had assisted me during preliminary fieldwork, and two other research assistants, based on MLSFH researchers' recommendations. These two other research assistants (male and female), resigned from the study very early on (see Section 2.5.3.3 below). I recruited three additional research assistants to replace them via advertisements posted in civic buildings in Balaka town, and selected based on a written language test and interview. Only Jonathan was employed throughout the six months. These final four research assistants conducted the vast majority of interviews and were the most influential in shaping the data constructed.

Of the six research assistants employed, three were Chewa, two were Yao, while Jonathan was Tumbuka and originally from the north, but had lived in the south for

more than 20 years. Although all spoke both Chichewa and Chiyao well, their English was variable. The youngest woman had the weakest English and was encouraged to receive translation of my instructions from Jonathan, the strongest translator. Four assistants were Christians of different denominations, and the two Yao assistants were Muslim. The two female assistants lived in villages around the sampled villages and knew some residents, though not the respondents. The four male assistants lived in small towns but were familiar with village life. Jonathan and the male research assistant that resigned early in fieldwork had received tertiary education, while the other four assistants had some secondary schooling.

Interview transcripts were analysed for evidence of the influence of interviewers' social locations on the co-constructed data. Table 2 summarises some of these reflections. Some characteristics were very important in shaping the relationship between respondent and interviewer and the data subsequently constructed (e.g. local knowledge and shared culture, language and wealth). However my reflections also highlight the potential to overestimate the influence of some interviewer characteristics on the power dynamics of the qualitative interview when the interviewer's ability to recognise these differences and respond sensitively to them is not taken into account (e.g. age, gender and marital status). In this study, when interviewer and respondent shared a social location, rapport could, and was, built around it during the research conversation. However, when interviewer and respondent did not share a particular social location, they engaged the techniques described above, either identifying other locations on which to establish rapport, or emphasising how much the interviewer could learn from the respondent given their differences.

Conversations with my research assistants during fieldwork and review of interview transcripts indicates that a research assistants' ability to successfully 'connect' with a respondent certainly reflected their training, but also the social desirability usually only discussed with reference to respondent bias. Interviewers were motivated to get along with respondents and have pleasant conversations. Equipped with incisive grasp of local knowledge to enable them to do so, interviewers seemed to naturally focus on their similarities or recast differences positively during interviews. As a result, for some social locations, neither matching nor contrasting characteristics

guaranteed better interviews. What was more important was interviewers' - and my own - ability to recognise, respond sensitively to, and reflect upon, the expected and unexpected products of the similarities and differences

2.5.3.3 Relationship between the research assistants and me

The relationship between research assistants and me was dominated by the dynamics of conducting international research in resource-poor settings. My first identity in the sample site was that of a rich outsider. Research assistants were poor insiders, albeit with some language skills that increased, but far from secured, their chances of economic or physical mobility (Swidler and Watkins 2009). By employing them as informants and interviewers, I asked them not only to act as intermediaries between me and the respondents, but for the period of the study, altered their social positions so that they were neither true insiders nor true outsiders. Training them, paying them more than they would have received from a local employer, and asking them to observe the community that they were part of and report on elements of respondents' lives that would closely mirror their own, separated them from their communities. I employed them for being 'one of them', and trained them to be 'one of us'. Research assistants therefore had the unenviable task of navigating between these two identities.

All but one, the youngest female research assistant, had experience of working temporarily or voluntarily for international research organisations and on one hand, appeared to enjoy the prestige attached to this position in their communities and aspired to find a permanent role. Further, within the study they enjoyed their authoritative status as experts[3] and were pleased to be bringing home a reasonable wage each week. They were motivated to present themselves to me, their families and neighbours as elites. On the other hand however, they had not found the

[3] Key informant training centred on shifting research assistants' expectations of the employee-bwana (boss) relationship and direction of knowledge-transfer. Preliminary fieldwork and early substantive fieldwork indicated that research assistants did not feel confident to volunteer local knowledge, give instruction or correct me as their employer; all essential roles of the key informant. On-going training therefore focused on introducing and working within an explicit knowledge and power hierarchy that placed older, experienced respondents at the top, followed by younger research assistants, with me, the ignorant outsider researcher at the bottom.

permanent positions they desired. They lived alongside those who did not know any English and did not have the same schooling. Assistants were still community members, and between their short spells of employment, subsistence farmers. They had a vested interest in their local community and were motivated to secure resources for them from what they perceived to be a well-funded research project. These conflicting positions influenced fieldwork dynamics.

For example, research assistants sometimes positioned themselves as intermediaries not just in the research, but in wealth flows between me and the respondents. I expect this reflects both their vested interest in their community's development and a desire to be seen by respondents as benevolent and generous elites. Consider the following excerpt of an interview conducted in the last week of substantive fieldwork and the last day of conducting interviews:

I *Thank you so much for allowing me to come to have these conversations with you*

R *Alright*

I *Emily and I have really enjoyed getting to know you*

R *Oh*

I *We can't manage to thank you [enough] for the help you have given us for the research*

R *Alright*

I *Is there anything else we could know about your life or things about older people or* kachilombo *[HIV]?*

R *[Calling to his wife (W):] Do you hear that? Do you remember what you were saying?*

[To the interviewer:] She was saying that if the mzungu *had come with you she would ask her to buy a blanket for us because it's very cold at night and she said she wanted to beg a blanket from her*

I *Since she has not come, are you going to send her the message through me?*

R *In fact I am asking you to tell her*

I *Oh this time you are asking me to do that?*

R *Yes [Laughs]*

I [Laughs] About a blanket?

R Yes

I Oh, I will not block you, I am going to tell her about your problem, I will do that as soon as I meet her, because we are meeting somewhere when I finish with you, I will tell her that if she had come you would have told her yourself

R Umm

I I will not eat your message I will tell her

R Thank you

I You should not think I will not tell her, if she has to do something about it you will see us coming

R Thank you very much…

I Today could be the last day to visit you but if anything you will see us coming again, Emily is about to return to her home

W Where is she from?

I She is from UK

R So she came from there?

I Yes, she came just to conduct this research,

R Oh

I As I told you that day [first meeting] she is at school

R Oh

I The research was part of her school

R OK, thank you very much

I But I will remember to deliver your message

W Please don't forget

I No I will not

R Thank you

I Thank you very much

END

[Third interview with Thomas, male, 60, married]

After the interview the research assistant and I discussed how it had gone. He made no mention of the respondent's request. The research assistant and I had previously discussed the cost and ethical implications of gift giving in research (Section 2.5.10). He knew that the requested blanket was probably too expensive[4]. Moreover, he knew that the interview with that respondent was his last and he would not be visiting again, either to deliver the gift or explain its absence. So why did he tell the respondent he would pass on his message? I think it reflects the tightrope I asked my research assistants to walk. I believe he wanted to provide the gift for the respondent, both as a community member, and as a benevolent elite. However I think my assistant also expected me to refuse to buy and deliver the blanket, and that I would reprimand him for not being honest with the respondent. Knowing that I would read the transcript, he fulfilled his promise to the respondent of passing on the message and maintained his identity as 'one of them'. However knowing that I could not read it until he had transcribed it the following day, just two days before I left Malawi, and that I was therefore unlikely to have time to discuss it with him, he was able to distance himself from the request and maintain his position as 'one of us' for the final days of fieldwork.

Research assistants' positions as insider-outsiders additionally involved negotiating complex and interwoven expectations, as identified by foreign researchers in other resource-constrained settings (e.g. Sherman 2009). What the researcher wants and what the research assistant wants are different. Given the challenges of negotiating between their own field identities described, and the short-term nature of the study, employment as a research assistant was unlikely to be many of my research assistants' chosen career, but options for other employment were extremely limited[5]. As a result, their search for economic advancement was constant.

[4] Blankets were available in Balaka town for around £10 if bought in bulk.

[5] For example, having advertised for a research assistant using just a few A4 posters in Balaka town, 25 applicants attended the open interview. Some had come from Blantyre, Malawi's largest city and centre of finance and commerce. They were university educated, had experience working with international development agencies (usually volunteering as "aspiring elites" (see Swidler and Watkins 2009)) and spoke good English. With few employment opportunities in the city, they had travelled the 70 miles to Balaka at considerable expense, to apply for a short-term job in the village, knowing they did not have the Chiyao language required but hoping they would be lucky.

The sudden resignation of the two research assistants, despite the good relationship we had built during my preliminary fieldwork in 2008, highlights this. After a week of training and a few weeks of conducting and translating interviews, on the way to the villages one morning, one research assistant explained that he had received a scholarship from a European institution to complete a diploma and would be leaving to start university the following day. He had conducted three good interviews with one respondent. The data generated were rich and I had many more questions to ask, but the respondent refused to be interviewed by another research assistant. He had also conducted a single interview with another respondent, who did, reluctantly, agree to be interviewed again by another assistant.

The following week my other research assistant did not come to meet Jonathan and I to go to the villages as we had arranged. She left a message that she had gone to visit a sick family member in the neighbouring district. In the weeks that followed, she arranged to meet me on several occasions, but did not come. Days were spent trying to find her. Occasionally she would send a text message some hours after I had given up waiting for her to say she was still visiting her family. With only one research assistant working, data construction was dramatically slowed. The missing research assistant had taken my audio-recorder, containing the last two interviews she had conducted. The data was temporarily lost and could not be fed into the on-going analysis. I could not know if I had more questions to ask the two respondents she had interviewed on her last day. Jonathan's investigations around the trading centre closest to her village finally revealed she had been approached by a large international demographic research project which, having employed her previously and wanting to avoid carrying out recruitment and training, offered to pay her K500 (around £2.20) per day more than any amount I was paying her. She had been working for them for three weeks. She had never visited her family in the neighbouring region but, according to hearsay, had wanted to avoid telling me she had resigned believing that she would then be able to resume working for me when the large research project finished the following month.

While the relationship between the research assistant and the researcher, intimately tied up with our identities in the field, certainly influenced fieldwork, it is difficult to decipher the exact impact of these dynamics on the data constructed. They are most

likely to influence data through the establishment and loss of rapport during research conversations. On one hand, research assistants' vested interest in the local community might serve to increase rapport and deliver higher quality data. On the other hand, the resignation of the assistant during an interview series here meant that another research assistant had to try to rebuild rapport with respondents who had been let down by the study, and the quality of the data constructed suffered.

2.5.3.4 Relationship between the respondents and me

"The researcher, engaged in an interactive, dialectical relationship with both the interviewee and self is, fundamentally, the primary research instrument."
(Arendell 1997, p. 343)

My identity as an outsider was highly visible in the field. The dirt roads between the villages are narrow, very poor and designed for travel on foot or bicycle. Cars passed by infrequently. Arriving in villages in a large shiny 4-wheel-drive vehicle[6], kicking up dust no matter how slowly I drove, was as intrusive an arrival into a village as possible. Within seconds the car was surrounded by surprised and excited children (and often their parents, standing a little further back but no less intrigued). This was only slightly lessened over time or when arriving at a village by bicycle or on foot. Regardless of transport, I was white, relatively very wealthy and for respondents in a setting where secondary education is rare and doctoral programmes do not exist, too old to still be at 'school' and therefore difficult to place (see Figure 10).

I visited the sampled villages every day of interviewing. Logistically, I was there to manage fieldwork: driving my research assistants between respondents' homes, widely dispersed in around 20 villages within a 25 mile radius; greeting village heads

[6] Shiny, because it was cleaned almost daily by my neighbour, who reminded me that as in the villages, in Balaka town where I lodged I was also considered to be very wealthy. Reflecting the role of mutual assistance and the sharing of resources in local culture, I was expected to create employment opportunities for neighbours, friends and their families. The visibility of my wealth as demonstrated by the hired car was additionally heightened when, as a result of continuous mechanical failures, I was sent a succession of four replacement cars during the fieldwork. I suspect that to local observers I now appeared to own not one but four large vehicles.

and requesting permission to visit each village; coordinating follow-up appointments with respondents, based on respondents' availability, but also each research assistants' other appointments and their location across the sample site; and responding to the catalogue of village events, relationships, over-run appointments, missing respondents, floods, and large and small problems that altered the pre-planned course of fieldwork each day. More importantly, I was there to greet respondents, answer their questions with translation from my research assistants, and spend time getting to know their routines and the spaces they occupied. These observational data complimented those constructed in the audio-recorded interviews.

Although I met and spent time with all respondents, I varied my presence during interviews depending on the logistics of the day's fieldwork and respondents' preferences. Previous research on similarly sensitive topics has warned against the presence of an outsider researcher during the interview (e.g. Coast 2006). However preliminary fieldwork indicated that respondents viewed local interviewers as an extension of the researcher, also noted elsewhere (Huygens *et al.* 1996). In addition, the nature of repeat dependent interviews and the referencing of specifically my interest in the things they had previously discussed meant that respondents were keenly aware that I would read the translated transcript of their conversation. Observations and reports by the interviewers during exploratory and then substantive fieldwork suggested that respondents were comfortable sharing their experiences with me, and respondents reported during the interviews that they enjoyed the opportunity to explain their understandings to the younger local interviewers and to the foreign researcher. The only discernible effect my presence had on the interview and data constructed was the additional time needed for translation between English and Chichewa or Chiyao during the interview and the resulting respondent fatigue on some occasions.

Regardless of my visibility to respondents therefore, respondents recognised that the audio-recorded conversations they were having were commissioned by an apparently well-funded research study. Although the research assistants emphasised both before, during and after interviews that we were engaged in university research rather than development, it proved impossible to communicate to some respondents that personal benefit was not a possible outcome. What these respondents chose to

disclose and conceal during interviews has to be interpreted within this understanding. Sometimes a request for assistance would be direct, as in the excerpt given above. Sometimes a request would be more subtle, focus on investment rather than goods, and be more embedded within a respondent's narratives. For example, one respondent, a married man with HIV who supported his four daughters, their husbands and his grandchildren, centred much of his early discussions on his ideas for various businesses, his reliability and work ethic and the difficulty securing a small-loan from the transient development organisations who he felt always favoured women. While I believe this in part reflects the salience of being a provider for his identity and experiences (discussed in Chapter 3), some of it I am sure was directed at the foreigner who might be persuaded to provide some start-up capital. Given the centrality of identity, work and provision in the findings of the study, the various motivations for respondents' presentations in interviews had to be carefully unpacked and accounted for in the analysis.

However, being foreign and a guest afforded me privileges in the field site outside of the interviews. I was party to places and experiences that would have been closed if I were local. I was also given exception from rules and practices. I did not speak either Chichewa or Chiyao other than basic greetings and the apology [*pepani-pepani*] that accompanied most of my interactions in the field site. Undoubtedly this limited my understanding of older adults' experiences. However, having designed data construction methods that addressed this deficiency, I found not speaking the language a useful tool in managing the balance of power in research dynamics. Combined with physical expressions of my humility (most obviously kneeling and bowing, but also more situational actions and demonstrations of politeness) and immense gratitude to respondents (silently clapping while bowing and smiling), respondents identified my inability to converse as a vulnerability, serving to shift power to them. I became "safe".

Respondents responded to this dynamic in two ways. The first, less frequent response, was to visibly relax. Having first established for themselves that I really did not understand them (by asking me questions directly and laughing good naturedly at my incomprehension), these respondents conversed with my research assistant as if I was not there. The second, more common response was to take

delight in introducing their uneducated visitor to the "imponderabilia" I expected was going to be difficult to access. For example, many wanted to give me foods they expected I would not have tried before, one respondent's husband insisted he take me to see his field (the excursion ended with him cutting some greens for me to take home to cook), while another respondent excitedly encouraged me to join her daughters to learn how to make *nsima*, the staple dish of boiled maize.

Being a safe outsider also afforded me access to sensitive knowledge that could not be shared with an insider or less safe outsider. This is most clearly illustrated with my visits to a *sing'anga* [herbalist and in this case, spiritual healer]. We asked if we could see some of the instruments used to detect the presence of witches and intruders that he had talked about during our research conversations. After some contemplation he explained that while he would never reveal them to a fellow Malawian, I was not dangerous and he would like to show them to me. Therefore, while my evident wealth shaped what some respondents reported during interviews, potentially obscuring more interesting elements of their experiences of ageing and HIV, my identity as an outsider enabled me to access rich contextual data and gave me socially sanctioned and permitted reasons to ask (lots and lots of) questions.

Figure 10 My car, and identity in the field

Table 2 Reflections on interviewers' characteristics

Individual characteristic	Expected to interact with	Expected impact based on literature reviewed	Observed impact in this study
Gender		• Gender matching expected to encourage rapport and discussion of sensitive topics (Chillag *et al.* 2006; Oakley 1981) • 36 of 43 interview series were gender-matched • For 6, the anticipated sensitivity required for an interview series (e.g. respondent who had recently diagnosed with HIV) made Jonathan the most appropriate interviewer • On 1 occasion, a male-female interview series was carried out for logistical reasons	• Jonathan's unique training as an HIV counsellor and familiarity discussing sensitive topics with women, combined with his superior grasp of training, resulted in high quality interviews • Moreover, women's unequal access to education was reflected in poorer understanding of training and subsequently poorer interviewing skills than all male interviewers employed, lessening the benefits of gender-matching
Ethnicity, religion and language		• Sharing an ethnicity, linked to language and religion, expected to influence the rapport developed and content of interviews reflecting both interviewers' and respondents' understandings about what did and did not need to be explained and elaborated	• Shared language was essential but no discernible impact of not sharing religion or ethnicity on establishing good rapport. This may reflect the integration of people of different ethnicities and religions in the field site, and the frequency of religious conversions among the sample • Subsequent interviews with each respondent overcame issues of non-elaboration of shared understandings
Age	Marital status Parenthood	• Age disparities could create social distance, preventing respondents from discussing taboo subjects and limiting interviewers' confidence, empathy and ability to ask insightful questions	• Being younger gave interviewers socially-sanctioned reasons to ask questions related to being an older adult

Marital status	Age Parenthood	• Never married interviewers may find it difficult to ask married respondents questions about sex due to embarrassment or lack of knowledge	• As age, being relatively sexually inexperienced provided a socially-sanctioned reason for asking sexually explicit questions. Respondents noted that they would have been embarrassed to recite such sensitive information to a married interviewer who should know the answer from their own experience
Parenthood	Age Marital status	• Respondents may not want to report difficulties caring for children to a childless interviewer who would not be able to empathise	• As age, difference inspired confidence. Since no interviewers had adult children, all interviewers drew on their lack of experience to ask what they could expect in future
Urban/rural	Education Wealth	• Urban interviewers may find village life distasteful or alien and subsequently struggle to build rapport with respondents and lack empathy and ability to ask insightful questions • Respondents' may feel intimidated or embarrassed by interviewers they perceive as wealthy or more sophisticated, and limit their responses or conceal certain beliefs	• Interviewers were from small towns or were resident in villages closer to the trading centre or road than most sampled villages. Early interviews indicate some limited response bias (e.g. denying use of traditional medicine or belief in witchcraft) • Following further training in communicating the very high value of respondents' understandings and practices, there is little evidence of these biases in subsequent transcripts • Repeat dependent interviewing used to identify and explore existence of and reasons for these biases
Wealth	Urban/rural Education	• Expected to create social distance, limiting respondents' discussion and interviewers' ability to ask insightful questions regarding financial insecurity • Perceptions of assistance from wealthy interviewers expected to alter the way respondents' present their financial situation	• Less wealthy interviewers were selected • Little evidence of social distance limiting discussion in the transcripts • However interviewers were perceived to be wealthy by product of their employment. Moreover, they were regarded as messengers to the wealthy researcher. Transcripts indicate that respondents presented

			themselves in ways they felt were most likely to lead to receipt of assistance from the research team
Education	Wealth Dress	• As urban/rural, interviewers expected to lack empathy and ability to ask insightful questions • As urban/rural, respondents' expected to conceal certain beliefs	• As urban/rural, strong presentation bias was successfully avoided using training. More educated interviewers were most successful at this strategy reflecting their understanding of English and training regarding power dynamics in research
Dress	Urban/rural Education Wealth	• Male research assistants reported for duty dressed in smart trousers, immaculately cleaned and pressed collared shirts and shoes and socks, to visit respondents wearing torn, dust-covered clothes and no shoes • Expected to increase social distance and limit respondents' discussions by projecting images of interviewer wealth and education and that the research conversation would be formal and highly structured • Respondents may be intimidated by formally dressed interviewers and feel they cannot refuse participation	• Smart dress was a sign of respect: Respondents also wore their best clothes for visiting friends and relatives • As the female interviewers, I subsequently dressed in recognisably smart clothes (full skirt, clean *chitenji* cloth wrap, plain t-shirt and handbag, rather than a backpack) • We were greeted warmly. MLSFH respondents commented that the difference in my appearance from other female *mzungu*, who wore *chitenji* but otherwise did not dress in locally-defined smart apparel, demonstrated that the research itself was more respectful
Personal interest		• Personal interest is likely to influence questions asked and topics pursued in interviews • In extreme circumstances could prevent study focusing on most salient issues for respondents	• Transcripts suggest some interviewers were more engaged asking questions about sex and HIV. This might reflect lack of interest in less titillating or controversial topics, or the belief that these were the topics I wanted them to focus on for a study about HIV and ageing • Use of repeat dependent interviewing helped rectify this bias by facilitating further discussion of other topics

Adapted from table presented by (Randall and Koppenhaver 2004)

2.5.4 Recording the answers

To reduce fieldwork costs research assistants typically carried out two audio-recorded interviews in a single day of visiting the villages. They simultaneously transcribed and translated them into notebooks over the following two days, giving them to me to read as they were completed. Transcription was completed before returning to the villages to conduct further interviews.

Transcripts aimed to detail the entirety of interviewers' time with respondents. Along with full transcriptions of the interviews, research assistants detailed their description of the respondent, location of the interview, any events or conversations that occurred before and after the audio recorder was in use and full transcription of any secondary conversations that occurred while the interview was in progress and audio-recorder was on (e.g. the respondent pausing her conversation with the interviewer to instruct her daughter to do a certain task, or the conversation between the respondent and a visitor who, passing the compound, stopped to greet him and find out who the research assistant was). Intonation, pitch, timed pauses, laughter, interruptions and other features and expressions were noted in the transcripts (see Appendix C for key to these features, which are included in the data reproduced in the following chapters), along with interviewers' thoughts on the mood or tone of interview. These contextual details and descriptions assisted interpretation of respondents' spoken words.

Words for which an exact translation could not be made were noted and both the original word and research assistants' interpretations were written. Meaning in Chichewa and Chiyao is heavily context dependent and partial reference to proverbs and folktales was frequent in respondents' narratives, rendering the direct translation difficult for me to understand as a non-speaker, unfamiliar with the cultural setting. Therefore research assistants added further description where they felt it would be necessary (e.g. providing both the translation and their interpretation of a proverb). In addition, transcripts were discussed with my research assistants to clarify meanings and debate the validity of my interpretations.

Of course, translation is never straightforward. Translation into English depends on the translator's positioning in the linguistic and cultural divisions within the English language. Although rarely spoken in the sample villages, English is an official language in Malawi (along with Chichewa, but not Chiyao). Malawian English is different from both everyday and academic British English. It contains many adaptations and modifications that reflect the cultural and grammatical requirements of Chichewa (Simango 2000). For example, someone expressing romantic interest, be it general, sexual or marital, is referred to as "proposing"; one who is sexually promiscuous is "movious" or "moves around". Research assistants' transcriptions contain all these locutions, which are retained in the presentation of data in the subsequent chapters.

However translation also depends on the skills and fluency of the research assistant. The final transcripts here represent only the best English the research assistants knew, and that very much depended on the research assistant. Unsurprisingly, the two university educated research assistants had a wider English vocabulary than other research assistants. Their transcripts are much less likely to show the interviewer phrasing a question exactly as it appears on the interview guide suggesting that their translations better reflect what was actually said during the interview. At the other end of the spectrum, following training and her first transcription, it was evident that the youngest female research assistant did not write English well enough to transcribe her interviews in a way that retained any interpretable meaning.

What is involved in producing the interview transcripts is therefore much more than just writing down what was said. Research assistants chose what to write based on their linguistic ability, cultural understandings and local knowledge, understanding of the research, their training and instructions, their opinion on what I would and would not need explaining, as well as their attitude towards the work that day –tired and bored assistants were less likely to offer sensitive interpretations or transcribe a secondary conversation they did not believe was relevant. Despite the rhetoric then, the findings of cross-cultural qualitative research are not presented in respondents'

"own words". Indeed a sizable body of literature has noted the construction of the transcripts that become data (e.g. Maclean 2007; Mishler 1991; Temple 2005).

However, Martyn Hammersley argues convincingly against taking the construction metaphor too far. He warns against the "epistemological radicalism" that would imply the carefully and reflexively produced interview transcripts presented here were somehow 'invented' by the research assistants or document something dramatically different from the research conversation (Hammersley 2010, pp. 558-559). In this study, a number of steps were taken to produce accurate transcriptions of the interviews; that is, transcriptions that reflected the conversation as much as possible and that, when read alongside research assistants' field notes and my own observations, can be used to interpret the respondents' words meaningfully.

Firstly, in order to reduce misrepresentation and verify my interpretation of the transcripts, respondents were asked whether what had been translated was what they meant during the previous research conversation.

Secondly, when a theme or analytical idea was built around the reoccurrence of a word or phrase respondents used to discuss a particular issue, care was taken to check that these words were accurate translations of what respondents said and did not just reflect an individual research assistant's interpretation. For example, before respondents' description of old people as being "like children" became a key analytical idea (Chapter 3), data were interrogated to check that there was no other English interpretation for the Chichewa phrase. During fieldwork, this was done by discussing the analytical idea with the team of research assistants. In subsequent post-fieldwork analysis, this was done by checking that the particular word occurred in interviews conducted and transcribed by multiple research assistants.

Thirdly, some words that were given the same translation by all research assistants, and the dictionary, still had confusing meanings for me. The most significant of these was respondents' use of the word "blood" to refer to blood, sexual fluids and the body's vitality and power (also discussed in Chapter 3). To clarify my understanding of "blood", the word and its meanings were discussed not just with research assistants but also with the respondents themselves. Asking respondents,

rather than relying on a standardised dictionary for example, yielded much fuller and more salient descriptions of what a term really meant to respondents. These conversations were particularly fruitful and constructed data that provided access to emic understandings.

Fourthly, the quality of transcription was dramatically improved by sharing the weakest research assistant's audio-recordings among the three male research assistants for transcription and translation. Since it is widely expected that transcriptions carried out by the interviewer themselves will retain better contextual information to assist interpretation (Coast *et al.* 2009), she continued to write field notes about her interviews. This division of labour had the additional benefit of making her available to conduct more gender-matched interviews with female respondents.

Fifthly, to check the degree of variation in research assistants' translations, the audio-recordings of six interviews were transcribed by two research assistants in differing combinations. The transcriptions were first coded for emerging themes and later the exact translation was compared. Some of the words used – and particularly the order of words – were quite different. However, different translations of words tended to have the same or similar meanings in English (for example, 'sad' and 'upset') and the codes used were very similar. This suggests that the transcriptions produced in this study are good representations of the audio-recorded research conversations, confirming Hammersley's contention that transcriptions are not "made up" (Hammersley 2010, p. 559).

A final step in producing and using transcriptions therefore was to recognise what the data could and could not tell me. It would have been inappropriate to perform detailed linguistic analyses in which words and their construction was the focal point. However, attention could be given to language in general and the way words (verified as described) are used to both reflect and shape experiences. Viewed this way, the transcripts are shown to be coherent, high quality and could be meaningfully interpreted.

2.5.5 Ensuring quality in data construction: the strengths of repeat dependent interviewing

The use of repeat dependent interviewing, applied within a constructivist grounded theory framework, facilitated a number of strategies to increase the quality of the data constructed by asking questions and recording answers, and the credibility of analytical interpretation offered. Repeat and repeat-dependent interviewing have been recommended as ways of accessing data about complex or sensitive topics, making up for missed opportunities within an interview (Campbell *et al.* 1999, p. 41; Vincent 2012, p. 5), and, from a more positivist epistemological perspective than used in this study, ensuring internal validity of collected data by allowing researchers to correct inconsistencies in respondents' interview narratives (Elliott 2005, p. 32). Both repeat and repeat-dependent interviews have been used by anthropologists, demographers and other health scientists in ethnographic studies to consider demographic-related questions (e.g. Day and Hitchings 2011; De Kok *et al.* 2010; Haws *et al.* 2010; Nyanzi 2011; Randall and Koppenhaver 2004; Schröder-Butterfill 2004; Van der Geest 2001; Van der Sijpt 2010). However the method has rarely been reported, described or evaluated in this context. Within demography, repeat interviewing has reportedly been used for logistical reasons, rather than as a specific strategy for building dependent conversations across multiple visits (e.g. Stash 1999), while in the wider social sciences, repeat dependent interviewing has been forwarded as a useful tool for investigating change over time within qualitative longitudinal research (QLR) (e.g. Vincent 2012).

There were (at least) seven benefits of using repeat dependent interviews within a constructivist framework in this study, aiming to investigate complex and nuanced experiences that may include an element of process, but are not centred on change over time.

1. The likelihood of constructing better quality data by encouraging the development of good relationships between interviewer and respondent over time has been identified in a range of settings (Campbell *et al.* 1999; Day and Hitchings 2011; De Kok *et al.* 2010; Oakley 1981; Vincent 2012), and in research among

populations more familiar with answering the closed questions of a structured questionnaire (Hollway and Jefferson 2000, p. 44). Data constructed here indicate that making numerous visits to respondents was especially likely to build rapport in rural Malawi, within the MLSFH field site, and particularly among older adults. As reflected in a number of Chewa (e.g. *Pakhomo pazibulera alenilo* ['A good household has visitors']) and Yao (e.g. *Ndawî sine cikamucisyo cikusatyocela kwa mlendo* ([literally, 'A stranger comes with a razor blade', meaning 'Visitors can be of help']) proverbs[7], visiting and greeting is a critically important part of daily life and a widely recognised demonstration of respect. While it is friends, relatives and neighbours who are most called upon to make visits, some respondents extended the imperative to research visitors. These respondents, and their relatives and neighbours, understood our return visits as evidence of our respect for the respondent and their experiences. Data constructed suggest that our visits were understood as our 'giving time' rather than 'taking time' from the respondent, and that by maximising time spent with such respondents, talking or just waiting for them in their compounds, we communicated the importance of the respondent and their answers.

2. The method provided opportunities to discuss a wide range of research topics and the flexibility to follow-up on topics discussed so that important areas for investigation are not missed, and so that previously unconsidered issues could be explored. For example, the method allowed fuller exploration of the familial support networks that were a dominant theme in the interviews. The importance of feeling like a capable and independent adult emerged during these further discussions (Chapter 3). By following up on and investigating this adult identity further, I was able to draw links between this and the way respondents presented their sexual capabilities (Chapter 5).

3. It has been noted that the method is particularly appropriate for constructing data that privileges process. The daily events and feelings that constitute respondents'

[7] Unless referenced to an interview transcription, proverbs quoted in this thesis were heard (or are very similar to those heard) in the field site outside of audio-recorded interviews and have been reproduced using translations provided by (Chakanza 2000) (Chichewa) and (Dicks 2006) (Chiyao).

experiences are rarely discreet; Everyday life is on-going. The crux of QLR is that repeat dependent interviews allow the researcher to enquire about the progress of a situation and in doing so construct a fuller analytical picture of respondents' experiences. Although this study was not specifically concerned with change over time, the sensitivity to process and 'micro changes' enabled me to construct a more in-depth understanding of experiences during the short research period (typically a few weeks, see Section 2.5.1). For example, one respondent discovered she was infected with HIV during the course of the study. Visiting and interviewing her on a number of occasions (6) during this period led to new insights regarding the negotiations involved in HIV- and age-related identity change and formation. A second, more 'micro' example (that would not necessarily inspire the demographer to conduct a longitudinal study) was one respondent's argument with her adult son. Although the argument could be considered a discreet event, the resulting shifting of allegiances, relationships and expectations occurred over a longer period. By enquiring how a respondent was feeling on more than one occasion, my understandings of the salience of familial support to respondents' experiences of ageing was increased.

4. People do not tend to speak in a linear fashion: We talk with asides, with rapid shifts in the topic of conversation, and we leave things unsaid because we expect that in the culture we share with our conversation partner, our meaning is clear. By mistake, we omit words in our sentences, or use a word we did not mean to use. The fluidity of narratives is especially likely to be disrupted when the topic of conversation is not one given regular or conscious thought, such as our more deep-seated emotions and feelings towards a particular issue. Older adults in particular might be more likely to present confused interview narratives as they are asked to recall longer lives with interwoven stories, while for some, also experiencing decreased memory and diminishing concentration. Interviewers (and audio-recording devices and transcribers) sometimes do not pick up what has been said. The repeat dependent interview method met these challenges to accurately documenting respondents' narratives and meanings by allowing research assistants and respondents to build narratives across interviews in which the research assistant could probe for further explanations, clarify complicated

stories, go back to an aside that was not followed-up at the time and resolve contradictions in my (or their) understanding of respondents' narratives. For example, the method meant that whether a particular respondent had said her son was in Lilongwe, Liwonde a market town 18 miles away, or Ulongwe, the closest trading centre only about an hour's walk away, could be clarified. In doing so, her comments about their relationship could be better understood and contextualised.

5. Given the challenges of translating both my and respondents' words discussed above, and the difficulty of translating concepts and definitions used in demographic data construction, repeat dependent interviews allowed research assistants to approach a demographic topic in ways that were relevant to the individual respondent by building on what they had previously said. In this way, not only did the question about a demographic concept make sense to the respondent, the discussion about the topic could then be assessed for its salience for understanding an ageing or HIV experience, and its definitions as understood by respondents. For example, rather than ask about 'marriage' as it is understood to the demographer, I could frame questions about partnerships around events that had been discussed in previous interviews, such as a change of religion, a migration or a description of transfers received from a now adult child. In this way some relationships that respondents omitted from their initial explanation of their marital histories came to light, as well as the relevance of these relationships in respondents' lives and why they had not been included previously.

6. The repeat dependent interviewing method gave respondents opportunity to verify both my understandings of their thoughts and experiences, and my early analytical interpretations. The possibility of subsequent interviews enabled my research assistants to return to previously discussed topics to ask respondents if they had captured their comments correctly, if they or I had understood the meanings and implications of those comments correctly, and if my initial interpretations of what the respondent had said and the links I had drawn between various issues, accurately reflected the respondents' experiences. In this, the credibility of my emerging interpretations was continually monitored, the quality of subsequent

data construction was improved and the analysis was better grounded in the data. For example, my impressions that work and productivity might be important not just for physical survival, as had been explicitly articulated in interviews, but also for identity (Chapter 3), was checked with respondents. They validated that working was important to them beyond survival and that not being able to work would challenge their self-worth.

7. Finally, and perhaps most importantly for gathering data on which in-depth and nuanced understandings can be built, repeat dependent interviews enabled the research assistant to approach a theme or issue in a number of different ways and in a number of different conversations, thereby encouraging variations and inconsistencies in respondents' interview narratives to arise. This element of repeat dependent interviews was central to the way data were constructed. Inconsistencies were not regarded as reflective of a change in respondents' perceptions, as in much QLR (Vincent 2012), neither were they regarded as problematic (Elliott 2005). Rather, reflecting the study's cross-sectional design and ontology these inconsistencies were treated as evidence of the contradictions and tensions in both, the way respondents positioned themselves within prevailing discourses and in their experiences at any given time. The possibility of subsequent conversations enabled further exploration as to how and why a respondent chose to present or conceal certain things, how and why particular meanings and experiences might co-exist, and the consequences of this for respondents' identities and experiences. For example, one respondent spoke about having never wanted a non-marital lover because he had always "had the heart for marriage". Later on however, he explained that a beautiful young girl had recently passed by his compound. He had "proposed her" but to his disappointment had been rejected. By looking at the context of his conflicting narratives in our conversations, I was able to investigate how and why he constructed such different identities. When he presented himself as faithful husband, he was discussing his roles as a leading *sing'anga*, a respected elder, and the husband of the village head. When he presented himself as a man still interested in sex with much younger women, he was talking about being referred to as an *agogo* [a respectable Chichewa address for an older adult; the Chiyao

equivalent is *anganga*] and whether he identified with the title. The two identities could therefore be seen and further explored as reflecting different and shifting age-related roles, behaviours and identities (Chapter 5).

These benefits of repeat dependent interviewing contributed to the construction of credible qualitative data and its grounded analysis in this study. It provided an appropriate alternative method to full participant observation and went some way to compensate for the difficulties experienced in translating Chichewa and Chiyao into English discussed above (Section 2.5.4).

2.5.6 Impromptu focus groups

If qualitative research is "characteristically exploratory, fluid and flexible, data-driven and context-sensitive" (Mason 2002, p. 24), good data construction is sometimes guided by fieldwork serendipity rather than careful planning. Conducting three impromptu focus groups was a response to such an unpredictable fieldwork experience. They occurred as a result of addressing individuals attending community-based HIV support groups in Balaka district at the invitation of the groups' facilitator, the National Association of People Living with HIV/AIDS in Malawi (NAPHAM) (see Section 2.5.8). Although I intended to carry out individual interviews with just the oldest old members, all members requested that I learnt about their experiences for my research. Explaining that they were not 'in my sample' and I did not need to hear to their stories to answer my current research questions about experiences of the oldest old would have been ethically objectionable, as well as narrow-minded. Three audio-recorded group interviews were planned for the following days.

Focus group participants were both male and female and aged between 30 and around 75. Reflecting the groups' membership, participants' ages were skewed towards older age. Interviews lasted between 60 and 220 minutes and were composed of around 10 -15 people. I was present for the interviews, which were led by Jonathan and conducted in Chichewa. The longest interview was additionally

attended by a member of NAPHAM who was well known to the group members and had participated in their meetings previously.

Possible questions and areas for exploration were written in an interview guide to assist Jonathan in facilitating discussion (Appendix D). He was encouraged to build discussion around participants' answers rather than rigidly follow the guide. Subsequently conversations focused on participants' support group experiences: the group's purpose and activities, experiences of joining the group, and the difference between joining the group as a younger and as an older adult. Discussion later turned to their personal experiences of HIV infection, including their choices about disclosing their HIV status to their families and communities.

It is the interaction between research participants that distinguishes focus group from individual interviews. As a result, focus groups conducted in cohesive communities are widely understood to highlight normative discourses since shared social relationships mean participants are unlikely to put forward unconventional ideas or individual perceptions for fear of social sanctions (Randall and Koppenhaver 2004, p. 68). However, the nature of the closed community groups interviewed here differs markedly from that of groups created for research purposes from a subset of members of a particular community. HIV support groups are pre-existing small groups, structured on trust and mutual-support. They are unique in being pre-established arenas for the sharing of personal and often intimate experiences and ensuring confidentiality. Outside of the research, members of the groups met weekly, in the same building, and sat in the same circle formation to discuss issues that were not dissimilar to those I asked about. As such, in Balaka, they yielded data that did not differ markedly in tone or expression of personal experiences from individual interviews.

2.5.7 Learning by seeing

Construction of interview data was accompanied by a demographer's – as opposed to an anthropologist's – immersion in the field. I lived in the small town of Balaka, about 18 miles from the midpoint of the sampled villages. Here access to

(intermittent) electricity, a bank, fuel and space meant the logistics of fieldwork ran fairly smoothly. For example, electric light and relative privacy in the evenings allowed me to write the following day's interview guides based on my readings of the day's field notes and interview transcripts, I was able to use a laptop to store digital audio-recorded interview data and charge transcription devices.

What could be observed from my home was not the village life of my respondents. However it was an element of it. Balaka's rural population is mobile and fluid. Both younger and older adults from the (not-sampled) villages surrounding Balaka town would travel to the town to access goods that were not available in the village, including (biomedical) healthcare. As in the sample sites, it was common for rural residents to supplement subsistence agriculture by earnings from trading. People came to Balaka to purchase goods such as soap and oil to resell in the villages. People also came to the town to sell goods to the semi-urban and passing urban residents[8], such as hand-woven mats or *isilisya*, the soaked and dried reeds used to make them.

I spent around four days a week in the sampled villages from around 8am to nightfall at around 6pm. Days were varied so that I could observe activities across the week. I observed life in the village as I walked between respondents' compounds or visited village heads. I observed respondents in their fields. I attended funerals, which were frequent, and once, by chance, attended the wedding of a respondent.

Interviews were conducted where the respondent chose. In almost all cases this was at their homes[9], usually on the "veranda" of their house within their compound. Respondents typically produced a mat or animal skin for the research assistant and me to sit upon. This was usually positioned so that the respondent, research assistant

[8] Balaka town is positioned just off the M1 road that crosses the country from north to south and connects the administrative capital Lilongwe with the centre of commerce Blantyre.

[9] Three male respondents supplemented farming with small businesses carried out at the trading centre. One owned a teashop, one was a carpenter and the other owned a small brick shop that ostensibly sold used electronics but where customers only came to purchase branded soft drinks in glass bottles. (He had no electronics to sell during fieldwork but his sons were in South Africa looking for some). At various times all three chose to be interviewed while they were at their places of work.

and I could sit in a line with our backs to the wall (see Figure 11). My research assistants explained that it was not common for two people to sit and talk with their bodies directly facing each other. Although from this vantage point I could not usually observe the more subtle non-verbal interaction of the interview as I had intended to, it was often possible to observe the much more revealing activity of the compound, the path and other compounds beyond.

Interviews were often long (up to three hours), and time spent in a respondent's compound was longer still as we waited for a respondent to do some task before or during the research conversation. During this time I would sit and watch. If possible I would go elsewhere in the compound to help with more obvious jobs that did not require verbal communication – shelling peas, hanging up washing to dry, and on one occasion following a theft, helping a respondent's husband move a full *nkhokwe* [granaries] of maize, sack by sack, into a more secure store inside a house.

Since I could not speak directly to respondents, my observations were based only on what I (thought I) saw. Some of what I saw was obvious and needed little explanation: a borehole, tobacco drying, a baby on an older woman's back. Much more required my research assistants' explanations and verification: who was at the borehole, tobacco being prepared for auction, whose baby is on the older woman's back. This knowledge of the local context was used to situate respondents' interview narratives within a meaningful framework, helping me to build grounded analytical interpretations.

My observations also raised more questions. These questions were often obvious and automatic ("who's that?"), but their answers generated new and better questions on the topic that, explored in further observations and during interviews, eventually led to new insights. For example, by needing to urinate while at respondents' homes I discovered that some respondents had a pit latrine but others did not and instead walked to the bush near their homes. By visiting a respondent's pit latrine I found out where it was built, what it looked like inside, how dark it was, the balance and dexterity needed to use it, its structural condition, whether it had a door or *chitenje* covering the entrance, who saw me walking to it and who saw me using it. I

questioned and discovered who owned it, who shared it, who was in charge of it and who cleaned it. And suddenly the significance of all this for older adults' concerns about privacy and dignity, their ageing bodies and the receipt of personal care, became relevant and ultimately insightful lines of enquiry.

Deciding which of my observations should be recorded, if at all, was a complicated decision. Observations were passive, secondary to the data constructed using interviews and not treated as "raw data" to be systematically analysed. The events that seemed most significant at the time – a bicycle accident or the prediction that I had been bewitched following a very difficult day in the villages – were dutifully noted down in the evenings but rarely led to significant insights. It was the mundane, chance observations described that led to the most telling questions. These were recorded in the interview guides: the process of seeing, asking questions of my research assistants, getting answers and asking questions of my respondents, represents the recording of these observational data and their incorporation in the analysis.

Figure 11 A respondent's husband joins us for a photograph following the end of an interview

2.5.8 Theoretical sampling

This study's theoretical sampling strategy was so connected to its analytical strategy it is difficult to know how and whether to separate description of them[10]. The two were joined in a cyclical process. Data construction is followed by analysis, which generates tentative ideas or 'categories' as well as further questions about those categories. Further data were constructed to answer these questions and explicate the categories. This was done by sampling in a way that maximised variation in the categories so that they may be juxtaposed and examined (Corbin and Strauss 2008). For example, "loss of physical strength" was identified from the analysis of exploratory data constructed as a potentially significant category for understanding ageing experiences. In order to investigate the "loss of physical strength" category

[10] A point also made by Juliet Corbin in writing her description of grounded theory (Corbin and Strauss 2008, p. 143)

further, substantive data construction began by sampling respondents who had experienced differing loss of strength. I expected chronological age would be an indicator of losing physical strength. By sampling respondents of various ages from youngest old (aged 50) to the oldest old (aged over 90), the category's dimensions, properties and relationships to other categories could be examined.

Theoretical sampling was therefore particularly appropriate for studying ageing and HIV infection since it allowed for discovery in this previously under-researched area. Its ultimate aim was the construction of grounded, interpretive theory that may be relevant to exploration of ageing and HIV in similar contexts. While the heavy use of MLSFH data allowed sampling to be randomised within each sampled category and thus some selection biases to be avoided, it did not aim to be representative, as is more typical in qualitative studies carried out by demographers (Randall and Koppenhaver 2004).

An initial sample for substantive data construction was drawn from the MLSFH southern respondent listing using the 2008 survey dataset (MLSFH-08) (which included positive HIV test results collected in previous survey waves). A random sample was drawn, stratified by characteristics relating to categories theorised to be important from analysis of exploratory data constructed and review of literature. These were: HIV status (tested HIV+ by MLSFH, not tested or tested HIV- by MLSFH), sex (male, female) and age, as described (youngest old to oldest old). As data construction proceeded and further analysis was carried out, the categories were elaborated and refined, their importance was confirmed and new questions were raised about their dimensions and relationships. Therefore, the next samples drawn were also stratified by these associated characteristics.

To return to the previous example, the category "loss of physical strength" was investigated by comparing what older old and younger old respondents did and did not say on the topic. As a result, the category was broadened to reflect respondents' interview narratives and became "the ageing body". This refined category included lived experiences of loss of strength as well as respondents' predictions about future

experiences. Exploring the newly constructed data also identified further gaps in my nascent analysis. More data were constructed, sampling on chronological age.

By juxtaposing the experiences of older and younger respondents I found that chronological age was just one of several dimensions of the category. The centrality of the body for respondents' ageing experiences was also tied to their giving, receipt and expectations of familial support. This marked the beginning of the development of a new analytical category. It was further investigated by drawing a sample of polygamously married respondents (randomly sampled from MLFSH-08 after stratifying for this characteristic) to compare to the monogamously married and single respondents already interviewed. In addition, I sampled three sets of older-old parent and younger-old child pairs and the aunt, brother and husband of three existing respondents. Interview narratives about familial transfers and the ageing body could then be compared and contrasted within the paired respondents.

Analyses of these data raised a further, more specific question: how do experiences of HIV infection relate to experiences of the ageing body and familial support? I investigated this by reconsidering the data I already had (in a process Corbin describes as theoretically sampling the data (Corbin and Strauss 2008, p. 150)) and in further interviews with HIV-infected respondents already sampled. However the MLSFH-08 dataset is skewed towards younger older adults; the oldest respondent with documented HIV was 61 years old. On-going analysis indicated that in general the youngest respondents had different experiences of familial support and the ageing body from the oldest respondents. To maximise variation in the sample, older old adults with HIV were needed.

Observation in the sample sites, including informal conversations with government and non-government health sector personnel providing HIV testing, treatment and support, indicated that older old adults were accessing their services. HIV support groups were selected as the most appropriate population from which to draw a further sample, since members had disclosed their HIV status, at least within the space of the group, and could therefore be approached there without compromising their confidentiality. Although formed at the community level, the groups are

coordinated by the National Association of People Living with HIV/AIDS in Malawi (NAPHAM). Three support groups were selected to sample from, chosen by the NAPHAM regional coordinator on the basis of group members' ages (2+ members suspected to be over 60 years) and location within the sampled district. The regional coordinator negotiated access with the group leaders who in turn negotiated access with the groups' members. I was invited by group members to meet the groups at their premises to talk about the research and invite them to participate. All older group members (including younger old members) were recruited to participate in the study.

Theoretical sampling is therefore cumulative (Corbin and Strauss 2008, p. 146). As more data were constructed and analysed, questions became more specific as categories were explicated, the relationships between categories were examined, and the categories and themes most important for shaping respondents' experiences of ageing and HIV became clearer. However this process was not as linear or neat as it is presented here. Various ideas and categories were formulated concurrently and were explored with further data construction by sampling on various categories at once. Ideas and explorations competed for analytical attention so that a particular idea might be formulated, exploration started, then dismissed in favour of a new theoretical lead, only for the exploration to be resumed at a later date as analysis of newly constructed data re-highlighted its relevance. Decisions about the focus of data construction and the emerging theoretical statement were tentatively made and reneged upon before they were finally adopted. For example, the decision to focus on the direct rather than indirect impacts of HIV infection that had been tentatively made following preliminary fieldwork was only confirmed after analysing data constructed two months into substantive fieldwork.

On the other hand, sometimes data were constructed to illuminate a category that, when explored, was found to be less relevant to building an understanding of ageing or HIV infection at older age. For example, one respondent mentioned a herbal remedy called *manpower*, apparently used by older men to strengthen their sexual desire and performance. Discussing the interview with research assistants that afternoon, Jonathan said that during MLSFH data collection in Mchinji and Rumphi

the previous year a number of respondents had also offered him *manpower*. I hypothesised how *manpower* might fit with the concepts I was developing around the ageing body and sex and developed further questions: Was there a *womanpower*? Which older adults' used it? What were their motivations? What were the consequences? How did it make the users feel? Where did they access it? I set out to explore these ideas and test the boundaries of the new category by constructing more data. I did this by introducing the topic into discussions with previously sampled respondents as well as by sampling an older *sing'anga* [herbalist and healer][11]. After investigating the "*manpower*" category further in interviews with all these respondents, it became clear that its users tended to be younger men and that it was not a salient part of respondent's experiences or the interpretive theory that was emerging.

Since the aim of theoretical sampling is to elicit data to help explore the categories emerging from on-going analyses, sampling on an indicator of a category continues until the category is explored to the extent that it reflects respondents' experiences and can be used as an analytical building block to construct an interpretive theory. It is rare that any category or concept ever reaches "saturation": there will always be more properties and dimensions to investigate (Corbin and Strauss 2008; Dey 1999). In this study, data construction continued until the analytical concepts I identified as being most salient for understanding experiences of ageing and HIV infection were sufficiently well developed. Numerous categories and concepts that are not presented in the following chapters as part of the final analytical account were identified, investigated with the construction of further data, but not fully explicated during fieldwork. Their presence in the dataset and absence in the 'findings' is one of the limitations of the study.

Considerable effort was made to locate each respondent identified from MLSFH-08 in order to avoid the sampling bias generated by selecting easily-found respondents. Because the MLSFH-08 listing represents adults the MLSFH attempted to find, rather than those actually interviewed, and since name-changes are common and

[11] Later, the sample included another *sing'anga*, recruited for having HIV rather than his profession.

mortality and mobility within the research site was high among respondents, this was often time consuming and difficult, as various leads were followed. Several respondents were eventually found to be living in villages outside of the MLSFH sample and interviewed. Four sampled respondents could not be found: three had died and one respondent had moved to Mangochi district. Three potential respondents, all sampled from MLSFH-08, declined to participate in the research without giving a reason. One respondent discontinued participation following her first interview reporting that she was tired of taking part in research studies. Two further respondents died in the interval between substantive and further data construction in 2009 and 2010. Some characteristics of the final theoretically-drawn sample for in repeat dependent interview are shown in Table 3.

Table 3 Background characteristics of sample for repeat dependent interview

	N
	43
Age (estimated)	
50-59	17
60-69	13
70-79	7
80-89	5
90-99	1
Gender	
Male	20
Female	23
HIV	
HIV+	15
Tested HIV+ during fieldwork	3
HIV- or unknown	25

2.5.9 Procedure for qualitative data analysis

This section describes how qualitative data constructed from repeat dependent interviews, observations, and focus group interviews were transformed into the

analytical account of older adults' experiences of ageing and HIV presented in the following chapters. The procedure for qualitative data analysis was loosely guided by those set out by (Charmaz 2006; Corbin and Strauss 2008), but adapted to suit the logistical and theoretical concerns of constructing and analysing data in an unfamiliar context and in another country. As is characteristic of grounded theory methods, the emergent process involved defining and indexing data using coding, producing analytical ideas about the data, writing successive memos about the data, and finally, sorting memos to produce an integrated analysis. A strategy of 'constant comparisons' was used at each stage. It involved comparing data from different respondents' interviews, comparing data from a single respondent's interviews, comparing data within and across codes, categories and finally, memos.

In the field, each transcribed interview was scrutinized line-by-line and I wrote memos about the emergent perspectives, experiences, concepts and themes I identified. My questions and thoughts were documented in interview guides to be used for further data construction. Further data were constructed and scrutinized and memos were revised based on comparisons across respondents and within the narratives of a single respondent. Analytical ideas were developed based on the memos. Data construction continued until I had enough data to elaborate these ideas sufficiently.

After the period of substantive fieldwork I began open coding (Corbin and Strauss 2008). I typed the handwritten transcripts and grouped them line-by-line into fluid concepts and themes using NVivo data analysis software (QSR International Pty Ltd 2008). I remained open to codes, coded for everything, and kept codes short and broad. Although coding is "active" in most applications of grounded theory and codes are continually revisited and revised, returning to all the data after the period of fieldwork to carry out what is typically regarded as the initial step in analysis is rare.

The procedure reflects the privileging of context in this study. After nine months of being immersed in the field site, the ways of life and Malawian English, returning to code all the data constructed meant that I questioned and re-assessed the meanings I

had originally attributed to texts and noticed things I had not noticed when I read them after only a few months of fieldwork. In addition, it meant that interviews conducted throughout the period of data construction could be re-examined and coded in light of the analytical ideas I had developed later. For example, I started to explore the significance of diarrhoea towards the end of the fieldwork period when exploring an analytical idea about toilet use in older age. In returning to code all the data I noticed diarrhoea was also talked about in the context of HIV in the earliest interviews but at the time I had considered this only as one of a few symptoms of HIV, rather than a stand-alone topic. By coding the data using initial coding at this late stage in my analysis, more abstracted ideas and concepts that I was developing remained fully grounded in the data and better reflecting respondents' experiences.

The codes remained active and continued to change and evolve as more data were coded and analysed. Again constant comparison was made across themes, between and within respondents' multiple narratives, using a series of more subtle and nuanced questions influenced by constructivism such as:

- What do respondents say about a certain topic? What is the range of discourses about a certain topic?
- Why is there a range of discourses about a certain topic? How else do these respondents differ?
- What cultural, social or linguistic references does a respondent draw upon? Why might they draw upon these particular references? What variation is there in these references?
- How does a respondent present themselves? Does this change during the interview? When and how does it change? Why might it change?
- Why might a respondent tell a story in a particular way?
- What is the influence of the researchers and research process on a respondents' narrative?
- How do the narratives recorded in the transcripts not only reflect, but also shape, respondents' experiences?

As in all research, the questions I asked of the data following their construction ultimately shaped the results. By considering not just the particular identity of being say, sexually capable or sexually reserved, but why a respondent might choose to present themselves in those ways at certain times, meant that I could draw links between the competing discourses to arrive at an understanding of how respondents were negotiating between these identities (Chapter 3-4).

Particularly close attention was paid to data that did not fit into the emerging themes and explanatory models to guard against selectivity in the use of data. Analytical ideas were examined for the relationships between them. Memos continued to be (re)written to document the increasingly elaborated and abstracted analysis and the evidence for it.

The final stage of the analysis was to integrate these memos in the way that best presents the relationship between the various analytical ideas. This was achieved first through reviewing memos and producing integrative diagrams (Charmaz 2006; Corbin and Strauss 2008). The emergent central story was then refined by reviewing its internal consistency (its 'logic'), 'trimming it' by checking that all the analytical ideas included really fit with this particular story and most importantly, returning to the raw, uncoded data to check that it can explain most cases (Corbin and Strauss 2008).

The quotations used in the following chapters were selected to highlight the themes and perspectives that emerged in my analysis. Quotations are accompanied by basic socio-demographic information and pseudonyms. Since the vast majority of respondents did not know their ages, approximations are provided based on what major events they could remember in Malawi's history, or, when no major events could be mutually recognised, based on the respondents', the research assistants' and my estimations. Care was taken to ensure quotations were selected from a full range of respondents.

2.5.10 Ethical considerations

Ethical considerations were central to this study. All older adults interviewed were in good mental and physical health such that they were able to consent to participate in the study, and participate without causing any mental, physical or emotional harm or discomfort. Participation of respondents was voluntary and followed lengthy explanation of the research that took account of any age-related decline in vision, hearing or cognition. This explanation was verbal but made use of written information sheets (Appendix E). These were left with respondents if they wanted them, and were appreciated by the small number of respondents who were literate or had school-aged grandchildren to read to them. However as fieldwork progressed and I became more familiar with respondents' understandings of research in general, questions about this study and reactions to being offered a written document, the inappropriateness of information sheets was highlighted. Later recruitment was done solely using verbal explanations of the study (covering broadly the same information, in more appropriate language). Respondents' questions during these explanations suggest their greater engagement and understanding of the research, and a more informed consenting process. Following this discussion, the information sheet was produced and respondents were asked if they would like to keep it as a record or for my contact details. Respondents marked consent forms or gave audio-recorded verbal consent to participate.

The study was described as being about ageing and HIV infection generally. Research assistants were not informed of the HIV test results of respondents tested by the MLSFH and did not ask respondents about their HIV status, leaving respondents with HIV to introduce this information during the interviews if they wanted to. Respondents were reminded about the purpose of the study and their right to withdraw each time we visited them. The confidentiality of information collected was enforced throughout data construction and analysis. Participants' identity has been kept anonymous by removing names of people, support groups and places from the transcripts. Explicit and informed consent was given for the photographs taken to be used in this thesis and in the dissemination of research findings nationally and internationally. This permission was audio-recorded. The photographs used at the

beginning of each substantive chapter are for illustration and do not reflect a link between the subject of the chapter and the photographed respondents' particular biographies or interview narratives. Both respondents and the information they provided have been treated with respect.

The study involved discussion of the problems experienced by older adults in the field site and risk and prevalence of HIV infection at older age. I have disseminated this information among relevant governmental and non-governmental organisations in Malawi through presentations at formal and informal meetings and conferences. I also encouraged Jonathan to share findings with ART dispensing clinics and charitable organisations focusing on water and sanitation in Balaka in response to specific problems reported by respondents. Internationally I have disseminated research findings through presentations to academic and development-oriented audiences.

As is considered good ethical practice among researchers in Malawi (Mfutso-Bengo *et al.* 2008; Watkins *et al.* 2003), and socially-appropriate for visitors locally, small gifts were given to respondents when visiting for a research conversation. As is customary behaviour for non-research visitors in Balaka, these were presented to the respondent on greeting, irrespective of whether an interview was conducted. Gifts consisted of soap, sugar and salt, or were personalised to reflect a previous conversation (e.g. other groceries, dried fish, cooking oil or a *chitienji*). When taking photographs of the respondents, I also offered to take family portraits. I had all of these photographs printed in Lilongwe and gave them to respondents as additional gifts. There is much evidence in the transcriptions that respondents were pleased to receive the gifts, but no evidence that their participation was a direct result. Instead there is evidence that respondents enjoyed the opportunity to recount their experiences and appreciated receiving visitors. My research assistants and I also received gifts. Usually these were gifts of food, either to eat in the respondents' compounds or to take away with us. On our last visit to one respondent he produced a mat that he said he had woven for me.

In addition, all respondents who expressed desire to be tested for HIV or concern about their risk of infection were offered transportation to the nearest HIV counselling and testing (VCT) centres. If requested, the trained research assistants were all able to give information and advice regarding HIV transmission and risk. As a trained VCT counsellor, Jonathan provided post-test counselling to a recently diagnosed respondent and assisted HIV positive respondents experiencing difficulty deciphering their results or how to collect their ARVs.

Permission to conduct research was granted locally by village heads, NAPHAM and support group leaders, nationally by the National Health Sciences Research Committee (NHSRC) through the study's association with the MLSFH's health-related data collection, and by the LSE Research Ethics Committee. However, receiving permission to conduct the study is the beginning, not the outcome of reflection on the ethics of research. The production, recording and dissemination of 'knowledge' are inherently fraught processes, embedded within a complex set of historical, social, political, economic and epistemological power dynamics.

Three ethical concerns were raised in this study relating to these dynamics in the context of conducting research in a resource-poor African setting. All three stem from the considerable gap in wealth and privilege between me and the respondents. As such, although solutions were sought, they were partial and restricted. The concerns raise ethical questions that are bigger than this study.

Firstly, the obvious wealth of my research assistants and I brought the expectation of change and development. Despite lengthy explanations to the contrary, data constructed indicates that a number of respondents expected personal or community development, such as a micro-finance loan or a hospital, to follow the study as a direct result of their participation. This has been identified elsewhere (Randall and Koppenhaver 2004; Watkins *et al.* 2003) but rarely questioned further. Research assistants established good rapport with respondents and were able to communicate complicated ideas, so why did they struggle to disavow them of this particular idea? Indeed, data also indicate these same respondents also understood that the research

was small-scale, being conducted as part of my "school work" (a PhD was not a translatable concept), and that they would not be paid for their contribution.

I suggest that the contradiction stems from respondents', and to an extent local research assistants', understandings of reasonable wealth-transfers. Both respondents and research assistants recognised the considerable gap in present wealth between us. In addition, the process of conducting the research was recognised to be lucrative; respondents and research assistants expected that I would further my career and secure a high-paid job in the West, and respondents expected that research assistants were being paid a significant foreign salary. Both also perceived that my privileged social and physical mobility would translate into influence over development organisations in general and government-run projects in particular. Therefore, regardless of what I had said previously while recruiting respondents, once I had visited respondents, heard their stories and demonstrated that I cared about their experiences, it was understood that I would not just leave respondents (and research assistants) without using my privilege to help. After all, *Tapita m'njira adasiya tonse m'khola* [literally, 'Those who said "we are just passing by the road" left us in the goat kraal', meaning, 'Those who do not visit do not help with problems, but those who visit see the problems and therefore are compelled to help'].

The situation also parallels the way other payments are made, such as those for sex or for herbal treatments discussed by respondents and documented in the literature on Malawi. Although *chibwenzi* relationships are understood to involve both sex and the transfer of material resources from men to women, a good *chibwenzi* does not ask for the transfers, she simply tells her partner "you can give me when you decide". Similarly, a *sing'anga* does not charge a payment for his or her services. Instead, the *sing'anga* and the patient know that once cured the patient will return to pay the *sing'anga* what they think the cure is worth. 'You can give me what you decide' was a phrase heard often during my time in Balaka – from the neighbour who cleaned my car to the men desperately trying to sell ornaments to tourists on their way to Lake Malawi. Indeed, my analyses indicate that there was an unspoken contract whereby a wealthy visitor having received hospitality, will return to compensate for this. This

then raises questions about the possibility of informed consent in settings in which firmly established expectations of wealth-transfers cannot be ameliorated.

Secondly, the comparative privilege of the researcher also raises a problem for the dissemination of the study findings to participants. Sharing the results of the study with participants is widely accepted to be an ethical imperative (Fernandez *et al.* 2003). Some respondents noted that they rarely hear what happens to the information collected and asked to be told about the final findings. Although the emergent nature of data construction and analysis meant that research assistants could feedback early and undeveloped findings during research visits, formal feedback of the final outcome - a nuanced abstracted theoretical understanding - to the population in question is extremely challenging. Research assistants will struggle to translate the complicated English words into Chichewa and Chiyao, and the concepts used are likely to be beyond the grasp of respondents who typically had no formal education.

Finally, challenges resulting from the incompatibility of the emergent nature of grounded theory with applications to institutional research ethics review committees (Charmaz 2006; Potrata 2010), in this study raised the question: when deciding whether a course of action is 'ethical', whose permission really counts?

Towards the end of this period of fieldwork, I interviewed members of three HIV support groups that were not resident in the villages sampled by the MLSFH. Both the idea to sample support group members and the invitation from HIV support group coordinators and members happened in short succession. As noted above, I approached the regional support group coordinator of NAPHAM to ask for his thoughts about the topic and his thoughts regarding recruiting older old adults with HIV to my study. To my surprise, while I was still in his office he suddenly picked up his phone and called the leaders of three support groups in the area and, speaking in Chichewa without my request or input, secured an invitation for me to visit them in the following days, provided that the group members gave their permission. Jonathan received a message that afternoon that the members of the groups would

like to meet us and arrangements were made to visit them at their meeting rooms over the following days.

Being outside the MLSFH-sampled villages, this previously un-planned primary data construction was not covered by previous applications to the LSE or NHSRC review boards. However, it quickly became clear that once the research had been explained and I had been introduced, to not conduct the interviews, or delay the interviews until updated approval was granted, would have been far more ethically dubious. Group members reported that their experiences were rarely listened to. Subsequently they were extremely enthusiastic for receiving the foreign visitor who had come to listen to their stories, even after the likelihood of personal benefit from the research was explained. My attempts to explain that I could not conduct the interviews because I did not have "permission" yet were met with confusion followed by ridicule. I had "permission" from the respondents, the group leader and the group facilitators. Who were these review committees to give permission on their behalf? In this situation, adhering to the approval of institutional review boards reproduced unequal power dynamics between researcher and researched by removing, rather than promoting, participants' choice and autonomy.

The decision was made to interview the group members without the updated approval from the LSE research ethics review committee (there is no social science research ethics review committee in Malawi; NHSRC approval is based on MLSFH collection of biomarkers). Fieldwork proceeded with great care. The content and form of the interviews did not differ from those conducted among respondents living in the MLSFH sample villages. Respondents reported their inclusion in the study endowed them with social standing that they felt had lessened with age and HIV infection:

> *R [Calling to her grandson (G) who is passing by the compound:]* Nganga[12] *I have received some visitors, they have come to talk to me, just imagine an old person to receive visitors like these?!*
>
> *G That is very important for you*

[12] General address

R I am proud! A person like me to have these visitors!

G That is your luck

[Esnart, female, mid-60s, single, HIV+]

2.5.11 Limitations of the data

By interviewing adults who were aged over 49, MLSFH respondents or attending HIV support groups, and able to participate, I attempted to explore the age and HIV-related experiences of older adults in rural southern Malawi. However, this sampling strategy has four limitations for eliciting data to do so. The first two concern the sampling frame, the third and fourth, the age of respondents.

Firstly, by including only adults who were in adequate mental and physical health to participate, I inevitably missed the experiences of less healthy older adults. These older adults may have forwarded different narratives from the respondents. Indeed, the analytical account presented in this thesis centres on older adults' negotiation of old age and reflects the narratives of older adults who were actively managing positive identities as productive adults. Nevertheless, some experiences of illness were explored: many respondents were experiencing on-going and sometimes considerable health problems, and a significant number of those with HIV had recovered from periods of severe illness from which they had expected to die.

Secondly, although adults over 49 years old account for 16.3 and 43.5 per cent of rural Malawi's considerable female and male HIV prevalence (Freeman and Anglewicz 2012), this equates to a small minority of the country's 1,201,000 adults of the same age (National Statistical Office of Malawi 2008). Identifying these adults would have been very difficult without the sampling frames provided by the MLSFH and the HIV support groups. However, both sampling frames are likely to have involved selection biases.

To begin with, MLSFH respondents differed from adult who are not MLSFH respondents. They were familiar with research and international researchers, and moreover the research agenda of these organisations. Health in general and HIV in

particular featured heavily in early discussions with these respondents as they directed the interview towards the topics they believed we were most interested in. Further, respondents I recruited from the MLSFH 'parent' sample, and respondents I recruited as family members of existing respondents, may have differed from other respondents and non-respondents in their kinship ties. Both groups of respondents were included on the basis of having family (a child in the MLSFH, or a husband, wife, son or daughter I had interviewed) resident within the same district. They are likely to have different expectations and experiences from older adults who do not have any relatives or whose relatives do not live in their district.

While the use of repeat dependent interviews allowed us to overcome the first challenge by providing multiple opportunities to explain to respondents the aim of this study and the probe past their first comments about HIV (usually the 'correct answer' with regards to transmission, risk and stigma), the second bias is difficult to correct. Nevertheless, respondents recruited through HIV support groups and from the original MLSFH sample can be considered as a reasonable representation of non-MLSFH respondents with regard to kinship. Further my observations, as well as respondents', confirmed that while important exceptions must exist, it is very rare indeed for older adults to live without any family at least within the district.

In addition, members of HIV support groups are also likely to be different from older adults with HIV who do not attend support groups. Although there are no estimates of the proportion of adults with diagnosed HIV infection attending such groups, it is likely that some do not receive this support. These adults may not perceive group membership to be useful or may be less able to navigate HIV infection as a result of non-membership. Further, support group members were familiar with talking 'publically' about their feelings and emotions and had gained considerable knowledge about HIV from their activities[13]. However, data constructed on the

[13] For example, consider this description by Jonathan of his third interview with Alick [male, early 50s, married]:

> *The interview was lively and we laughed at times during the interview. The respondent was open and made very good use of his knowledge gained from the support [group]. He could express his feelings on the subject of having*

experiences of older adults with HIV recruited from the MLSFH respondent listing provide some contrast to these experiences.

A further limitation of the data concerns the difficulty defining who qualifies as an older adult. Sampling used chronological age based on the initial research questions which concerned the experiences of adults over 49 who are excluded from HIV estimates and are under-represented in African research more broadly. However, as identified in other African settings (Cliggett 2005; Cohen and Menken 2006; Tengan 2002) analysis of data constructed here suggests that the chronological age of 50 years was of little significance for respondents, many of whom did not know the year of their birth. As a result, respondents include some adults who did not self-define as 'older'. This situation is clearly incompatible with the study's aim to reflect respondents' concerns and perspectives.

To respond to this challenge, respondents' non-chronological understandings of their age were used in the analysis and little attention was given to the exact chronological age of respondents we had deduced (although attention *was* given to being broadly younger old or older old). The approximations of chronological age given alongside quotations used in the following chapters are presented for the benefit of the Western reader only.

Finally, following demography's tradition of interviewing population subgroups, almost all respondents were older adults. I therefore missed perspectives from other actors that would have contextualised older adult's experiences and allowed comparisons to be drawn. For example, the systematic inclusion of younger adults with HIV may have further highlighted the effects of older age on experiences of HIV, and the incorporation of younger adults' understandings and perspectives of old age and older adults may have provided new areas of investigation. This limitation was partially addressed during data construction by speaking to younger adults in and around the sampled villages about their understandings of older age, the inclusion of younger adults with HIV within the three focus groups conducted, and

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different HIV results with his wife in an honest manner. This is not very common with men to come in the open and say the truth.

by eliciting the understandings of old age held by the younger representatives of organisations concerned with care for older adults or people with HIV in Malawi (see Section 2.6 below). In addition, since some of these organisations were not solely focused on ageing (e.g. The Food and Agricultural Organisation and the National AIDS Commission), key informants were able to discuss their understanding of the role of age for particular experiences, such as HIV infection and receipt of government assistance. Further, the focus on older adults in the sample was addressed in the analysis by regarding respondents' narratives as situated and personal perspectives that may or may not be shared by non-respondents.

2.6 Further fieldwork: Situating older adults' experiences

Analysis of data constructed, on-going literature review, and the dissemination of early research findings in 2009, emphasised the need to situate the ageing experiences detailed in the repeat dependent interviews and focus groups in rural Balaka within the broader policy context of ageing in Malawi. Three research questions emerged:

- What governmental and nongovernmental (NGO) provision is made, or is planned, for older adults in Malawi?
- What is the gap between policy and implementation?
- What understandings of old age and ageing experiences underpin policies regarding older adults?

However, very little literature exists to answer these questions and information about age-related policy and programmes was either not accessible outside of Malawi, not publically available, or not documented. I therefore returned to Malawi in 2010 to carry out further fieldwork. Basing myself in Lilongwe, I arranged research meetings with 19 individuals, identified to be key actors in the field. The affiliation of these key informants is listed in Appendix F.

To the best of my knowledge all of the main national or multi-district organisations concerned with ageing in Malawi were identified and invited to a research meeting.

No organisations declined to participate, but meetings with representatives from all government organisations were difficult to arrange and some were kept quite short (20-30 minutes) by the participant.

I conducted the research conversations in English during official working hours at participants' offices or in a café when the respondent preferred this or if they did not have an office, such was the case with almost all of the NGOs. Aside from purchasing drinks in cafés, participants were not given gifts as the older, rural respondents had been. Only one key informant did not agree to have the conversation audio-recorded. Notes were written during this interview. Key informants were asked only to speak officially about the work and plans of the organisation they represented. Some civil society key informants broadened our conversation to include their personal comments and observations. Written (emailed) consent was given to use the names included in this thesis following our conversations.

During meetings and over the course of the further fieldwork I collected documentary data. This included draft national policy documents produced by government ministries, research reports and NGO funding proposals. I also searched the internet for the events, authors and organisations that key informants mentioned but could not elaborate on, such as "a conference in Germany" or the fleeting involvement of an international development organisation that has no permanent presence in the country. Issues emerging from my review of interview and document data were investigated with the construction and collection of further data.

Following my research meetings I was invited to attend an international conference entitled *Ageing in Africa: Sensitizing the Nations*, held in Lilongwe on 2-3 June 2010. The large conference was attended by all major stakeholders working on ageing issues in Malawi. I introduced the broader study and the purpose of my current visit to all delegates I spoke with.

The conference provided a unique opportunity to observe how the various stakeholders I had met with interacted with each other, how decisions and priorities for ageing were set, on what basis priorities were put forward and what those

priorities were, as well as gain access to actors I had not been able to contact or was not yet aware of. Lengthy field notes and memos were written about the conversations I had with key informants and my observations of the conference. I collected copies of all presentations made and with the full permission of conference organisers, audio-recorded the key note addresses and short question and answer sessions that followed presentations.

The objective of this element of the study was to broadly describe and review the policy and programmatic context emerging in Malawi. Therefore, although an inductive approach was used to construct and collect data regarding this context (for example, identifying key actors for interview as data were constructed, and tailoring interview questions to the picture emerging from my reading of the data constructed previously), the careful theoretical sampling and repeat dependent interviewing detailed above were not used. Similarly, data were subject to descriptive qualitative analysis that aimed to summarise the policy context and identify the dominant understandings of older adult within it. This strategy contrasts sharply to the way data from interviews with older adults were analysed, which aimed to develop a nuanced and grounded in-depth analytical account.

2.7 Summary

The study used constructivist grounded theory to investigate experiences of ageing and HIV that were most salient to older respondents. This approach, combined with the use of repeat dependent interviews, enabled me to produce a set of contextualised, nuanced understandings that reflect the complex and multiple realities of ageing with or without HIV infection in rural Balaka. I have argued that repeat dependent interviews, set within a constructivist grounded theory framework, were the most appropriate method for generating data to answer the study's broad research questions.

Chapter 3 | “Finished blood”: Old bodies, livelihoods and the challenge to identity

The research aimed to explore experiences of becoming old in rural Malawi. This chapter introduces the first part of the underlying tenet of these experiences, and the analytical account presented in this thesis: that old age was considered a challenge to personhood. This challenge was based on body-centred understandings of old age and the life course. I explore the ethnophysiology of ageing in the field site and suggest a reason for the prominence of the body in respondents’ narratives. I discuss how these understandings of old age challenged respondents’ sense of self by drawing on sociological and social psychological theories of identity.

3.1 Blood and the corporeality of old age

Life for older adults in the field site was diverse. Some enjoyed later life; others longed for easier days gone by. Some respondents lived comfortably in tin-roofed homes surrounded by supportive family. They had larger smallholdings and children to help them farm it. They were healthy, active, and for most of the year, well-fed by local standards. Others survived in collapsing homes under the patchy cover of grass roofs that were long overdue renovation. They had smaller smallholdings that they farmed more-or-less alone. They were in pain, hungry, lonely, and lacked sufficient support. Nevertheless, respondents highlighted common themes underlying what it is like to grow old in rural Malawi.

Central to all respondents' understandings and experiences of old age and ageing was the body and, in particular, the body's fluids. For respondents, all bodily fluids contained a life force – a quality of 'being alive', translated by all of my research assistants as "power" or "strength". This life force was strongest in the blood and, as I will explore in Chapter 5, ejaculate. All fluids, and the bodily power they both contained and equated to, were referred to as "blood". As Thomas clarifies:

> *R The importance [of blood] is that it makes the body strong, but when you don't have adequate blood you are weak…When they say a person is strong, it's the power of the blood.*
>
> *I When talking about blood, are you talking about the actual blood, or semen or just power?*
>
> *R Those things all contribute to make strength…Strength and blood go together… Blood is strength.*
>
> [Thomas, male, 60, married]

The quantity of these fluids in the body, and the flow of these fluids around - and sometimes away from - the body, was a central determinant of an individual's strength and vitality. Various physiological processes and illnesses were described with reference to the circulation of good blood around the body and the removal of bad blood from the body. For example, a number of respondents suffered *nyamakazi*, translated as "rheumatism", neuralgia in the hip and thigh, and sciatica.

Respondents who experienced it described a constant ache in the affected body part (for them, the hands, back and legs) that made movement difficult. It was understood by respondents and research assistants to be caused by the build-up of blood in the affected area, which then hardened and prevented blood from flowing around the body. Although effective "blue pills" were given for *nyamakazi* at the hospital, the more easily-accessible and frequently-used cure was to cut out the dried, darkened blood, expelling it from the body and allowing the blood to flow again. For a while at least, the individuals' vitality and strength returned.

Respondents conceptualised the life course as a linear trajectory of diminishing strength and "blood" over time. Both were understood to be finite and at their peak in young adulthood. In very old age, the quantity and quality of the fluids in the body were reduced. An old body had "thin", blood, and "even if it is sweating, [a young man] sweats greatly, while an old man's sweat is low". The reduction in fluids left the old body with little strength:

> *When a person is born he has all the strength… Each passing day the strength is removed little by little… And when he is growing very old it goes down … It all ends when God has taken you back to him.*
>
> [Robertson, male, 80s, recently married]

In death, the body was therefore empty of fluid, the source of life and strength[14]. These ethnophysiological understandings were shared by Yao and Chewa respondents.

Bodily strength was understood to fade gradually over time based on the quality and quantity of the fluids. However certain activities and events, such as farm work and childbearing, required a lot of strength and blood and 'used-up' an individual's finite store, hastening their decline and making a person "grow very old quicker". As

[14] This was well-illustrated by the rumours of witchcraft circling during my time in the field site. In the rumours, which were conflated with suspicion about the international researchers who had visited Balaka in 2008 to take people's blood away to America (Soldo and Anglewicz 2009), the culprit put a needle in the door of their victims' homes. In the morning the victims' empty bodies would be found, completely drained of blood.

Tryness and Patuma explain, recalling how they lost their blood and strength as young women:

> *When somebody is ageing the blood is lost because that person has done a lot of work…Looking for firewood at the game [park - some kilometres from the respondent's home and now fenced-off], pounding [maize], sometimes we could walk up to [name of village far from the respondent's home] for the maize mill… With that we lost a lot of energy.*
>
> [Tryness, female, 70s, married]

> *So [people] become weak because of old age. Sometimes if they were having children, their strength was going to the children because they were sharing their strength with the children…We can differentiate it because a barren person has more strength than a person who has got children…To us who have got children, we lost more things. Each time when you are delivering a child, we lost more things - blood. Yes, sometimes, you can see that other people become weak at that time [of delivery], because they have lost more [blood]. Have you seen it? That time? The body becomes weak each time when you go to deliver a child. If you have got nine children like me, or I can say that, I went there for ten times [had 10 births]… the strength is gone now.*
>
> [Patuma, female, 58, married]

Age-related decline in strength was conceptualised as an inevitable and irreversible physiological condition. Further, it was presented as God-given and unquestionable. Since "everyone will get old", regardless of current strength, all respondents anticipated their strength would decline in the future:

> *I don't feel good [now I am getting old], but because Jehova, God, has accepted it that I become [old], I cannot refuse it…I am worried because the things I used to do, I can't do them now…because things have changed now, you cannot go back to where you were when you were young. You just know my time is over. You cannot prevent the body from getting older… because it is God's will.*
>
> [Winford, male, early 80s, recently divorced]

Decline in strength was therefore both natural and normal. As also noted by observers of the development of Western geriatric medicine (Tulle-Winton 2000, p. 72), the distinction between normal (disease free) and abnormal (diseased) could not be applied to the old body in rural Malawi since normal included physiological decline. Respondents, typically those experiencing only minimal decline in strength and no other health problems, commented that they could not "be worried" about ageing because of this. Rabson explains:

> *God has reduced the power, that is what I told you… I am happy because it is not a disease but it's nature. It's a long time since I came on this earth…No need to be sad… it's a sign that I am a grown up person.*
>
> [Rabson, male, 75, married]

Nevertheless, while old age was indeed not a disease, the old body was more susceptible to disease. Emic understandings of age-related immune decline centred on the "finishing" of blood and the body's power. In respondents' narratives blood and diseases were presented as two forces acting within the body. When the power and quantity of the blood were strong, it would weaken the power of the disease so that it would become dormant and unnoticed in the body. However when blood was "finishing", it could not withstand the power of the disease. The disease would then continue reducing the quantity and quality of the blood, increasing its susceptibility to further disease and cumulating in death. Here the same respondent goes on to describe his future:

> *R Now I am able to do that [points to a pile of firewood in his compound], organizing firewood from cotton stems for my wife. In 6 years' time, I will not be able to do that because the strength will be lost. At the moment I am very fine, I know that I have got enemies in my body but I don't see them with my eyes and I don't feel the enemies now. But they will be felt… I know I will feel them because sometimes when I do my work in the garden and come back to rest in my house I become zero [empty of energy], I don't feel ok. That teaches me that sometime I will become more ill.*
>
> *I What sort of enemies will make you not to feel ok?*

R Diseases…For example if TB attacks me, I will be finished…. Sometimes it could be general body pains.

[Rabson, male, 75, married]

Respondents relied on potent imagery to explain this linear and traumatic process. The body "rots" the blood is not "fresh". Rarely used to discuss topics that might have been similarly emotive (e.g. birth, death, HIV), respondents' use of this imagery illustrates the understanding of old age as a predominantly negative life phase. When viewed with reference to the body, respondents considered old age as a period of deterioration:

Nowadays I am frequently attacked by illnesses…I can't say [why] because that is God's plan; what God has sent to you is yours. It's like when a tree starts rotting, the same is to human beings. We just start feeling the body is not functioning well. Different diseases start attacking you…The coldness is there… it shows he is [not] strong… The younger one has fresh blood while the older one has finished blood… The old person can complain while the young can still be healthy…Because the blood in our bodies is different… the old person will be affected because his blood is not fine…[it is] finished blood.

[Charles, male, around 70, married]

Decline in strength was measured by, and experienced with reference to, the body's ability to work and produce. Old bodies could not farm, do housework or reproduce. As identified in other rural African settings (e.g. Cattell 2002, p. 169; Cliggett 2005, p. 10)) in neighbouring Botswana and Zambia and Kenya) the body's biological and non-biological productivity was a key determinant in defining age for both men and women. Respondents who recognised themselves as older adults did so based on their experiences of declining strength and productivity. As Winford and Lizzie explain:

I Other people do not want to be called agogo*…*

R It can happen if you do not see yourself as being old in your body, why should other people call you agogo*? So people will not accept to be called* agogo*…but if people call you* agogo*, it means they have seen*

something in you that makes them call you agogo*, they know you are growing.*

I *How did you feel when people started calling you* agogo *for the first time?*

R *I was surprised with that, but I knew that if they are calling me* agogo*, it means they have seen something that has changed in my life. It could be that I was behaving as an* agogo*, so I just accepted it…*

I *You have said a person can be called* agogo *according to how they feel in the body. The time when you were first called* agogo*, how were you feeling in your body?*

R *I was able to do some jobs but I had problems lifting heavy objects on my own, which I used to lift before. And the children would come and say let us do it for you, you are old now. That was when I knew that I am becoming old when I couldn't do all the things I used to do.*

[Winford, early 80s, male, recently divorced]

An old person cannot work the same as a girl because she is a girl and you are an old person, the strength is reduced... It is not the same as that time [in the past]… I was working very hard. Eee! I was able to pound [maize]. When I went to the field I could come back the time I wanted because I was strong. But now the strength has declined. My strength has finished.

[Lizzie, female, divorced, late 50s]

The emphasis given to work and productivity in respondents' prioritisation of the body in their definitions and understandings of old age and ageing indicates that the meanings ascribed to old age and ageing were not essentialist responses to the inevitable consequences of biology. Rather, the old body can be considered as a socially constructed product: in the dominant discourse of the interviews, the body was a social, as well as physiological phenomenon. It was the old body's inability to work and produce, interpreted within the particular social and structural context of respondents' lives, that underpinned it being understood as "finished". Through production, the body contained the possibility for development and positive change, whether through having a child, amassing wealth, remarrying or constructing a house. Without strength, the body became a "useless" body:

My legs are aching and I fail to work, this is the eighth month that I haven't been to the water source. Water is being fetched for me; the children of my child fetch water for me… My body is useless. Before I was farming, but this year, no.

[Ruth, female, late 70s, married]

That's why I do farming, to get money and buy things like relish[15]*… At my age I can't manage to buy things of high price… I can't think of, say, building a good house, because I passed that age. I can't manage to farm and get enough money for such things… I want it but I have no such strength. The money I get is little… I can't think of getting such big things. I passed that size. Not that I don't want to get such things, but I have little strength.*

[Loveness, female, late 70s, widowed]

Discussions about the menopause are illustrative of the social construction of the ageing, bloodless body. Although two female respondents discussed the menopause very positively in terms of freedom from the intensive burden of washing fabric and their bodies, other respondents, both female and male, conflated the menopause with entry into a period of decay and decline. During this period, in which a woman's "eggs are no longer fertile and they are rotten", productivity and possibility were absent. As has been identified in non-African settings (Greer 1991), the biological process of the menopause was therefore understood as distinct sign and symptom of an old age that was negative:

A-ah, I cannot have children, I am too old, m-mh. Sure. If a person has stopped our things [menstruation], to stop it is that good? ... Are you going to have children again? ... It means that you have finished. You are now old. So that is a sign of becoming old… When you have stopped having menstruation, year by year, you just know you are old and your door is shut.

[Patuma, female, 58, married]

[15] Vegetables, meat or fish eaten with *nsima*. Although most respondents had access to vegetables (typically pumpkin, pumpkin leaves or greens) for relish for most of the year, meat and fish were rarer. During hunger season and periods of scarce resources, *nsima* is eaten on its own.

It is God who stops us from menstruating… it tells you, you are now finished, because you do not have enough blood in your body, you already have lost a lot of blood.

[Zione, female, late 70s/early 80s, widowed]

The importance of physical and biological productivity in respondent's discussion of the body, and indeed the dominance of the body in narratives about ageing, can be traced to two aspects of social organisation in rural Malawi: the complementary systems of self-sufficiency in agricultural production and familial support networks. In the next section I will argue that these livelihood systems underpinned respondents' understandings of old age, imbuing them with a set of culturally-embedded meanings that influenced both, individual action and identities, meanings and experiences, and the collective experience of old age through social norms regulating the behaviour, care for and visibility of older adults.

3.2 Work, production and livelihood

In constituting daily routines in the field site, livelihood systems were central to older adults' narratives about a wide range of issues. Discussions about old age, the future, marriage, sexuality, children, illness, work, food, poverty and politics were all interwoven with reference to agricultural production and familial support networks. The dominance of livelihoods in research conversations reflects high levels of food insecurity in the field site (Section 2.4.4). All respondents reported experiencing food shortage during the annual "hunger season", and some during other periods:

During hunger [season] I stay without money, without food, without piecework. So I say to myself to say what should I do? Only God knows… So I have nowhere to borrow to buy fertilizer, even if I borrow, where will I get the resources to pay back? Or even if I borrow the fertilizer after the harvest I pay back maize more than 50Kg. If I do so what will I remain with? I will remain with nothing. So I just stay and say there is nothing I can do.

[John, male, 63, married]

Food security for respondents implied self-sufficiency in maize production, due to both 'tradition', and the absence of a developed market economy (Mataya *et al.* 1998, p. 36). In the field site this subsistence agriculture, often yielding inadequate food harvests, was supplemented by modest earnings from cash crops such as cotton and tobacco; limited and/or poorly paid labour, such as bicycling people between villages and trading centres, or field *ganyu* - occasional agricultural work on the farms of comparatively wealthy neighbours, relatives or others; and small businesses, such as weaving and selling mats, selling cooked food, or buying goods (e.g. soap, sugar, small dried fish) at larger markets and reselling them locally. With the exception of bicycling, old and young carried out these activities. In the absence of other opportunities for employment, the body's capacity for physical labour was therefore essential.

When an individual lacked the capacity for self-sufficiency, temporarily or permanently, the family and household were called upon to provide care and material resources. Confirming findings of previous research in Africa (Carsten 2000; De Klerk 2008; Van der Geest 2002a; Whyte *et al.* 2004; Whyte and Whyte 2004), for respondents, these support transfer relationships were not innate and based on pre-determined roles (e.g. parent-child), but continually evolving social processes formed and shaped through daily interactions. Respondents' experiences of ageing were situated within a complex web of support networks, based on the principle of reciprocity, and associated deserving and undeserving recipients.

At their core these relationships involved the giving and receiving of bodily strength. Support transfers that had 'used up' some of the giver's finite supply of strength ought, in time, be repaid by support transfers that used up the strength of the original recipient. Strength and capacity to work, founded on an individual's supply of blood, were essential for investment in these reciprocal exchanges.

Although most respondents could call upon wide networks of family, friends and social groups (e.g. church or mosque congregations) at times of crisis (e.g. a death, a

significant but short illness, theft of maize), adult children[16] and spouses were the most important exchange relations when longer-term, regular care in older age was needed. It was these relations (or the absence of them) that respondents most often referred to when discussing the management of current or expected age-related declines in strength and ability to work. Respondents explicitly prioritised these relations because of the level of investment they had made in them. Investments and exchanges were played out daily and over years.

For example, conception (discussed in Chapter 5), pregnancy and labour were understood to use a substantial amount of a woman's finite blood (and in the giving of semen, a smaller quantity of a man's blood). Children were expected to 'repay' the strength this blood equates to by caring for their mothers in later life:

> *When I am careful with [maize] it takes me through the year. But if things are not well, it does not last me a year…I tell my children that my food is finished in the house…and the children assist me with food …Because I know that they are the ones I shared my blood with. I tell them because there are no other people who can assist me apart from them. They understand because I am their mother, I gave birth to them and I suffered a lot for them. And they assist me with whatever they have.*
>
> [Lizzie, female, late 50s, divorced]

Similarly, respondents understood that the strength used and lost in the work required to raise children (for example, farming to providing food, clothing and school fees),

[16] Understood to include both biological and, in the parlance of international development-oriented observers in Lilongwe and beyond, 'foster' children. These were most typically grandchildren, but also nieces, nephews and other kin, who were cared for by the respondent, either partly (along with another family member, such as the child's biological parent) or exclusively, and for long or short periods of their childhood. Although rarely featuring in the lament discourses discussed in Chapter 1, care of these children by older adults was typically not a result of crisis fostering. This is especially the case with regard to the care of younger grandchildren. Many respondents were currently living with their grandchildren without the children's parents, sometimes illustrative of a transfer to the respondents, and sometimes as a transfer from the respondent (and regularly both). Moreover, even when living with grandchildren and the children's parents, unmarried respondents typically slept with grandchildren in order to provide space and privacy for their daughters and their husbands to have sex and expand "the village" (the size of the family).

ought to be repaid when the older adults' strength and blood has weakened and decreased. For example, Mercy comments of her friends:

> *They invested in their children by educating them, and because of that, they are reaping what they sowed. So it seems the children are doing well because the parents had a vision for the future… Mrs Nkotsi and Mrs Blackson. I see that the support is good and those parents live happily… Because she tells us that her sister or child has come and taken a pail or done this and that for her. So we see that they are happy because they made a good future for their children. Now, it is like the children are paying back.*
>
> [Mercy, female, 50, married]

Respondents understood that transfers made to children either through conception, child birth or child care ought to secure assistance in older age. For example, Robertson complained about his stepson's failure to support his wife with reference to reciprocity in blood and strength. He explains that his stepson is not supporting his mother because "he claims that he was taken by his grandmother when he was young and he grew up with her... he regards her as his mother and not this one [Robertson' wife]." Both Robertson and his wife questioned the validity of this argument since "a person who knows he saw the sun because of his mother, can't fail to support his mother".

However, respondents who had not made sufficient investments could not expect to receive support from their children in older age. Unlike his wife's son, Robertson comments that he cannot complain about the lack of support from his own children because, having left them and his wife while they were young, the conditions of reciprocity were not met:

> *No, the children I have at [village outside of the field site] and the relatives at home don't come to visit me here... No, when I go there to visit them they are happy, when I ask them why they are not visiting me here they say they will come sometime. I stop it there [the conversation]. I did my job, that's all... I produced them [but didn't then continue to*

care for them]… It would be different if I had paid a lobola[17] *- I would be worried then because they would be living with me here [and receiving his support] and if they would not support me then, I would be worried.*

[Robertson, male, 80s, recently married]

Married and unmarried respondents discussed the importance of marriage in later life. Longstanding spouses were recognised as a reliable source of support because of the 'bank' of reciprocal transfers of work produced over the course of such a marriage. For example, Rhoda recognises her husband's declining productivity as being a result of his ageing body, and affirms her intention to care for him since he has provided for her in the past:

My husband helps me with farming… he has two wives so he farms a little and the other time is spread doing other jobs to raise money for the two houses… He is not working much as compared to those days when he was energetic… The time he was coming [to her home to marry her] I had no kitchen but he constructed the kitchen, toilet and put up the fence. But nowadays he cannot manage to do that… This time he is unable to provide us with money. I understand the situation is that he is ageing… so I just say let us just be keeping [caring for] each other.

[Rhoda, female, 56, polygamously married]

In contrast with observations from Kenya (Cattell 2002, p. 163), but in line with those from Indonesia (Schröder-Butterfill and Fithry 2010), both older men and women cared for their spouses when they were ill or frail. This care, particularly that given by husbands to their wives, centred on providing intimate, personal care that involved seeing a person's genitals – a job respondents considered inappropriate for their children.

Of course, the familial support system was rarely enacted as smoothly, deterministically, or as reciprocally as described here. Relations contested the investments that had been made and the support that was due. Children and spouses

[17] 'Bride price' paid to a wife's family. While common in the patrilineal north of Malawi it is not much practiced in the matrilineal south. In Balaka, where children belong to their mother's family, paying lobola would have meant that he 'owned' the children, so that on separation, they would have left with him, rather than staying at their matrilineal home.

died, leaving respondents without the support they expected to receive. Children migrated and "forgot" their parents. Respondents bemoaned their adult children who, through habit or laziness, still relied on them for support. Other respondents continued to support their adult children until advanced old age out of love, rather than as 'investments'. Moreover, respondents' expectations of support were based more on shifting resource availability than on reciprocity. Regardless of the level of investments made, given high levels of food scarcity and poverty in the field site, respondents only expected support from children or other relations who could afford the resources or time to provide it. Having made the same choice when their own children were young, a number of respondents commented that, with such limited resources, their adult children must first prioritise caring for their "own families", that is their spouses and children, over caring for them. Change or weakening of the familial support system over time did not feature in respondents' narratives.

Since no respondents had families able to support them fully, all respondents were engaged in some kind of productive activity. In short, retirement from work altogether was not an option. Older men and women continued working and contributing to their and their families' economic and social viability as they grew old. While continued work in old age has been noted in African settings both with and without non-contributory pensions systems (e.g. Bohman *et al.* 2007; Cattell 2002; Cliggett 2005; De Klerk 2008), in rural Malawi, the absence of this safety net made work imperative:

I What types of people fail to do their work?

R Other people, like old people, they can't work, they just stay.

I Are these people the same age as you?

R No, I am younger. These are very old people

I What do these people do to help themselves?

R Some have grandchildren who can look [for food] for them and do other jobs. But there are some who have no one to help them, so they still work, because they have no one to help them.

I Oh-ho

R Eee

I When you see these people doing several jobs how do you think they feel?

R They feel hurt in their heart

I Oh-ho

R Eee

I How are they hurt?

R Sometimes they don't have strength, they also become sick often, but they still force themselves to work

[Ethel, female, late 80s/early 90s, married]

Respondents employed a variety of techniques in response to their diminishing physical strength in order to piece together livelihoods. They ensured survival by working harder in their fields, and for longer. Where they could, some respondents diversified their activities, switching to lower impact tasks such as mat weaving or baking cakes for sale and thereby reserving some of their finite and diminishing bodily strength and "blood". They also continued to invest in support relationships. For example, some respondents nursed or cared for young grandchildren so that the children's parents were freed to farm the maize that would then be shared within the household, or leave the village in search of economic opportunity elsewhere.

As has been identified in other kin-based farming systems in Africa (e.g. Halperin 1987), working was required by everyone. Both children and older adults made essential contributions to their household's survival. Children carried water, washed plates and when big enough, pounded maize. Even in more advanced old age, individuals were expected to work as their strength permitted. Within the complementary systems of self-sufficiency in agricultural production and familial support networks, respondents understood work to refer to more than simply the farm work that ensured material (food) production and physical survival. It also included non-material work that secured the social survival of the family and transfers of support between family members. Able adults were expected to contribute to their

households through paid work, farm work, housework - including childcare and reproduction - and "bed work", to use respondents' term for marital sex.

As the structural underpinning of livelihoods that ensured survival, work was embedded within the social fabric of daily life, and respondents' interview narratives. Work in rural Malawi could therefore be regarded as a "situated body practice" (Twigg 2009, p. 2) dependent on physical strength and blood; part of respondents' lived experiences, necessary for survival; and an important element of 'culture' in the field site. The importance of work and working was expressed frequently during interviews:

> *You should also work hard; you should not shun away from hard work. Then you can see that there are no problems.*
>
> [Mercy, female, 50s, married]

> *Aaah! The way I think. I will stop working when I am dead. No matter how old I am, I will continue working...For your daily life, you have to work. You have to work for the life you are living. There is a saying which says* osagwira ntchito asadye *[he who does not work should not eat]*.
>
> [Lyness, male, 68, married]

> *Everybody is supposed to do working at this home. Yes everybody…For a place [home] to be known as a place one has to work. You have to work to have soap for bathing and washing clothes. [In old age] even a few tasks you should still be doing.*
>
> [Youngson, male, 70, married]

It was also documented in a large number of proverbs:

> *To pluck vegetables for relish one has to bend down.*
>
> *Gnawing comes after you have walked for it.*

Working was regarded as a social and cultural imperative. Individuals who were self-sufficient and could support their families were widely regarded as successful, and respected, individuals. Through successful production (food, money, children)

therefore, work imbued this positive character traits with a tangible reality. As Fiskani explains of his friend:

> R *If you work hard you do not have a lot of problems. Indeed, if you do work hard, your home becomes* mwana alirenji *['you name it you have it', a home or person without want]. You do not lack anything as such, instead of doing* ganyu, *people come to you for* ganyu.
>
> I *Do you know of anyone whose home is* mwana alirenji*?*
>
> R *Yes, he harvests a lot. He can harvest 40 or 50 bags of maize. He also has a big dimba*[18]*for sugarcane, bananas and papayas. He also grows a lot of cassava and potatoes. He has vegetable gardens too, so he has money and food all year round. He also employs some of us in the hunger period. His hard work rewards him very much.*
>
> [Fiskani, male, 61, married]

For Rhoda, in the past her hard work earned her the respect of visitors:

> *I could have been happy how I used to do [work] those days. Because the house was looking clean and even when you have visitors anytime you were not worried… Those days I could clean my house and when the food is accidentally dropped you could pick it [up] without dust. All the people could admire my cleanliness. They were saying I am a good wife, I know how to clean my place.*
>
> [Rhoda, female, 56, polygamously married]

While successful work may have resulted in high social status, in respondents' narratives the attempt at self-sufficiency and providing for family was associated with a more fundamental social position: that of an adult. Associating work with survival, for respondents, to work was to be alive – to be a person. Rhoda continues her discussion of the importance of work:

> R *To work [is] to achieve something. You farm in order to harvest the maize. You wash your clothes to put on clean clothes. You go and fetch water to be used at home… Everything has its own importance.*

[18] A well-water plot used for growing fruits, vegetables and rice

I So you think, what are the results of just staying [not working]?

R It's like you are dead

I Dead when you are alive?

R Yes. Dead when you are alive.

[Rhoda, female, 56, polygamously married]

The following quotation and proverb extend Rhoda's comments, referring to work as central to 'being a man' and 'being a woman'. In this, they further highlight the relationship between work and personhood, or the role of 'grown-up' men and women:

> *If we reach at a garden, we just work. Because although we can be feeling lazy, there is nothing we can do [to avoid work] when we come here. Like this time, my body is weak and I don't have strength. I am just doing the work because I am a woman, I cannot do otherwise.*
>
> [Patuma, female, 58, married]

> *He is a real man after he has eaten* [Meaning, 'He can only eat after he has worked hard, and to work hard is the seal of virility'].

That work (to an extent, regardless of outputs) is important for social respect and/or personhood has been observed in a variety of southern, eastern and western African settings and across a variety of historical periods (Alverson 1978; Apt 1993; Cattell 2002; Cattell *et al.* 1997; Comaroff and Comaroff 2001; Hammond and Jablow 1976; Livingston 2002). Many of these studies have observed that older adults continue to work into very old age to prevent negative social labelling. For example, in a setting also dominated by agricultural production and familial support networks, Maria Cattell's ethnography of the Abaluyia in Kenya identifies the importance of being "active" and "useful". She notes how even the frailest older adults work in their fields and homes, observing that "it is their way of claiming full personhood and worthwhileness. To be considered or to feel useless calls into question one's value as *omundu* – a person, a human being" (Cattell 2002, p. 170).

Ethnographic writings on the life course globally have frequently made a distinction between older adults in their productive prime, (often specified as being aged

between about 45 and 65 years) and very old people, who are less physically productive and subsequently play marginal roles in society. The association between personhood and productivity is reflected in the names that have been documented for this group: the "old-dead" among the !Kung/Ju/'hoansi of Botswana (Lee 1992; Rosenberg 2009) and the "completely far gone" among the Akan of Ghana (Apt 1995). Earlier anthropological work on ageing in "primitive" African societies, while now very dated in its eurocentricity, determinism, and a-contextual, a-historical and positivist approach, nevertheless identifies similar themes, albeit less nuanced ones (e.g. Glascock and Feinman 1981; Simmons 1945). As Leo Simmons concludes in his review of Ageing in Preindustrial Societies: "Among all peoples a point is reached in aging [*sic*] at which any further usefulness appears to be over, and the incumbent is regarded as a living liability… terms among primitive peoples are the 'over-aged', the 'useless stage', the 'sleeping period,' the 'age-grade of the dying,' and the 'already dead'… All societies differentiate between old age and this final pathetic plight." (Simmons 1960, p. 87).

In the following section I extend this body of work in two ways. Firstly, having identified, as previous studies, that work and the able body are linked to notions of social worth and personhood, I discuss *how* they are linked. I do this by drawing on two theories of identity to account for and contextualise respondents' narratives. Secondly, in contrast to the societal-level ethnographic narratives of these previous studies, I explore and present individual respondents' understandings of this association. This approach offers a more in-depth analytical interpretation of older adults' lived experiences - as they themselves present them - than has previously been documented.

3.3 Identity theories: The 'contributing adult' as an important role and social identity

Through the possibility of social contribution, the ability to work had consequences for respondents' sense of self: the set of meanings held by an individual that constitutes 'what it means' to be them (their "self-relevant meaning") (Burke 2004).

This sense of self was (partially) based on being a member of the social group of 'adults', and on the performance of work and independence as part of the role of an 'adult'. In identifying both group *and* role bases for respondents' identities, I follow Peggy Thoits, Lauren Virshup, Peter Burke, Kay Deaux and Jan Stets in drawing parallels between social psychological and sociological approaches to understanding the self (Deaux and Burke 2010; Deaux and Martin 2003; Stets and Burke 2000; Thoits and Virshup 1997). I suggest that being an adult presented both a salient social identity and role identity for older adults in rural Malawi. One of the central tenets of this thesis is that this adult identity represented the core identity respondents associated with and aspired to. It underpinned all of the experiences of ageing presented in this thesis.

In social psychology's social identity theory, an individual derives a collective-level social identity (Thoits and Virshup's 'we' identity) from belonging to a particular social category or 'in-group', that exists in contrast to an 'out-group' (Hogg and Abrams 1988). This position is arrived at through a process of "self-categorisation", involving the accentuation of perceived similarities between the self and the in-group, and the differences between the self and the out-group. This is followed by a process of "social comparison", involving the evaluation of the in- and out-groups on those dimensions or characteristics that result in a positive judgement of the in-group (Tajfel 1981). Individuals' behaviours are influenced by their group memberships as, throughout their daily lives, they select from a range of possible behaviours according to the behaviours associated with particular memberships, as enacted in particular situations (Campbell 1995). Having a particular social identity means identifying, understanding, and acting as part of a particular group.

In sociology's identity theory, an individual derives an individual-level social identity (Thoits and Virshup's 'me' identity) from the role they play within the social structure, based on the socially-constructed shared meanings and expectations associated with that role and its performance, held in contrast to other roles (Burke and Tully 1977). These expectations form a set of 'identity standards' that guide behaviour: "in order to be (some identity), one must act like (some identity)" (Burke and Reitzes 1981, p. 90). This process is reciprocal, so that individuals classify

themselves as having a particular identity based on their behaviours, and individuals behave in ways that reinforce and confirm their identities. A role identity is arrived at when: a) an individual identifies with, and is committed to, a socially-recognised category (the role), b) others identify the individual as occupying that role, c) an individual achieves gratification by performing in that role, and d) the demands of a particular situation make enacting the role socially appropriate and appreciated (McCall and Simmons 1966). Having a particular role identity means acting in ways that fulfil the shared expectations of the role identity, and coordinating and negotiating with individuals with related, complementary, or counter roles (Burke and Reitzes 1981; Stets and Burke 2000).

Therefore, although the basis of self-classification differs between the two theories, both recognise individuals' identities as being formed with reference to meanings of groups, roles and behaviours, developed within a structured society (Stets and Burke 2000). As such, both sets of theories are relevant for understanding how respondents' understandings of contribution within the livelihood system, the social position of an adult, and the meanings of work outlined above informed older adults' sense of self[19]. Of course, within both psychology and sociology there are several distinct approaches to social identity. I use Catherine Campbell's extensions to social identity theory (Campbell 1995) and Peter Burke and Donald Reitzes' role identity theory (Burke and Reitzes 1981) to frame respondents' 'we' and 'me' identities.

3.3.1 Adult group identity

In the social and structural context of rural Balaka, to be a contributing and independent member of the social world was to be an 'adult' (in this sense, used interchangeably with 'person', 'man' and 'woman'[20]). As observed in other settings, through working, an individual not only produced life (secured their survival), they

[19] In Chapter 8 I return to this point to explore the absence of theories to understand the influence of identity on behaviour and experiences in demography.

[20] Although 'man' and 'woman' also had clear implications regarding the gendered division of labour in respondents' narratives.

also produced their entitlement to be a valid member of the social world – an adult (Comaroff and Comaroff 2001). Those who did not work failed to produce this entitlement and were discursively excluded from the social system. These individuals were defined in opposition as being 'children', but were rarely young (as in Botswana (Guillette 1992) and Kenya (Cattell 2002)). The production of the contributing and independent adult identity was therefore embodied in the act of work, as it was broadly understood by respondents.

My analyses of respondents' and others' narratives and comments suggest that in subtle, never explicitly-voiced ways, not everyone was regarded as a valid member of the social world (an adult/person/man/woman). Instead, 'adulthood' presented a distinct social category for respondents. Older adults defined their membership of this in-group by emphasising their ability to work and therefore contributing to the care of themselves and others, and distancing themselves from those in the out-group whom they evaluated along the same dimensions. The out-group consisted of those who did not work, typically the very young, very old, and the long-term very sick. Members of the out-group were disengaged from the social world, socially and physically, and were rarely present outside the private space of the compound[21].

In the following example, Nyuma centres her discussion on clothing as the embodiment of productive activity (since clothes are earned through work) and the in-group identity. Without appropriate clothing, Nyuma believes that she does not 'fit' with the in-group, and is therefore out of place in the social world. In line with Tajfel's social identity theory (Tajfel 1981), Nyuma evaluates the 'adult' in-group ("a woman") on those characteristics that result in the positive judgement of the in-group ("walking without being ashamed"):

[21] More broadly, rather than with specific reference to work and production, anthropologists have documented similar out-groups with reference to 'liminality', a phase of a rite of passage in which the participant is physically, socially and symbolically detached from normal life and maintains an ambiguous position of less than a social person (Turner 1967). Shalinsky and Glascock's now-dated review of data from the Human Relations Area Files, collections of ethnographic materials catalogued for deterministic statistical comparative purposes, noted that infants and elderly were considered 'pre- and post-social persons' in non-industrial societies, including some in Africa (Shalinsky and Glascock 1988).

I am the poorest of them all! Can a well-to-do person borrow? Can they borrow clothes? No. They own their clothes. But I do make myself up [with borrowed clothes]. When people see me, well dressed, with borrowed shoes sometimes, people say there goes a woman. But when I come back, I take them off and put on my dirty clothes. [I borrow from] my daughter… if we disagree on other things [so she doesn't lend her clothes], it means that day I cannot walk [in public]. I just stay at home. Even to my [HIV] support group, I can't go. How will I go without clothes? You see, that day you came [our last visit], I put on another cloth. See me today? I am putting on a different cloth [so] I am 'number one'! I can walk without being ashamed [laughs].

[Nyuma, female, 68, single]

A defining characteristic of group-based identities is the identification of the self with the group: "who we are" (Thoits and Virshup 1997, , my emphasis). Respondents affirmed their membership of a collective identity group by using the first person plural "we", rather than singular "I", when discussing the out-group "they". In the following examples, respondents discuss very old adults who, in failing to work, become members of the out-group (children) that is distinct from their collective identity in the in-group (emphases added):

When someone gets older, aaa! It means their health becomes weak, so they behave like a child… A child is always told what to do, and it cannot do many things on its own. A child will always complain you didn't do this for me. The same applies to the old person, they want people to do things for them just as a child, that is how an older person behaves. It is not that they are children but they behave like children. They always want people's attention, they can't farm, they want things to be given to them, if there is a thing next to them, they would want someone to pick it for them …If they need water in the house, they will need someone to bring it for them, they can't farm, you have to do it for them. That is old age; you are just like a child.

[Lyness, male, 68, married]

You can know one is old when they become weak, others cannot do anything. The way they do things is like they are becoming children… It is like you are telling the old man what to do, when we know that an

adult is not told what to do, for a child, yes they need to be told what to do.

[Kondwera support group member, 60s]

Despite loss of body strength we plan our work. Some strength or power is for farming, and when we are tired we come back [from the field]. But not just after [digging/weeding/planting] 2 or 3 ridges, that would mean being playful.

[Estina, female, 55, single]

3.3.2 Adult role identity

It was behavioural norms (rather than attitudes, values or styles of speech for example) on which respondents identified with the social category 'adult'. These behavioural norms were also understood in context of the role of an adult. For respondents, the role of an adult, associated with self-sufficiency and contribution, was understood with reference to a variety of other roles, including the childlike-dependent counter-role, but also the role partner of non-dependent adult (that is, someone who shares the same understandings and meanings).

In respondents' narratives, to be defined as having the role identity of 'adult', one had to act in ways that would be interpreted by oneself, and observers, as being independent (and not being wholly-dependent), and as making a contribution to the household (and not only receiving contributions from the household). Since work was interpreted by respondents and others in the field site as being the only behaviour available to achieve independence and make a contribution, to be an adult, an individual had to recognise their own behaviour as working, and others had to recognise the individual's behaviour as working. Work then, was the meaning held as standard for the role identity of an adult (Burke 2006). As well as embodying identity therefore, work both reflected and shaped identity for respondents.

In contrast to group-based identities, in which only the individuals' perceptions and actions are involved in identification with a social identity based on a social group, in role identity theory it is only through interaction with others in counter or

complementary roles that an individual identifies with their role identity (Stets and Burke 2000). In the field site, it was through interaction with others in the context of performance of work (or not working) that the meaning of the role of 'adult', and in particular, the counter-role of 'child', became known and understood by respondents.

The phrase 'what have you seen in me?' or 'I knew that they had seen something in me', was frequently used during audio recorded interviews and non-audio recorded conversations, and was applied in many different situations. Often the 'something' was socially unsanctioned sex, and the phrase was used by someone who was suspected of having HIV (e.g. "they suggested I got tested so I asked them, 'what have you seen in me?'"). Regardless of the context, the 'something' always referred to behaviour. Respondents' use of the phrase underlines the salience of other people's perceptions of an individual's behaviour for that individual's construction of their identity. In the following excerpt, Lyness refers to the reactions of those around him to confirm to the interviewer that his behaviour matches his role identity of an independent, contributing adult. He explains that his financial provision for himself and his family lead his friends to "look at [him] as someone different". He distances himself from the very old who "can't do anything":

R *I am old and people respect me. Other people take as an adult, not an old man, because I am working and have power… You know I am working at the mission [hospital, as a porter]. This makes me have some money to support myself and my family. There are others who don't work but are staying at home. Maybe they have a grocery [stall], those ones can also not look very old [like me]. But there are other old people who just stay. They only have to do farm work. They may look older than me [because] they don't have proper care… Just because I am working, my friends look at me as someone different. When they come to me, they know that they can ask for help…*

I *You said when people get old, they become children?*

R *[Nods his head]*

I *Would you say this old age is good or not?*

R *Very old. They can't do anything. Even if they are married, they just stay [without having sex], and cook food and share. They don't do*

> *anything else… That old age, it's like you are finished… This thing of waiting to be helped, it is a big problem. You complain 'can't you do this thing for me?'… I am an old person. I try to do things which can help my life. I have to make sure my family is well looked after. Then I have to work to get these things… I am old, but I am not very old.*
>
> [Lyness, male, 68, married]

Through declining bodily strength, ageing undermined an individual's ability to be productive and contribute reciprocally. At its culmination, this inability produced dependent behaviour that was incompatible with the adult identity. It signalled disengagement from the social world and the practices of the social order - at its basest, the ability to secure survival. In withdrawal from participation, the very old became less than fully human - fully 'adult'.

The following excerpt clearly highlights the process of adult and non-adult social and role identity formation and performance. Wyson was very old and experienced mental and physical health problems. Those observing his behaviour referred to his inability to work to distinguish their own in-group membership from his membership of the childlike out-group. On hearing their perception of his behaviour, Wyson immediately directs the conversation to this behaviour, evaluating it as falling short of the role identity standard for an adult, or for him, "a man":

> *Field note*[22]
>
> *On arriving at Wyson's compound for the first time, we were greeted by his sister. We explained we had come to visit Wyson to talk with him about our research. She seemed amused that we thought we might learn from him and warned us that he was "just like a child". Other members of the household came over to talk to us. His 48 year-old nephew, in particular, was interested to know why we should want to talk with Wyson. He implied we would learn more by speaking to another older adult of the household. I am sure that Wyson, sitting close-by within the compound, could hear this conversation.*

[22] Written by me after discussion with my research assistant.

Interview

I So at first you should please tell more about yourself

R Here my family ended some time back. And at this time I have nothing to do with marriage. Currently it is my sister and my in-law who are taking care of me…

I So what do you do here at home?

R Here at home?

I Yes

R What I do?

I Yes when you are here at home, maybe you perform some other tasks?

R I do nothing. I stopped hands. I can't do any task

I OK. So in this community, do they use you as a very old person to perform some duties?

R I do nothing.

Respondent's sister (S), shouting across the compound: He does nothing!

R I just stay

I Mmm

S I am just feeding him!

I [To S:] Would you please allow me that all the questions should be answered by your brother?

S OK

[Interviewer changes position and speaks to the respondent so only he can hear the questions]

I Do you farm?

R No I don't cultivate, I stopped

I Do you do any business?

R Nothing. Aah I just stay idle

I May be cooking when your sister is not here?

R What?

I Cooking, may be porridge?

R No I can't.

I OK. Do you take yourself as an old person?

R I am an old person no doubt about that

I OK. Thank you grandfather. So since that time you were born, up to this time, what has changed on this earth, in the world, but also in your life?

R The time I started realising that the world is changing, [was] the time Muluzi was elected [1994]. During Kamuzu I was able to farm. But since Muluzi was elected, since that time- the time Bingu was elected [2004], no.

I What has really changed?

R What has changed is that I am not able to do things. I am not a man enough.

[Wyson, male, mid-80s, single]

Wyson recognises his farm work (and later bed work, explored in Chapter 5) as being incompatible with the identity standard of an adult. He returns to his ability and inability regularly in his narratives, reflecting the salience of these corporeal changes and their meanings to his identity.

Throughout our conversations, respondents put forward a multiplicity of identities that constitute the 'self' (for example, 'adult', 'mother', 'Muslim'). However, the 'adult' identity and the behaviours understood as standard for that identity were frequently discussed. My analyses suggest that for respondents the 'adult' identity formed a central, salient identity. Following both Burke's role identity theory, and Campbell's extension of social identity theory, I argue that both group- and role-based identities became 'activated' in response to particular contextually-dependent social situations or "Life Challenges" (Campbell 1995). In these data, respondents' identities as 'adults' became activated when those identities were threatened. Threats were both physical, through the ageing body, and discursive, through questioning respondents about their understandings of old age.

3.4 The challenge of ageing

As noted, older adults continued working for as long as they were able. In the context of reciprocal exchanges of support balanced over a lifetime, receiving a lot and working just a little (cooking, watching over children, bathing oneself) was an acceptable social status, and one that could be associated with the 'adult' identity. However, respondents recognised that if they lived long enough, the inevitability of physical decline would eventually prevent them from carrying out any work. At this point, the individual would become totally incapacitated and totally dependent: totally "useless". Their behaviours would not match those required by the adult identity standard:

> *The aged walk like children, senseless things. Yes, they don't take care of themselves and we take care of them. To say let us take care of the aged, because she is now useless. Yes so we fetch some water for her to bathe. Cook the food and give to her so she doesn't get worried... [At that age] there are a lot of problems you face: you crawl [rather than walk] and at times you are pushed by children, because you are useless.*
>
> [Ethel, female, late 80s/early 90s, married]

Lack of autonomy, ownership and agency were characteristic of this period in which an individual required an intensive form of (non-intimate) care that tested the strength system of reciprocal support. Respondents frequently cited the powerlessness of the very old who "just stayed", waiting for assistance from their family for their survival. Wyson continued his discussion with us highlighting the differences between the time he was married and lived in his own home and now, living with his sister:

> *There is a difference. This time there are rules. Those days I was the one making rules, [but this time] I cannot, it is not my house. There is no way you can order them to give you water to bathe.*
>
> [Wyson, male, mid-80s, single]

Other respondents discussed this position in the abstract:

> *[Getting old] is not good because you become a child, but also when person is old they just wait to be fed, and that people should do things for them. Eeh, it is a bad thing, because you become a child, and the things you used to do when you were young, you cannot do them because you do have the strength... it will be painful [to reach that stage]… because a person can do something for you which you didn't want, in so doing you start remembering what you used to do in the past while you were strong.*
>
> [Ethel, female, late 80s/early 90s, married]

Ability to work and avoid such childlike dependence was universally referenced in respondents' descriptions of what constitutes a good or a bad old age:

> *A good old age, I do put it at the stage, where one is still able to do some work, not just being kept in the house, that kind of old age is not good. But the [good] old age, is that you should be able to go out and do some work. But when you fail, even to sweep, that type of old age, I feel, it is not good. Because we had a certain old man, he just died recently. He couldn't walk out of the house by himself, he couldn't do things on his own. His grandchildren would pick him to go outside to have the sun, he could be crying. So when we saw that the old man, [we thought] that old age is too much. He was not eating by himself because he was just like a child. He was just like a child, he could even fear a goat, when it is [only] a goat! [laughs lightly]*.
>
> [Alick, male, early 50s, married]

> *The good old age is like what I am. You wake up do your work, when tired go and sleep, without anyone telling you what to do.*
>
> [Gertrude, female, 70s, widowed]

Of all the behaviours and activities that might be compromised by the ageing body, it was incontinence and inability to provide intimate care for oneself that presented the greatest danger of losing personhood and the competent adult identity. That receipt of intimate care can undermine an individual's respect (Van der Geest 2002b) and status as a complete social being (Schröder-Butterfill and Fithry 2010; Twigg 2006)

has been observed in a wide range of settings. For example, in the UK Julia Twigg has observed how personal care "marks the boundary of the wholly personal and individual in modern life. Having to receive help in such areas transgresses social boundaries and undermines one's status as an adult. These things are normally only done for babies" (Twigg 2006, p. 122). Here, receiving personal care threatened personhood.

In respondents' narratives the meanings of the receipt of intimate care were not compatible with those of productivity that were held within the identity standard of the adult. It was understood as evidence of the lack of the basest level of self-sufficiency. Moreover, it required a level of support transfers that went beyond those covered by the covenant of reciprocity. The blood received would be greater than the blood that had been given throughout the life course. At this point, the individual could no longer be considered a contributing member of society in the balance of a life time.

As observed in Ghana (Van der Geest 2002b), a situation of exceeded investment was most likely when the only carer available was from outside the nuclear (as locally-interpreted) family. Although they could offer examples to the contrary (e.g. as a younger man, one respondent provided intimate care for his former boss), respondents reported that in this situation, prolonged dependency would become socially unacceptable. As Fiskani explains:

> *There is an age where a person can be respected, even though they are old. Mainly that will happen when they have children who can support them. Even if they become very old, they will have the support they need. But if you don't have children to support you, and you depend on other people to help you, you don't get respected.*
>
> [Fiskani, male, 61, married]

Respondents feared having to rely on relationships they had not made sufficient investment in. They perceived that these carers were more likely to demonstrate feeling burdened by providing insufficient care:

I Have you ever seen somebody very old who was being taken care of by some other people?

R Yes my grandmother

I How old was she?

R I don't know… but she reached a point that when she has slept she could not wake up alone

I How was she taken care of?

R She could be carried from the house to the veranda, cooking for her

I Bathing her?

R Yes, washing her clothes

I The time these people were helping our grandmother were they happy or not?

R They could complain because they were troubled

I What were they saying?

R Sometimes you can tell because of how the people are behaving. Let's say the time she wants something, you found that there was no one to provide that thing.

[Susan, female, mid-60s, widowed]

When the caregiver was an adult child, some respondents discussed the balance of transfers in terms of love rather than reciprocity in material and physical support. These respondents were concerned that demanding intensive care from their children would burden them and hinder their opportunities to work to improve their lives. A good parent demonstrated love by first providing for their children and enabling them to "develop", and then, when this was no longer possible, receiving less support and "blood" from their children than they had given them. The meanings of the behaviour of a parent who burdens their children, taking more blood than they gave, were not compatible with the meanings of familial provision held within the identity standard of an adult.

3.5 The childlike "possible self"

Although respondents perceived bodily decline and subsequent dependency as inevitable, no respondents persistently identified with the 'childlike' adult identity throughout our conversations, regardless of their current health and ability to work. Instead it presented for all respondents a "possible self" (Markus and Nurius 1986) – an identity they may have sometime in the future when the meanings of their behaviour cannot be brought into line with those held in the identity standard required by the role or group membership of adults.

In these data, although only a minority of respondents had seen the childlike aged first hand, all feared this possible self. Indeed, for respondents, fear of the possible self, was fear of losing oneself; passing beyond what it meant to be 'them':

> *In the future I will not be same person. I will not be able to do the things I am doing now. Time will elapse. By that I mean I will be very old man.*
>
> [Rabson, male, 75, married (emphasis added)]

Hazel Markus and Paula Nurius' theory of Possible Selves focuses on the dissonance between the current identity and the future identity. It argues that individuals are motivated to avoid negative future identities and pursue positive future identities. Possible selves thereby become incentives that guide behaviours, thoughts and strategies (Markus and Nurius 1986). In this thesis I argue that older adults in Balaka were motivated to maintain their adult identities and avoid their childlike non-adult possible self. In the next chapter, I explore how they do this.

3.6 Summary

The experiences of growing and being old were understood in relation to their corporeality. I have argued that this body-centred understanding of ageing was linked to the importance of production within the social and structural framework of agricultural self-sufficiency and reciprocal transfers of familial support. I have in turn suggested that through productivity, the body was understood not only as a

socially-mediated product, but as the embodiment of identity. 'Working' bodies were necessary for the behaviour that defined an individual as being a member of society: an adult. I suggested that the dominance of this adult identity in respondents' narratives highlighted its salience for men and women living in rural Malawi.

Reflecting the social construction of identity, I also noted that this identity was understood to be dynamic, changing in response to the exigencies of the body. A weak body constrained an individual's ability to behave in ways that were compatible with the meanings held within the standard for the adult identity. The very aged or very ill body was understood to be useless. It was associated with the opposing identity of a child. However, at the end of this chapter I noted that while respondents' conceptualised ageing as an inevitable process of decline, no respondents consistently presented themselves as occupying a childlike role or social identity. Instead, it presented a possible self, a potential identity that guides behaviour.

The importance of work for self- and social-worth in old age, the labelling of the incapacitated as 'children' and the importance of a positive balance in the bank of familial support for the receipt of care in old age, have all been identified previously in other African settings. By drawing on identity theories from sociology and social psychology to deepen my analytical engagement with respondents' narratives in rural Malawi, I have extended these descriptive accounts. I explored *how* experienced or feared bodily changes lead to the loss of this core and salient identity. The incorporation of these theories is unique in studies of African ageing. Their utility for understanding older adults' experiences of ageing, and experiences while ageing, is further developed in the next chapter as I introduce the second part of the underlying tenet of these experiences, and the analytical account presented in this thesis: that older adults managed their identities in order to resist their possible selves.

Chapter 4 | “The body grows old but not the heart”: Maintaining positive identities in the face of the challenges of the ageing body

While respondents conceptualised the ageing process of decline as linear and one-way, an individual’s journey did not follow this trajectory. Instead, respondents presented themselves at different points along the trajectory of ageing at different times during our conversations. In this chapter I account for competing narratives about ageing experiences by suggesting that they reflect respondents’ attempts to avoid the childlike possible self identified in the last chapter. I explore a series of

discursive strategies through which respondents managed the threats presented to their adult identities to maintain positive identities. I draw on social psychology's Identity Control Theory (Burke 2006) to produce my analytical account, which is communicated in the way I present empirical data in this chapter.

4.1 Making sense of competing narratives of old age

The body's ability to work and the understanding of a childlike old age marked by decline and decay, frequently and consistently emerged during research conversations with all older men and women. However, respondents offered contrasting and competing narratives regarding their personal experiences of ageing. While some respondents were in good health and produced food and resources that supported themselves and familial dependants, others struggled with limited eye sight, poor mobility and *nyamakazi* [rheumatism neuralgia or sciatica], and were more frequently the recipients than providers of familial support. Furthermore, individual respondents presented seemingly contradictory narratives across multiple interviews. The following extract is from a single conversation with Rhoda. It is from our first interview. In this, and across a further three, she offers contrary presentations of her experiences of growing older and the loss of physical strength and ability to work:

> *R Sometimes I have malaria, plus* nyamakazi *which makes me to fail weaving mats. But it affects me more while early in the morning*
>
> *I What have you been doing during this week?*
>
> *R I was doing some housework, like sweeping on the ground, cooking relish,* nsima*, taking water from the borehole.*
>
> *[….]*
>
> *I What has changed in your life over the last 20 years?*
>
> *R My body. The changes which I have seen are that I am failing to do hard work, and when I force myself to do it I become sick… I am failing to do the work… It pains me much.*
>
> *[…]*

I How do you feel about getting older?

R I feel good about getting older with my husband, because we work together in our works… I am looking forward to it because I take care of myself and my husband

[…]

R Paining of headache, I fail to work most of the times because of that problem.

[…]

I So what do you think is the best time of life for a person?

R It's when you are a girl or when you have 2 children. Because in this time, you have full of blood in your body.

[Rhoda, female, 56, polygamously married]

Rhoda's report of decreased strength but continued working reflects the narratives of many respondents, all of whom discussed being engaged in some work at some point during our conversations. This productive activity was essential for securing their survival. However, my analyses suggest their contrasting narratives about strength, work and independence may also be understood as a reflection of respondents' active negotiation of both the experienced, and expected, challenges to their adult identities by their ageing bodies.

The final stage of the ageing process has been usefully conceptualised with regard to Western ageing experiences as a "black hole", exerting a gravitational pull on those too close to this phase (Gilleard and Higgs 2010, p. 125). The metaphor certainly accords with respondents' oscillating narratives presented here and the way they appeared to 'pull back' from discussions of inability. I argue that respondents were motivated to maintain their preferred self-identities as adults and avoid the "black hole" of the childlike possible self explored in the previous chapter.

Two responses to the dissonance or potential dissonance between behaviour and desired identity were identified in my analyses of the conversations. In the first response respondents attempted to realign perceptions of their body-centred productive endeavours with those mutually understood to be required by the adult

identity standard. The second response indicates a gradual shifting in respondents' understandings of what it means to be an adult and what behaviours are associated with that identity. In this response, respondents emphasised the separation of the body and its productivity from the identity. I draw on Identity Control Theory (Burke 2006) to frame these two discursive strategies. I suggest that this theory can provide valuable insight into understanding the way men and women experienced growing old in rural Malawi.

4.2 Identity Control Theory

According to the group- and role-based identity theories explored in the previous chapter, individuals engage in behaviours that are understood to correspond to the shared meanings of the parts of an identity that serve as a reference for measuring the self against the so-called 'identity standard'. For respondents the parts of the adult identity that served as a reference for measurement were contribution and independence. Individuals have numerous positive identities, and rely on them at different times. When a particular identity is relevant in a situation (becomes 'activated'), the individual perceives the meanings implied by their behaviour, either through their own observations (as in group- and role-based identity theories) or through receipt of others' appraisals of their behaviour (as in role-based identity theories). Individuals then compare these perceptions about who they are in the situation, with the meanings of the identity standard. Individuals verify their identities by controlling perceptions of their behaviours to ensure that they match the identity standard.

Identity Control Theory argues that the discrepancy between the meanings of an individual's behaviour and the meanings of an identity standard evoke an emotional response such that "we feel distress when the discrepancy is large or increasing; we feel good when the discrepancy is small or decreasing" (Burke 2006, p. 83). Individuals are therefore motivated to maintain their identities. When the discrepancy between the meanings of the identity standard and an individual's behaviour persist, and the individual is unable to modify their behaviour, the identity

standard itself may change over time, in order to become more in-line with perceived behaviour. If an older adult in rural Malawi perceives their behaviour as being less productive and more dependent than they associate with their identity as a capable and contributing adult, they will first attempt to change perceptions of their behaviour to improve their 'fit' with the meanings they hold for the adult identity. At the same time however, the discrepancy will act to slowly change the meanings they ascribe to the adult identity standard, from contribution and independence to meanings more in-line with the perceptions of their behaviour.

The theory provides a useful framework for understanding how respondents' various and competing narratives about ageing might reflect a common motivation to maintain positive adult identities and avoid the negative childlike possible self. Through the competing narratives about personal ageing experiences, three broad responses to the experienced or expected dissonance between behaviour and desired identity can be identified in the data. Respondents:

1. emphasised their ability to work and successfully produce;
2. acknowledged their failure to achieve self-sufficiency and provide for their family through their work but stressed the externality of the challenges to this adult-compatible behaviour citing exogenous factors that did not reflect changes 'in them'; and
3. separated the body and the identity ('the person inside') by emphasising meanings of the adult identity standard that were not based on the body and its productivity.

The first two responses fit neatly with the first of Identity Control Theory's strategies in which individuals attempt to realign perceptions of their behaviour with the desired identity. The final response, in separating the meanings of the body and the meanings of the identity entirely, accords with Identity Control Theory's second strategy, in which an individual gradually alters their understanding of the desired identity so that it reflects, and is compatible with, the meanings of their behaviours. The next sections discuss each of these three strategies, detailing the multiple narratives used by respondents.

4.3 Focusing on successful production to (re)align behaviour with the identity standard

Respondents frequently disassociated their behaviour from the meanings of possible self. Respondents who were not experiencing any significant age-related changes in their bodies did this by stressing their continued – or even increased – physical productivity. Highlighting their success in securing resources, these respondents distinguished their behaviours from the childlike very old. They cared for themselves and were the main provider for their families.

In this example, Rabson discusses his increased hard work and productivity:

I *Now, what do you think has changed in your life in the last 20 years?*

R *Ah nothing…I haven't noticed the changes yet….I feel I am fine at the moment because I am able to work without any problems…[There is] no difference, and I can say I am feeling better now than before. Very much. You can see all these [points to his cotton garden and the maize filling his nkhokwe]. I have done myself with my hands. I have also grown potatoes, pigeon peas, I had no such things in the past… I am enjoying my growth… Even if the* alangizi *[Agricultural Advisor] comes today he would recommend my work in my fields. To me good life means being able to cultivate, children not lacking essential things. I thank God for that. I don't complain because God is assisting me.*

I *How can you differentiate the way you were getting these things in the past and now?*

R *It's really different. Now I am able to work [and] clothe my wife and myself - even food, I am getting a lot of food now.*

I *Was it difficult to get clothes for you and your wife in the past?*

R *No, I could not find clothes*

I *And food?*

R *No, I was half-half and could not last the year around. In January [hunger season] those years I had nothing to eat.*

I So you are better off now than in the past?

R Nowadays I am better

[Rabson, male, 75, married]

In the following examples, Ethel and Teresa are quick to distance themselves from those who are "lazy" and do not work. During our first conversations, both women report that they have lost strength as they have aged. Ethel, the older of the women, notes that age-related illness has left her "so weak". However in later interviews, particularly when our conversations turned to older adults who cannot work, the women focused instead on the continuity of their adult-compatible behaviours over time. Both women present hard work as being associated with more than physical survival. When Ethel corrects the interviewers' understanding and reports that she is "used to working", and Teresa reports that it is hereditary, they imply that working hard is 'part of them' – a consistent and immovable component of their identities. As Ethel is quick to point out, any laziness is temporary:

I Last week you told me you fail to work, because you feel weak in your body. You also told me other people of your age do work more than you do. Am I correct or not?

R Did I say that the time I was sick?

I That time you said you wake up feeling very lazy. Did you say this, or maybe I misunderstood you?

R You didn't understand me. I said that one time I was sick so I was feeling weak and lazy, but when I got better I am working more than I used to do when I was sick.

[…]

I How do people look at a person who awakes up in the morning and stays without doing anything?

R ...We would think they are lazy people.

I How do you feel when you wake up and do nothing? Is this a good thing or not?

R *It's not a good thing. I am used to working, and people can regard me as lazy person when I do that… I am used to working. And I feel I am troubling those people who help me by doing the job for me.*

I *You last time told me that you failed to do a job which you wanted to do. Is this [because of] old age?*

R *No, it is mainly when I am sick, when strong I can work*

[Ethel, female, late 80s/early 90s, married]

I *The last time we met you said as elders of your household you have to work despite losing strength. Did you expect to work at your age?*

R *Yes, I expected that… Aaah, I am now stronger than I was when I was young... This time around I can't stay without doing some work. I am used to working.*

I *You just like working?*

R *Yes, I am used to working*

I *What about other women of your age in this village, do they work as you do?*

R *No. There is a difference. There are others who do very little work compared to how I am working… The difference comes in that other people are born lazy. Me, I will stop working when my life is gone… Even if someone is a hundred years, one can continue working. My mother died after forty- she died after a long time - but she was still working*

I *Mm. Is it hereditary?*

R *Yes. It's* zakutundu *[like mother like daughter]. She was working up to the time she died… I still feel the same this time around just as I was when I was a young woman.*

[Teresa, female, 59, married]

Other respondents were experiencing age-related declines in their bodily strength that made highly physical work more difficult. However, these respondents employed a number of rhetorical strategies to emphasise the continuation of their adult-compatible behaviours. Some stressed that they now worked harder to achieve the same level of productivity as they had previously:

Aaa! I do the work while feeling pain. When I am able to move around I force myself to work…I am able to do my household chores. I also go to the garden and cultivate. For the waist and the eye, they have just started hurting… the arm pains a lot. It seems this thing [illness] moves in the body, sometimes it goes to the legs.

[Loveness, female, late 70s, widowed]

Some balanced or qualified their reports of receiving support and care from their children with reports of the support and care they offered in return:

I have not reached that age, if I am determined, to depend on someone to help me… Mainly it's when a person is very old that they would need someone to help them, but it should not be in everything…I am at the prime old person, I have not reached to be very old… At my age, it's an age where you need to help yourself, and also you can help other very old people, and also the children can also depend on you.

[Fiskani, male, 61, married]

Others stressed that although they could no longer perform some tasks, they continued to contribute to their self-care and household by performing other types of work:

[Since last week] I have met the same problem of failing to walk, pain this side [pointing at his waist]… additional pain is from here [pointing at his chest]… I have worked a little. I was working while seated… I had some isilisya *[reeds] used in weaving cane chairs and I was just processing it.*

[Charles, male, around 70, married]

Each of these narratives allowed respondents to present themselves as people who are not unproductive, entirely dependent or unable to make any contribution. In doing so, respondents managed the interviewer's and their own perceptions of their behaviour, physically and discursively realigning it with the meanings of those held as standard for the adult identity.

4.4 Focusing on the externality of causes for unsuccessful production to realign behaviour with the identity standard

Some respondents who had been unsuccessful in gaining resources stressed continuity in their potentially-productive behaviours over time. However, they emphasised that the absence of outputs was due to external challenges, rather than changes in their behaviour and attitudes to working. For example:

> *I have raised all the four children alone… they look up to me for support, that's why I am always heated by fire when making doughnuts [for sale]. We don't have a factory here where we can get salaried employment hence we rely on the pot. So if one pot breaks, I go and buy another one and life goes on. Perhaps you saw me carrying a bottle of cooking oil for the doughnuts? Did you see me? Nobody sent me to buy it but it's mine. So I have always been poor…it's just the same.*
>
> [Estina, female, 55, single]

> *I The older adults of your age, do they also face the same problems when it comes to working?*
>
> *R They are able to work. Like the one who was here - that one is my friend. We were born the same day*
>
> *I She is able to farm?*
>
> *R Yes, she is able to farm and cook. But she has grandchildren [to help her].*
>
> *I So you were born on the same day with that friend of yours. You are failing to farm but your friend is able to farm. What had happened that you have a problem which your friend doesn't have?*
>
> *R Because of my illness. That is why I am failing to do some other things.*
>
> *I Your major problem is not ageing but the illness?*
>
> *R The illness*
>
> [Zione, female, late 70s, widowed]

Like other respondents, Estina and Zione stress that they are unable to produce sufficient resources for themselves or their families. Rather than being due to ageing and the physical decline of the body, they report that illness and poverty prevent them from working. Poverty in particular, was forwarded as the main challenge to their continued and persistent attempts at self-sufficiency and provision for family. In doing so, respondents were able to distance themselves from internally-driven dependent or non-contributory behaviours that would be incompatible with the meanings of the adult identity. They stressed that they disapproved of the childlike attitude of the possible self, stressing they believed in the need to work.

4.5 Shifting the meaning of the identity standard: the un-embodiment of identity

Although the association between the body's physical strength and the adult and childlike identities outlined in the previous chapter featured in almost all respondents' narratives, some respondents only highlighted these meanings when discussing general ageing experiences. When discussing their own ageing experiences, these respondents avoided linking declining strength and physical productivity with discussion of being childlike. Instead they drew on a further understanding of the childlike old age, one in which the body and the mind had failed:

> *What the aged are like is that there is a difference in how they were previously thinking and this time around, they differ. The way they talk, they talk like children… like children senseless things. Yes, they don't take care of themselves and we take care of them. To say 'let us take care of the aged, because she is now useless'. Yes so we fetch some water for her to bath. Cook the food and give to her so she doesn't get worried.*
>
> [Ethel, female, late 80s/early 90s, married]

> *You can tell if a person is old when they have wrinkled on the body, two, their walking step changes. This shows that a person is old… The way*

> *they talk… When a person is old, they run out of ideas, their wisdom goes down. They used to give good advice but now they can't, they end up being advised… You even tell them to go to the toilet, then you know a person is really old.*
>
> [Matthew, male, 59, married]

By highlighting this further meaning of the identity standard for the childlike possible self, respondents were able to discuss declines in their body-centred productivity without aligning their behaviour with this identity. They presented their personal experiences of ageing by:

1. normalising age-related declines in strength and production;
2. emphasising past productivity; or
3. focusing on highly valued qualities of the aged that were not based on physical strength.

Where previously the body, through work and production, was presented as the embodiment of the adult identity (Chapter 3), in these of three types of narrative, the adult identity becomes un-embodied: the 'person inside' is separated from the individual's present physical productivities. With reference to Identity Control Theory, this final discursive strategy might be usefully conceptualised as a strategy employed by older adults to redefine some of the meanings associated with the identity when the two strategies outlined failed and behaviour could no longer be brought into line with that required by the identity standard.

4.5.1 Normalising the ageing body

The first response was to normalise loss of strength and declining productivity with advancing age:

> *When I see that I am failing to work because I feel weak, I just leave and don't do that job… I don't get worried because I am an old person. All these things come from God. He created me and the strength comes from*

Him. So if He takes off my strength I cannot complain.

[Gertrude, female, 70s, widowed]

I often have malaria but still have to work at this household… Change is normal. When you are young you are stronger than when you are old. That is what just happens.

[Estina, female, 55, single]

In these examples, respondents stress that the body-centred changes they experienced were nothing to worry about and that by implication, their identities remained unchallenged. In this understanding, ageing happens only on the outside. The 'person inside' the body is essentially the same. My analyses suggest that these respondents appear to shift their understandings of the adult identity standard slightly so that the desire to be productive becomes more important than the act of being productive.

4.5.2 Emphasising past productivity

A second response was to reposition dependent behaviour within a discourse of reciprocal exchange. When discussing declines in their strength and productivity, respondents referred to past self-reliance, productivity and care for their dependants. Since the capital of a body is its ability to be productive, the older body becomes a capital store, able to trade on past productivity. In the following example, Polly normalises her ageing experiences and goes on to frame her discussion of declining strength by focusing on past work. In doing so she presents the 'type of person' she is: her underlying identity.

I You have talked about loss of strength in your body. How does that affect your life?

R I know it's because I am an old person

I What do you fail to do because of loss of strength?

R Nothing, in the past we used to pound maize, but nowadays even young girls don't pound [they go to the maize mill]. I used to carry a

big bundle of firewood but nowadays I can't carry it, if I dare then I would feel pain in the head, neck, back, legs. Or cultivating, I can't do as I used to. In the past I was cultivating a large area before getting tired… I am not worried because I know I have stayed on this world for a long time. […] I am used to it now. But the best thing is to work hard in order to get money, but it will never be the same as it used to be. It is not a big problem that can make a person suffer, every period has its own activities. I carry the bundle which I know I will manage… It can't be possible to go back and be a girl again. I was very powerful but I have shared it [the power] to other people so I cannot be worried.

[Polly, Female, 60s, newly married]

In situating their discussions within this discourse, respondents were able to describe their current receipt of care in terms of support relationships that were without dependency, and thereby shift the meanings of their behaviours away from those associated with the identity standard of the possible self.

However, at the same time, past productivity was emphasised as representing the 'real' person. Ageing was something that happened to the body, leaving the adult inside unchanged (akin to 'ageing as a mask' theories have long been propounded in Western gerontology (Featherstone and Hepworth 1989)). In these narratives receiving care in old age was a reflection of high past productivity, rather than a reflection of low present productivity. An individual was only without strength and blood in old age *because* they had 'used up' so much of their strength and blood working hard in the past. Present identity again was un-embodied as respondents invited the interviewer to judge them on their past body-centred behaviour as an indication of the type of person they are now.

4.5.3 The elder as the model adult

While the two strategies outlined above separate identity from the body, they are framed by the body-centred understanding of capable and childlike old ages. However, there is another, parallel description of old age in these data that is not

based on physical strength and production. In respondents' interview narratives, as well as in conversations with younger adults in the field site, policy interviews, proverbs and art work, old people were also presented as the custodians of wisdom and good morals, and the givers of advice. They are treated with deference and respect by younger adults. Indeed, in Malawian proverbs an old person is 'like the marsh where the fire goes out' [*akulu ndi m'dambo mozimira moto*]. Asked about this proverb, respondents frequently explained "it means that the young people cannot think how the older people think. Because elders know more about people" [Yotamu, male, 80s, married]. The role of an old person is an "*ozimitisa moto* [fire fighter], you should make sure that the family is assisted in time of need, especially when there are disputes" [Teresa, female, 59, married].

This understanding of old age, often represented by 'the elder', is familiar in ethnographic writings about old age in Africa (Apt 1995; Cattell 2002; Guillette 1992; Rasmussen 1987; Sagner 2002; Van der Geest 1998b). Elderhood has previously been discussed as a definitional component of old age. For example, in Botswana, Julie Livingston explores changes to conceptualisation of old age which historically implied "a complex state in which physical decrepitude, spiritual potency, and aggregated knowledge and experiences of striving converged in an individual near the end of a long life" (Livingston 2002, p. 137). Indeed in Malawi, the elder is a label that implies seniority of social standing that goes beyond simply being 'the oldest'. As Charles notes:

> *R He was my nephew*
>
> *I Who was older between you?*
>
> *R I was the oldest but because he inherited the name from my late uncle, I regarded him as an elder*
>
> [Charles, male, around 70, married]

The elder was calm, restrained in pleasure seeking, slow to anger, forgiving, generous, cool rather than hot, avoids gossip and was wise:

> *Here in this village, everyone calls me* anganga [older person]. *Whenever there is a problem, which needs to be solved with good*

understanding, they come and ask me for advice. I am happy that the people of the village - including the chief - come and ask me for advice on crucial matters.

[Arnold, male, 91, polygamously married]

What really happens is that you think more constructively, you don't just think about today, you also think about the future, in so doing you become wiser than when you are a young man… If you give me money I will not go to the market straight away. I will sit down and think what are the things I need most. After that then I can use the money if there is nothing I can keep it. But with a young man they will go to the market and spend it. They will not think of anything… The thing that an old person can do which a young person can't is that an old person does things their own way. An old person would want to avoid picking quarrels with people. They would easily apologise even though they are not in the wrong. They want to live in peace with other people. Old people easily forgive when they have been wronged. They can also share what they have with other people even if they don't have enough… An old person would want to follow procedures while young men prefer shortcuts.

[Fiskani, male, 61, married]

However, while this image of old age has been well documented, so has the observation that the social standing of older adults has lessened as the social and economic changes transforming the rural African landscape have undermined the utility of older adults' experiences and lessons (Cattell 2002; Guillette 1992; LeVine and LeVine 1985; Livingston 2002; Sagner 2002). While respondents' narratives do not necessarily indicate change in the status of older adults over time (and indeed, some respondents reported that they had not shown deference to their own grandparents), some respondents commented that although older adults may well be 'the marsh where the fire goes out', younger adults "don't come" to listen, and when they do, the advice is rejected.

Old age was neither sufficient nor prerequisite for the qualities of the idealised old person. Advice and leadership roles (for example, village heads, marriage advisors and leaders of initiations) were often occupied by younger adults, and according to

respondents always had been. Older adults could be foolish or have outmoded ideas. A clear distinction could be drawn between the elder and the older adult. Not all older adults attained this idealised state:

> *I Last week you told me that when somebody gets old she becomes more wise?*
>
> *R Mm [nods]*
>
> *I And they talk and give advice a lot and some other things?*
>
> *R Mmm. An aged person yes knows how to talk. But sometimes the youth can also be wise, it depends on the wisdom one has. How one thinks in the heart. It happens sometime to be advised by a child. To say, 'mother that is not good you could have said like this'. And you are able to acknowledge that the child is right… Sometimes an aged person can talk [advise well] and sometimes you fail to talk properly and you are guided by the child to say 'do this' and you do that, and things get solved. It is the head of a person which has the wisdom.*
>
> [Tryness, female, 70s, married]

> *There are different types of old age: in some cases there is no wisdom. Then there is another old age in which you are wiser than youths... There is this old age in which a person does things which cannot help them, you do things which can bring you problems. There are other people who are old and cannot work, and someone gives them an assistance of K500. Instead of them keeping the money, to help in their daily life, due to their childish behaviour, they take the money to spend it on drinking, until it is finished… that type of old age is not wise. Then there are other old persons who are wise. When they receive the money, you can even know that the money you gave them is still intact.*
>
> [Lyness, male, 68, married]

Perhaps reflecting this nuanced and changing understanding, respondents referred to this image of improvement in old age inconsistently. Conversations with Polly about her role as a community health advisor[23] offer a good example of this. In her

[23] The voluntary role is an unpaid but formally organised arm of the health care delivery system in rural Malawi.

discussions Polly draws upon both body- and mind-centred narratives of old age, navigating between the wish to direct her declining strength (discussed in interviews 1, 2 and 3) towards other, more essential work (discussed in interviews 3 and 4), and her increasing mental ability to offer the advice and wisdom required by the role (discussed in interview 4):

> *I Last week you told me that you don't want to continuing working as a health advisor because of age?*
>
> *R Um, I am very old… I should tell you the truth, it's because I am old. And I want to tell them to find another lady to do the job because I want to retire*
>
> *I Do you think you are tired because your strength had finished in your body [as discussed previously]?*
>
> *R No… but I just want to stop…The work is good and it requires an old person. To be an advisor it does not require youth… [but] I need to rest*
>
> *I You are tired?*
>
> *R [Laughs]*
>
> *I Alright [3] You told me that the reason you want to quit your job is that nowadays you are busy. What exactly keeps you busy?*
>
> *R … I have to organise things in my home. The busiest thing I do is weaving [mats]. When weaving I am very busy. I do that to get what can assist us in our life [money]*
>
> *I Um [4] That time you told me it's because you are busy, but now you are telling me it's because you are old. Which one should I take?*
>
> *R Just take that I am old*
>
> *I Because you are old?*
>
> *R Yes because the business is for every day, but I have decided to retire…I will tell them to get the youth who will be doing that.*
>
> [Polly, Female, 60s, newly married]

Advice-giving has previously been considered the "special work of old people" (Cattell 2002, p. 166), used to distinguish between older adults worthy of social

recognition and those who are too old for either physical or social work (Apt 1995; Cattell 2002; Sagner 2002; Simmons 1960). Although some respondents reported that their advice and wisdom was not listened to by the young, respondents' narratives suggest that such advice and wisdom, along with the example set by leading controlled and restrained lives, were still recognised as valuable social contributions by respondents themselves. My analyses therefore suggest that some respondents emphasised this "special work" in their narratives in order to discursively realign their behaviour with the identity standard of the contributing adult. This was especially the case among respondents who at other times, reported that their ageing and failing body limited their self-sufficiency and physical contributions.

In the following examples Fiskani and Tryness direct their conversations away from discussion of behaviours that are incompatible with the identity standard, that is, their struggle to do physical work, and towards their non-physical, social work. By focusing on their wisdom and advice-giving, they present themselves as occupying contributory roles:

> *Being very old is good but not to the point of being helped to do things or being carried… My family benefit from me in many ways. One, they are happy they have a father and they do get support from me. Two, we do assist each other on the work which we undertake in this compound, I act as the foreman… They also can learn things on how to live and also I am the one who supports the family… The thing which they can benefit in the family is that as they live, they do face some difficult situations, where they can't know what to do or how to deal with it, thus when they go to the* agogo *and ask for guidance, so the* agogo *can tell them, do such and such a thing. Even when you have a case they can tell you how to approach it, we can also interpret people's attitude which the young people can't understand, because they have not lived longer… Ahhh from me [in 20 years] time there is nothing my family will benefit [through my physical work], but they will know that we have a parent who has brought us up to this age, there are other people who don't have that chance. They will benefit in that I will be able to give them advice. [And] I am a weaver. I can still give instructions on how to weave a good mat despite being very old so they can benefit from my skills in weaving. Like*

the young brother to Lionel [his son] is the one who made the mat we have sat upon, but I told him that it is not good enough and told him where he needs to improve.

[Fiskani, male, 61, married]

I You said that you are able to send your children to celebrations?

R Yes

I Can you tell me one of the celebrations where your children were sent? The last celebration if you remember just one celebration

R Initiation celebrations, they go there and help their friends

[…]

I Why did you not go, but tell your children to go [without you]?

R I have said that it is their time and they are helpful there because they are able to work there [take part in the preparations]. I wait here at home… It is their time. My time is gone. I spend my time here at home weaving mats and when coming [back] they tell me everything so we cannot all go there

I How do you feel when you are staying here at home?

R I am happy

I Not so?

R Yes because I am at home. I am happy because I should be stopping them [grandchildren who stay around the compound] when they are fighting

I That is the reason?

R Yes

I Meaning that others [the children's parents] cannot manage to do that the way you do?

R They can't, but the grandparents are able to do that

I What is the difference?

R I am like the shepherd for the children

[Tryness, female, 70s, married]

In focusing on social rather than physical work, these respondents shifted the meanings of the behaviour associated with the identity standard of an adult to reflect a more abstract notion of contribution than the self-sufficiency and physical provision for kin emphasised previously. As in the two previous rhetorical strategies, respondents disassociated adult-compatible behaviour from the body, un-embodying identity and focusing instead on the 'person inside'. Further, and in contrast to these strategies, through the idealised image of the old person, respondents were able to create an alternative understanding of the adult identity. The meanings held within the identity standard of the adult shift. Although still centred on productivity, this now encompasses social or 'moral' production, rather than solely physical production as respondents explained at other times. In this understanding, to have the (group and role) identity of an adult, an individual must act in ways that they and those around them perceive as being morally or socially productive. Non-morally or socially productive past behaviours and the behaviours of younger adults are therefore dismissed as being "childish". Old age is reconceptualised as the pinnacle of life and adulthood.

I Has life got harder or easier as you have got older?

R It's easier. It's because I am growing old. The work I was doing in the past is different from how I am working now. Nowadays I am doing a lot of work. In the past I was doing a little work. When I was a youth I was not working hard… [Now] I have to work hard, in the past I was mixing with childishness… I was concentrating on moving around [having sex with different women]

[Interview 2]

R Ageing is good. Because you stop doing what you used to do when you were young. You start a new life

[Interview 3]

[Thomas, male, 60, married]

R The youth of today, they are bantam *[a newly-available maize variety that can be harvested just three months after planting]. They grow fast, but with no reasoning capacity to say at this age what am I supposed to be doing? At this age how can I be aware of the girls,*

how dangerous they are? But we the locals [previously available slower-growing maize – the older adults], we are able to reason. We know that a Zebra is beautiful due to good behaviour…

I What qualifies one to be an old person?

R If first that person accepts the situation that he is aged, because there some aged people who behave like children… That is not ageing. But when you accept yourself and start behaving like an aged person, stop doing some other things.

[John, male, 63, married]

By shifting the meanings held in the identity standard for 'the adult', Thomas and John are not childlike *because* they are old.

4.6 Summary

In this chapter I have explored the ways older men and women in Malawi negotiated ageing. I have argued that they employed a number of rhetorical strategies to maintain positive identities and avoid the childlike identity of the possible self. These strategies can be grouped as those in which respondents attempted to (re)align their behaviour with the behaviour they associated with the adult identity, and those in which respondents changed their understandings of the adult identity in order to improve congruence with their behaviour.

The analytical account presented in this chapter, together with that presented in Chapter 3, provides a framework for understanding older adults' lived experiences of ageing in rural Balaka. It was produced from my analyses of how respondents talked about older age in the abstract and how respondents talk about their own experiences of older age.

The prominence given to the ageing body and the avoidance of a childlike old age in these data suggest that older adults' understandings of ageing, the life course and their ability to retain their group- and role-based identities as 'adults' was an important element of their experiences of older age. In line with both theories'

emphasis on the self as mediating the relationship between social structure and individual behaviour (Hogg *et al.* 1995, p. 255), these data suggest that the adult identity has implications for older adults' broader experiences and behaviours. The following chapters explore how the various understandings of old age discussed here and in the previous chapter frame older adults' discussions about sexuality, sex and HIV.

Chapter 5 | Sex that gives and takes in older age

There is a widespread appreciation that sexuality is socially constructed and context-dependent (Dixon-Mueller 1993; Kellett 1991). This chapter sets out respondents' understandings and experiences of sex at old age within the wider meanings of sex in rural southern Malawi, as well as within the experiences of ageing and understandings of bodily decline and identity maintenance or resistance set out in the last chapters. The complex and apparently contradictory discourses about sex reported by different (and sometimes the same) respondents are accounted for.

The chapter first describes respondents' understandings of sexuality: the ethnophysiology of sex, and beliefs about sexual strength and sexual desire in light of this. The chapter then goes on to explore respondents' experiences of sex: how

understandings of sex shaped the way respondents felt about their sexual behaviours and how they presented themselves during the interviews.

5.1 Understandings of sex

Attitudes to sex in rural Malawi were extremely positive. Sex and sexual desire were described as natural and God-given. Sex was understood to be a necessary, and typically definitional, element of marital and non-marital romantic (*zibwenzi*) relationships:

> *You should give your goods [body] when you accept the marriage that means you agreed to have sex with your man, you signed for it.*
>
> [Nyuma, female, 68, single]

> *Sex is important at any age of life. If you are getting married you apply for a job and that job is sex.*
>
> [Arnold, male, 91, polygamously maried]

Both men and women spoke of the need for sex as a prime motivation in having such partners. Respondents were unanimous that in general, "sex is important because it's nature. It means that God has made a pair of people." [Patuma, female, 58, married]. Since sex is God-given, sexual desire was considered to be innate in all people, and in principle, to continue throughout the life course. Those who did not at least desire sex were ill, or dead:

> *[Lacking sexual desire] it means you are sick. A normal person can't just become cold. To have desires is a part of life, if you don't have it means you are not normal.*
>
> [Violet, female, early/mid 50s, married]

In the following excerpt, Fiskani is incredulous at the suggestion his wife and he may abstain from sex in later life, noting that having sex is "part of us" – him, his wife, the interviewer, and all people:

It [sex] is still important for me, we are used to doing these things - this is our habit [laughs]. That will remain. As such it is part of us, we can't do without it [laughs]… Sex is important for relationships, otherwise the family can end. Should I stay with her [his wife] like [she is] my sister?! [laughs]" .

[Fiskani, male, 61, married]

Sexual humour was used frequently in and around the field site, and by respondents and their families. For example, on my visits to their compounds, some male respondents loudly announced to anyone passing by that I had 'come to marry them', understood by all to involve a proposition of sex; Female respondents would joke that I had come as a second (or third) wife for their husbands or that I had come to marry another older man in their compounds. During interviews, respondents spoke explicitly about sex, they described exchanging information within families about sex and sexual health in particular, and although two respondents strongly denied talking about their own sexual experiences with friends, all respondents' awareness of gossip involving sex suggested they were party to such conversations. All suggest a level of openness towards sexuality that is consistent with the understanding of heterosexual[24] sex as a natural and essential element of living.

[24] In the interview narratives and observational data constructed, sex was exclusively heterosexual. Although recent research using sensitive snowball sampling among hidden homosexual populations in Malawi's first cities Lilongwe and Blantyre identified bisexual men, infected with and at risk of HIV(Baral *et al.* 2009; Fay *et al.* 2011), and it is not uncommon for adolescents to form close same-sex sexual relationships (Morris 2000), homosexuality remains illegal in Malawi and strongly censured. Even in private, one-to-one conversations, my research assistants, who were aware of the acceptance of homosexuality in my British culture and at other times demonstrated strong social desirability bias in their discussions with me, were unanimous in their disapproving disbelief. I did not observe or hear about rumours about two men or women cohabiting or having any kind of romantic or sexual involvement in rural Balaka.

During my fieldwork, a story about the arrest of two men in Lilongwe for "unnatural practices between males and gross public indecency" reached prominence in international news, and perhaps as a result, dominated the print and radio media for some weeks (Somanje 2009) (and see (Amnesty International 2010) for Amnesty International's UK coverage). In contrast to almost-all other large local and national news stories (for example, the political situation, the nationalised price of maize or cotton, a witchcraft allegation, rape case or other trial relating to some other socially-unsanctioned sex event), no respondents discussed this story during their formal interviews or in the sometimes extended greetings before the audio-recorder was turned on. It was however discussed more frequently in the trading centre, on

Although procreation featured in respondents' interview narratives, sex was much more frequently discussed in terms of pleasure and general wellbeing. This emphasis on sexual pleasure accords with previous research among younger adults in Malawi (e.g. Morris 2000; Tavory and Swidler 2009) and middle-aged women in Bostwana (Lee 1992) and urban South Africa (Orner 2005), but offers a sharp contrast to research focused on sex among older adults in Ghana (Van der Geest 2001). Sexual pleasure in rural Balaka was discussed by, and for both men and women who clearly articulated the importance of attaining "sweetness" in sex, a metaphor used across southern and eastern Africa (Bond and Dover 1997; Holtzman 2011; Hunter 2002).

Both men and women talked of the importance of bringing pleasure to their partners through foreplay (again sharply contrasting Ghanaian experiences (Van der Geest 2001)) :

> *I play with her, touching her breasts and even her private parts. She was becoming aroused, crazy. So the same applies to me. I was aroused and in doing so we found ourselves satisfied in the end, yes. Without preparation, it's just as if you have raped each other.*
>
> [Steven, male, 56, married]

- And through the movement of their bodies during intercourse: women moving ("dancing") their hips and buttocks (*kunyekulira*) and men thrusting their penis (*kukundila*). Both discussed the use of herbs to enhance these skills in order to please their partners. For example:

> *What happens is that maybe you have married a girl. So when failing to meet her sexual desire you end up using herbs. You use the herbs so that*

---

public transport and in Balaka town. In conversations I had and overheard, the idea of homosexuality was met not with direct disapproval, but with sheer incredulity. In both these conversations and in Malawian media reporting, the case was considered to be orchestrated by western organisations (Amnesty International in particular) and donors, and acted out by two heterosexual men (photographed on the front cover of the national newspapers on their 'wedding day' wearing full women's celebratory dress), who, along with their wives and *zibwenzi* [lovers], stood to profit financially from the 'media stunt'. As such, homosexuality was not broached in interviews by my research assistants for fear of unsettling the respondent, but moreover, for fear of directing the conversation into an emotive area that did not appear to be salient for any of my respondents' experiences of ageing.

she should be satisfied. Yes, but not only to have children, but just to satisfy her.

[Thomas, male, 60, married]

Concurrently, both men and women spoke frequently of the importance of sexual pleasure for themselves. Respondents reported that men and women evaluate - and disregard - lovers based on the sexual pleasure they delivered, as indicated by compatibility in size of penis and vagina, the length of time taken to orgasm, the look of a woman's buttocks and length of her labia, and as I will explore further, consistency of ejaculate and a man's vigour.

All of these things were able to bring sexual pleasure in as much as they encouraged the "charge" and then release of sexual fluids during vaginal penetrative sex. However it was the timely mixing of compatible male and female ejaculate that was understood to be the essence of sexual pleasure – the vital element in achieving "sweetness". The following excerpt illustrates the shared understanding between interviewer and respondent that exchange of sexual fluids is the source of pleasure, and what constitutes sexual intercourse:

I From today when was the last time you had sex with him?

R On Wednesday

I On Saturday?

R No, on Saturday he failed…On Saturday we had sex, but he failed

I But on Wednesday he managed?

R Yes

I So on Saturday it was like you did nothing

R Yes when he has failed to produce the sperms, that is nothing [Both laugh]

I But on Wednesday you were happy unlike on Saturday?

R Yes

I How do you do feel when he is releasing the sperms?

R It's so sweet

[Rhoda, female, 56, polygamously married]

[Interviewer, female, 19, recently married]

Although the importance of giving and receiving semen for healthy, pleasurable sex has been noted in other African settings (e.g. Bond and Dover 1997; Coast 2007; Holtzman 2011), respondents in rural Balaka emphasised the importance of both male *and* female ejaculate. Their significance is situated within the broader understanding of the life-generating and sustaining potencies in the body's fluids outlined in Chapter 3. While the life force was strongest in the blood, the life force contained in ejaculate was also significant, and (confusingly for me) also referred to as "blood" by many respondents.

Since ejaculate contained and partly constituted power (along with other bodily fluids), the exchange of ejaculate during intercourse represented the exchange of this power. Male and female ejaculate was considered to contain "vitamins" and "oils" that brought strength, health and pleasure. Several metaphors in which sex was linked to "eating" and "food" reflect respondents' understanding of ejaculate as containing nourishment for the recipient. In the following examples Jane (joined by the interviewer), talks of her own experiences of receiving strength from her previous and current husbands' seminal fluids, while Thursday and Nyuma speaking in general, discuss the need for both men and women to receive each other's sexual fluids for health and pleasure:

I Maybe I didn't get you during our first meeting, but you said that staying together between a man and a woman you get vitamins, but also the body functions properly? Can you tell me where these vitamins come from?

R From the husband, to the wife, what they give us makes our body to look good… With the vitamins you are strong… Even when you go to the hospital you will be told you have the medicine… You have enough blood. The body is also fresh: you don't feel pain here and there. Yes you have enough vitamins [after sex].

[Interview 2]

R I get some fats [from sex]. You can see my body is improving in complexion

I [Laughs] I can see!

R Aaa

I Even your arm

R It is becoming fat...

I Yes because of the fats

R Vitamin A

I Vitamin K. It is not vitamin A, but it is vitamin K

R I tell you

I God is not ignorant

R To give us that nature

[Conversation continued in interview 3]

[Jane, female, 54, recently married]

[Interviewer, female, 19, recently married]

There are ways of making sex sweet which is the shaking of the body... When you do this the semen will come in more [higher volume] and more powerful. And when your power [ejaculate] and the woman's power [ejaculate] meet, you all feel the sweetness... People share vitamins. This vitamin is called yowonjezera thupi kuti likhale la mphamvu *[RA: this is an energy-giving vitamin for the body]... If you don't have it, you become malnourished. At the hospital they call it marasmus*[25].

[Thursday, male, 51, married]

This blood [ejaculate] is important. In nature, if your blood is good and your friend's [sexual partner's] is good, they come together, and you become fat and the skin looks good... They look very healthy. Their bodies become dibwiridibwiri *[healthily fat]... The man and the woman when they have sex, they exchange blood, [but] if you only give [fluid] and don't get, you lose strength... This blood, the man gives out sperm*

[25] Marasmus is severe malnutrition characterized by energy deficiency.

and also women give our strength. When they meet inside they form blood inside… [If a man] puts it in the condom, and they would remove it and throw it away, it has no use, the woman just feels pain… now when they have sex, can it not cause pain to a woman? ... You need to exchange the blood, for you two people to feel good.

[Nyuma, female, 68, single]

In respondents' narratives, the health-giving properties of sperm underpinned the encouragement that men have sex with their wives during early pregnancy often to boost the development of the child, as well as the now infrequently-practiced widow cleansing. Rhoda explains to the interviewer:

R Sometimes when the husband had died, they said they should remove the mipingwi *[bad spirit] so that the body should be cleansed. When your husband has died they say it's* chiphaka

I Chiphaka*?*

R Those sleeping in their houses who eat with you [co-residents in the compound]

I What happens to them?

R They got bad luck. They said that when getting married to another man, the [new] man should find that all mipingwi *had already been removed. So the woman had sex with another man so that when getting married all should be well…*

I They had that belief that when their husband has died their bodies are not clean?

R Yes

I So they get somebody to clean up their body through sex?

R Yes because the sperms are medicine on its own… The sperms [laughs], the sperms are medicine… They say that men are the medicine for women

[Rhoda, female, 56, polygamously married]

The power stored in seminal and vaginal fluids was considered to be visible in its consistency: thicker fluids signalled potency, while "watery" fluid was weaker,

containing less power and vitamins. When men and women's fluids were powerful, and compatible, they mixed to produce blood inside a woman which became a baby. New life was understood to be a combination of a man's life force and a woman's life force. Sweetness in sex at all ages was therefore directly related to the exchange of more potent, fertile fluid.

In light of this, infecundity in women and men signalled a reduction in the quantity and power of their sexual fluids. Women who were infecund were described as being "dry" – emptied of potent blood. As a result of the association between fecundity and sexual sweetness, some respondents (Mercy, Rhoda, Daniel, Esnart, Thursday and Zione) understood post-menopausal women to both give and receive less pleasure:

> *When you grow older marriage became less important, because you stop from monthly period that brings desire of sex. You will notice that, when you are close to the days of menstruation period, you will have more desire of sex, and with that a man feels more sweet.*
>
> [Rhoda, female, 56, polygamously married]

Infecundity in men was similarly linked to reduced sexual pleasure. Jane's comparison of sex with her current husband and her first husband highlights this association:

> *The one who I married is an old person, a finished one [later clarified as "he fails to perform"]. But the one I was married to [before], a father to this one [her daughter], I was aware that this is a real man. He could erect at all times. And we were able to have children after sex. But the marriage broke down…Better that one [her first husband]. I had a man…The other one [her current husband] is lazy… It is a woman who never gets old*[26].
>
> [Jane, female, 54, recently married]

[26] Referring to the proverb *mamuna sakalamba*. Literally 'a man never ages' and understood by respondents to mean either a man's sexual desire never declines or that a man's fecundity never declines.

Significantly, Rhoda and Jane were grandparents who had finished childbearing some time previously, as had their husbands. Nevertheless, for both women, it was the power and potential fecundity of the fluids exchanged during their sexual encounters that continued to underpin their understandings of sexual sweetness.

A second element constituting power and potency in the ethnophysiology of sex in rural Malawi was temperature. While (Kaspin 1996; Marwick 1968; Wolf 2001) have theorised a coherent Chewa understanding of corporeal temperature as culturally defined (or 'ritual') body states, in these data, 'hot' and 'cold' were used in to denote a more diverse range of states for Chewa and Yao respondents. All stemmed from the temperature of the body's fluids, described as being hot or cold to reflect the potency of the life force contained within them.

An individual with intense sexual desire was described as being "hot". Although this temperament was innate, it could change over time, commonly cooling with age. Conversely, the heat generated during a sexual encounter could heat a person's sexual desire, reigniting passion in a previously cold individual.

Bodily strength was also described as a state of being either hot or cold. Weaker individuals were cold. As bodily strength, discussed in Chapter 3, an individual's heat was understood to decline across the life course. This cool state was connected to poor health, either as the cause of "diseases" by increasing susceptibility, or as the consequence.

Most frequently however, heat was used to refer to sexual strength and ability, in turn associated with the sweetness of sex. Hot lovers were sexually and physically competent, reflecting both the quantity of their blood and the heat of the life force in their blood. They were capable of vigorous, forceful sex that usually involving more than one "round" (orgasm). Throughout the interviews, the metaphor of "fire" was used to both describe a sexually powerful man ("fireman") and the temperature of sexual fluids ("fire from the woman and a man meet"), reflecting the power contained in these men's and women's blood. Sex with cold lovers was slower, reflecting diminished life force and temperature. This sex was not usually as sweet as 'hot' sex. Again therefore, the meeting and compatibility of warm, powerful and

healthy blood during intercourse was associated with both reproductive potential and sexual pleasure. Robertson explains:

> *And there is blood which corresponds well with the hotness of a person. Twice-twice [it matches]. And you know that if I continue with this one she will become pregnant… Then there is blood that when you make sex with her it's just like as if you have put [your penis] in water. It is very cold. You could even decide not to continue with her… because your private parts also become cold. Because the coldness has come from inside [her] and to release [orgasm] you need to try harder… [But if] you both feel good [the power matches] she could also say to you that if you continue with her she would be pregnant shortly: she has seen that you have performed well.*
>
> [Robertson, male, 80s, recently married]

Like Rhoda and Jane, Robertson had finished childbearing and had recently married a "dry" post-menopausal older woman (aged mid-70s). He was firm that he did not want to have more children:

> *I have children; now I am tired…I don't have the heat that I should be having children wherever I go. That's why I chose this dry woman so that I should be staying with her [without further childbearing].*

Nevertheless, Robertson considers himself to have an active and mutually satisfying sex life with his wife, based on their continued sexual strength. Here, focusing on his wife's pleasure, he comments:

> *But I don't have problems. My wife sometimes says that if at my age I am managing to do like that, what about when I was a youth?! Because I ask her after having sex if she is satisfied. She says she is more satisfied and runs short of words. And I am happy about that because I have a good reputation. Because I know that if the marriage ends I can marry another wife and do the same to her.*
>
> [Robertson, male, 80s, recently married]

Therefore, my analyses suggest that rather than resulting in fertility, or involving any real fecundity, sex was pleasurable when it was only suggestive of the "power" of

one's sexual partner. Ideas about procreation and the transfer of healthy, powerful bodily fluids instead underpinned a linking of "strong and fast" sexual intercourse with attaining sexual "sweetness". These ideas remained relevant after childbearing and into very old age.

5.1.1 Sex as a matter of strength

Reflecting this ethnophysiology of sex, pleasurable sex was understood by respondents as a matter of physical strength. Sexual strength was referred to as a person's "power" or "engine", and good sex required energy. Teresa [female, 59, married] illustrates this association, recounting advice she received from her parents to prepare her for sex when married: "*give him water to bathe and some good food so that he has the strength*".

Reflecting the high physical demands of pleasurable sex, sex was discussed by men and women as being "house-" or "bed-work". For example:

> *[Marriage] is difficult because it is like a job. To you it's work. In the morning, eeh! They [men] say all the time [they want it], you say I don't have the energy. So it's like work.*
>
> [Ethel, female, late 80s/early 90s, married]

> *For me I would say I am hot if I am performing in my house. I am hot, but not hot enough to boast about, but because I am able to work, I am hot.*
>
> [Danger, male, mid-70s, married]

The link between sex and work has been made previously, though for quite different reasons. (Lee 1992) documented increasing sexual boldness and activity in older age female !Kung in Botswana in the 1960s. This was in part explained by Lee as a reflection of their withdrawal from work in older age and increased time to divert to sexual expression. More recently, Van der Geest's descriptive ethnographic research in Ghana identified similar narratives of work and strength. For men this was connected to the more general strength needed for courting a woman, while for

women it was associated with a "tiresome" task from which they derived minimal pleasure (Van der Geest 2001).

Sex 'used up' a person's physical strength, and the quantity of life force contained in the bodily fluids they released during intercourse. Youngson explains:

> *R The blood comes out of you to the woman's body, yes…[and] when you are having sex, it's when the blood comes out of the woman's body [to your body].*
>
> *I So does it mean that every day you have sex with a woman you lose blood?*
>
> *R Yes every day*
>
> *I Or you lose the power of the blood?*
>
> *R The sperms which you produce, it is your blood ['life force']. That is why after releasing the sperms you become tired*
>
> [Youngson, male, 70, married]

A woman's loss of blood and power during sex was, according to respondents, the reason they had refrained from having sex with their husbands and wives during the final months of pregnancy, ensuring that all the "vitamins" stored in a woman's blood were shared with her unborn child, rather than her partner. A man's loss of blood and power was the reason they ought to limit the number of sexual encounters they have as young men to ensure they remain with some power for later life.

Good sex therefore required both, an adequate supply of physical strength for vigorous and prolonged intercourse, and a sufficient quantity and quality of bodily fluid ("blood") for pleasurable exchange. However, the ageing process was understood to gradually deplete men and women's finite store of bodily strength, as discussed in Chapter 3, as well as their store of blood. In older age, the quantity, strength and flow of blood decreased, reflecting the decline of a body's potency and life force. This decline was evidenced by, and embodied in, both the menopause and erectile dysfunction. The menopause was considered a sign from God that a woman did "not have enough blood in [her] body, [she] has already lost a lot of blood" and therefore had no more of blood to lose [Zione, female, late 70s/early 80s, widowed].

Erectile dysfunction on the other hand was understood as evidence of the drying of blood in old age which, containing less life force, was not "running normally", but instead congealing around and "coating" the nerves in the groin (*chinena*) [Robertson, male, 80s, recently married].

Extending the discourses about ageing explored in Chapter 3, old age was therefore conceptualised as a time of infecundity, drying and coolness. Old bodies were unhealthy bodies, described as being "not fresh", "rotten" and "of no use". Young bodies were, in contrast, hot, fecund, healthy bodies. Subsequently, although desire for pleasurable sex was considered innate and universal, old age limited the ability to act out these desires:

> *Some people are cold because of ageing, if they need a woman the body doesn't respond… When a man has a desire for a woman and he fails to make sex with her. There we say the hotness in that man is finishing… [he's] cold. But for the young man, they have fresh blood and they are hot… [but old men's] strength is finishing.*
>
> [Danger, male, mid-70s, married]

Some respondents reported experiencing declining sexual ability themselves. In the following excerpt, married couple Yotamu and Ruth, discuss their diminished ability for sex. Comparing themselves to the young who are still "fresh", Ruth comments that her husband can no longer "do anything", while she herself "can't manage":

> *B I married and have 8 children*
>
> *I Do you want to tell me that this time you can also produce children?*
>
> *B Mmmm [3] I am very old*
>
> *I What about you Yotamu?*
>
> *E I am also very old [3] I will just be sleeping with my wife without having sex*
>
> *I Father, do you want to tell me that you are just sleeping without dreaming for sex?*
>
> *E Mmm*

B Mm - *this one is very old he cannot do anything…I and my husband we are all very old we just sleep together without enjoying sex…When you are still fresh sex is important… [But] I am very old, I can't manage as I have been doing in the past…I can advise the youth to do sex because it's very important [3] that's life.*

[Ruth, female, late 70s and Yotamu, male, 80s]

Male and female respondents reported declines in both the vigour, and more commonly, the frequency, of their sexual encounters as a result of their or their partners' changing abilities. In the following examples, Thomas discusses a decline in sexual contact between him and his wife as a result of his loss of strength while Rhoda extends this narrative, explaining that imbalances in sexual partners' strength can cause sex to be painful to the weaker partner. Like Thomas, she reports that her husband and her now have what she regards to be infrequent sexual contact ("we do not do sex. Maybe we do it once in a week"). Both respondents report that sexual vigour declines with age, Thomas noting that sex becomes less hot, and Rhoda that sex is less forceful.

For the old person the strength is lost and is a little cold. The strength is lost to others… When they say someone is hot it means that at first he had much more strength than he has now. A person can enter his house[27] *and when he does the chat [has sex] the strength comes the same time. And there are other people when they enter into the house, it takes time for them to decide and when they decide [to have sex] it takes the time to have strength…There I am not talking of other people, but I am giving an example of what happens in my house. Sometimes you are strong and other times you don't have the strength… If I do today it takes many days without thinking about the woman. But in the past if I enter, I was doing it more often. That is the difference… That time I had much strength, but now I have lost some strength.*

[Thomas, male, 60, married]

[27] As noted in Chapter 2, houses are used only for sleeping and sex. Therefore "entering the house" carries sexual connotations.

As of now, we are just sleeping, we do not do sex. Maybe we do it once in a week, and my husband goes to sleep with my co-wife, and maybe he sleeps once in a week there. Like in the age I am, if I got married to a boy who had strength, I could go to the hospital with sex because I have no strength, and he can come with force in sex.

[Interview 1]

The boys are too strong, they have the sexual desire more often: in the morning, in the afternoon, in the evening, early in the morning. So if you don't have such energy will you not fall sick? There are some, when their man sleeps without having sex [with them] they say 'the marriage is over, what type of a husband are you?'… [But if the man is strong] you can get injured [because] the man becomes more powerful when he is about to release the sperm, so if you don't have the sexual desire you just feel the pain.

[Interview 2]

[Rhoda, female, 56, polygamously married]

Since a body's strength and power were finite and limited, and sex was considered to require strength and power, respondents sought to manage the declines they experienced. For some respondents, this involved balancing 'bed work' against other work tasks, such as farming and housework. Motivated to avoid becoming dependent on familial networks, these respondents believed that it was more important to use their limited strength for farming than for sex:

People tire each other [through having sex]. The issue is dangerous. After sex if people are not strong, they cannot go to work in the farm the next morning, they will be tired. But those who are strong, they can do it and then go to the field…We should say it is the old people who get tired more than the young people. That is why [old people] do it only once in a while.

[Esnart, female, early 70s, single]

However, since sex was regarded to be pleasurable, this involved a difficult trade-off:

You have to know that sex is work on its own. After the sex the following day you feel [weak] like [you have] malaria…you feel sweet [during sex] but after the sex you feel like you are sick.

[Rhoda, female, 56, polygamously married]

Other narratives therefore focused instead on maintaining the ability to give and receive sexual pleasure, noting that limiting bed work for farm work went against human nature. As Youngson explains:

R When you do sex in the morning you are unable to work

I Mmm, does that happen to you?

R Yes I feel lazy in the whole body

I After the sex, the following morning you don't work?

R I don't work, I am telling you, I just stay and I wake up late. I just feel lazy.

I So does that not make you think of stopping having the sex?

R No, its nature, it is not possible [to stop]. I will still be doing once in a while, yes.

I: There is no problem, even you don't work the following day after the sex?

R: No problem, there is no problem

[Youngson, male, 70, married]

Based on the understanding that power was finite, decreased with age, but was required for sex, respondents' narratives oscillated between the receiving and giving of blood during intercourse, in order to either strengthen or prolong their sexual ability respectively. For some respondents, the "vitamins" received from male and female sexual fluids became especially important in later life, as their strength-giving properties could compensate for some of that lost due to ageing. For Rhoda, having "a man" was definitional of a successful old age since "when you sleep with your husband, you feel so fine because they share to you their blood which strengthens your body". Having been strengthened by the "vitamins" received and heat created during intercourse, respondents' sexual abilities were fortified. In the following

example, Nyuma blames not having a sexual partner for her declining sexual desire and strength:

> *R Like me, I am only using my blood, the man's blood is no longer there, it is finished.*
>
> *I If you had a man, would your body have improved?*
>
> *R Yes… I am saying the truth. I would have changed. If I had a man, we would have shared, your body you share with me, and I share mine with you. If we agree each other [have sex], you would have grown fat and I would have grown fat. So with a good diet, people would say, there goes a woman.*
>
> [Nyuma, female, 68, single]

Other respondents however focused on stemming the loss of "blood" from sex in older age. A small number of male respondents discussed limiting sexual frequency within marriage, and in particular, avoiding the use of *manpower* (so called 'Herbal Viagra') - herbs that would in fact only concentrate a man's remaining strength into a few sexual encounters leaving him empty in the future. However, male and female respondents more frequently discussed avoiding *chiwerewere* (illicit sex, in this case, outside of marriage) in older age.

There were a number of warnings about the dangers of *chiwerewere* for men and women reported in the interviews. Some of these warnings were based on the simple correlation between loss of blood and the increased sexual frequency having an extra-marital partner was universally understood to involve. Accordingly, older men and women should avoid *chiwerewere* since their weakened bodies and lower reserves of "blood" could not withstand further losses. Doing so would "finish" an older adult prematurely:

> *Those who do much* chiwerewere *grow very old quickly… Us old people, if we do much* chiwerewere *we finish very quickly…If you don't want to look very old avoid sleeping with many men… you will be finished.*
>
> [Polly, Female, 60s, newly married]

However other warnings, particularly for men, focused on the mixing of sexual fluids of different temperatures during intercourse. The commingling of these incompatible fluids was considered to be dangerous, causing the cooler partner's blood to weaken and their fecundity to decrease. In all the stories respondents recalled, the extra-marital partner had hotter blood than the married participant.

For example, Robertson was in his 80 and a *sing'anga* [herbalist and healer]. He reported seeing many men, usually while still in their 40s, who having had *chiwerewere*, no longer had powerful blood. Their blood has been lost because their lovers were "hungry" for sex, and subsequently released their dangerously hot sexual fluids before the men could release theirs to cool them. He explains:

> *But some women can kill a man, if you find someone who is sex hungry - who has stayed for a long time without sex. During sex she will be the first one to release her fluid before you release the sperm. You can become ill. After having sex with such a lady he could even have so much pain when passing out urine he could cry. Because she has released first, and a man needs to be the first [so that] when she is releasing you have already cooled her… Because you have released first and this makes her slow to release because by then she is already satisfied. She has no strength to release quickly.*

It was to avoid the dangers of losing strength in this way that Robertson himself reports getting married shortly before we met him. Noting that "if you are faithful you retain your strength", he presents marriage as a way of ensuring continued sexual pleasure ("freedom"):

> *I made up my mind to get a wife. So that we should be farming and getting food which we will be eating together. I didn't want to do* chiwerewere *because I am an old person and I would be finished. It was a way of caring for myself. I wanted freedom.*
>
> [Robertson, male, 80s, recently married]

Although declining sexual strength was met with concern, and often disappointment, it was accepted in long-term marriages. Men, but much more frequently women in my sample, reported that while sexual dysfunction at younger ages would most likely

have signalled the end of their relationships, the love developed over years together meant they would continue in their relationships when their spouse was no longer able to please them sexually. In the following example, Esnart speaks fondly of her now deceased husband and her acceptance of their changing sexual relationship.

I What about in bed, people say 'a man never ages'

R For me he does, maybe [not] to other people. In my marriage a man ages. After I gave birth to our last born, he was just looking at me. We reached a point where we were sleeping on different mats. I know that a man ages, [but] I don't know what happened. So I just said 'I have lived with him, he did it when he was able to do it, I can't force him to do it'. So I too just started getting used to it. I didn't even tell people that my husband is failing in bed, why would I expose my old long-time husband?

I When he was not asking you for sex how did you feel?

*R [Laughs] When he wanted to joke, he would say '*anganga*, I don't have the desire for a woman as I am now, I don't know what the problem is'. So I was telling him 'it is OK, what will we need sex for? We are not young people; it is enough that we have had it'. He would ask, 'what about you?' I would say 'no, don't worry, my heart is OK'*

[Esnart, female, mid-60s, single]

This acceptance was more likely if a spouse had avoided *chiwerewere* throughout a lengthy relationship because the loss of "power" could then be conceptualised as the result of having shared bodily resources. In the following example Rabson explains that his wife cannot complain about his loss of sexual strength since she is responsible for having used up, and benefited from, his sexual fluid over the course of their marriage.

I The power reduces naturally as you grow older. For example in my case, a month can elapse without having sex. The power is no longer in me.

I How is sex important to married couples?

R It is good, but to us who have stayed in marriage for a long time, since 1961, it is not as important as it used to be. We are just friends now,

> *we have both developed grey hair. We are no longer in marriage but friends. Nowadays even if I stay for ten months without having sex, she cannot ask me why. She knows she is the one who finished the food from me.*
>
> [Rabson, male, 75, married]

However, since sex was considered to be a necessary element of marriage, all respondents reported that sexual inability in older age would hinder developing or maintaining newer relationships. These discussions were frequently accompanied with citing a much-used proverb in this matrilineal area, that "a man doesn't leave his home for [just for] *nsima*", both men and women suggesting that it was the opposite sex who would insist on sex. For example, Wyson's longstanding wife had died six years before we met him. He had been married once, and unsuccessfully, since. Throughout our conversations he returned to the breakdown of his latest relationship, reporting to have been "chased away" for "failing to perform". For him, erectile dysfunction made any future relationship impossible since "the penis is the owner of the friendship [marriage]" [Wyson, male, mid-80s, single].

Similarly, Nyuma talks about feeling undesirable and not being able to marry again:

> *I can't manage marriage. I have written it off, I have rubbed it off, about marriage in my life... I don't need a man now, my body parts are now dead [laughs], what will he get from me?... Can you find such a man [that doesn't want sex]? Do you have them in this world? Who can just keep a person like a bottle, is that true? Are you telling me the truth? [Laughs]... He will come, the first day you will sleep on different beds. That is my bed, and this is for the children, so he will sleep here, and I will sleep there. Another day he will say, did I come here for this?*
>
> [Nyuma, female, 68, single]

5.1.2 Contrasting narratives of sexual desire

Unlike sexual strength, which was universally understood to eventually decline in old age, the data contain contrasting narratives regarding the decline of sexual desire. The following excerpt from a focus group interview highlights this:

I What do you think are the qualities of an old person?

R[1] An old person like some of us, we can live without wanting to have a man for marriage [sex], but others!

I My mother here said 'one of the qualities of an old person is that they don't want to get remarried'. Do we agree with her or not?

R[2] It's true when a person get older, the sexual desires become weak . It is different from someone who is 18 years to 30 years

R[3] Aaah! I can say it is true, but also it cannot be true. It depends on the person. You may have a 60 year old person[28] proposing for marriage. For example a certain old man sent me to propose marriage to a certain old woman [on his behalf]. The man is very old, but he still wanted to marry, so it depends on the person.

[Kondwera Support Group members, male and female, all over 50 years]

My analyses indicate a relationship between narratives of sexual desire and those of sexual strength. For those respondents who asserted that sexual desire was innate, it could not be diminished even in very old age. As Youngson explained, "a fisherman is always a fisherman". Subsequently, declining sexual ability to act on this sexual desire resulted in a painful old age. For Youngson, as others, it was a source of frustration:

I So grandfather how do you differentiate sex nowadays and sex those days?

R There is a total difference

I How do you stay nowadays?

R I struggle

I But you still want the sex?

R Yes why not? A fisherman is always a fisherman

I And some other times you do have sex with your wife?

R Yes why not? I don't last a month without fishing

[28] As noted in Chapter 2, respondents typically did not know their birth years. Here, as in a number of interviews, reference to chronological age 60 is simply reference to someone of advanced age, and specially, older than any of the group members.

[....]

I So is ageing good?

R Ageing? Ageing is not good. We grow old but ageing is not good

I In future do you want to grow older than this?

R I don't want

I Why not?

R I want to be having sex some other days

I You don't want to grow old because of that only?

R Yes and some other tasks at home

I You also said that you are losing power as you are growing old

R Yes

I How does that affect you?

R I am affected. I get annoyed this time because I am ageing. Yes I get annoyed...I should be like a young person... If it is dying, I should die at this stage [of ability].

[Youngson, male, 70, married]

A number of respondents discussed older men and women who "refused" to be called *agogo*, a respectful address for adults in later life. Although no respondents personally knew of anyone to have done this, all were confident that they existed. In their reports, the older men and women in question continued to have strong sexual desires and refused the title in order to attract sexually vigorous younger women and men because partners their own age had failed to satisfy them:

They think that if they are called agogo *the boys will not propose them… They want to be having sex with the boys. They feel that men of their age have not enough power. Eya! Because when having sex when one is getting old, he takes long to release his sperms. But the boys are strong and fast. So that is what they want.*

[Rhoda, female, 56, polygamously married]

However, respondents who reported declining desire for sex forwarded declining sexual ability as both its cause and consequence. These respondents, most of who

were without a sexual partner, reported having no sex, or having sex very rarely. Since "to enjoy sex and feel its sweetness it means you put your whole heart in it" [Mercy, female, 50s, married], declining sexual frequency was a proactive response. At the same time however, just as having sex produced heat, abstaining from sex was widely understood to "cool" a person, and declining sexual desire was in turn a passive response to declining sexual frequency.

5.2 Experiences of sex

These broad discourses about sexual desires and strength were played out in individual narratives in which some respondents spoke of "finishing" with sex, others of being still potent, while still others oscillated between each position across their interviews. By situating these narratives within both, respondents' understandings of sex set out here, and respondents' understandings of ageing and identity set out in last chapters, two dominant themes emerge. Firstly, that sexual ability is demonstrative of "power", productivity, and the quality of being alive that is aligned to the meanings of physical productivity held in the identity standard of the adult. Secondly, that refraining from sex in older age is demonstrative of wisdom and coolness that is aligned to the meanings of social and moral productivity held in the identity standard of the 'idealised' adult: the elder. In light of these two themes, respondents' competing narratives about sex can be understood as distinct discursive strategies through which they negotiated ageing. I will first elaborate each of the themes before exploring how they shaped respondents' presentations during interviews.

5.2.1 Sexual potency and personhood

Good sex was understood to involve the passing and mixing of warm, compatible and potent sexual fluids between two healthy bodies. To desire sex was healthy and sexual ability demonstrated the life force of an individual. Only those close to death were so emptied of "blood" and heat as to be fully beyond sex. To desire sex and

deliver and receive sexual pleasure was therefore to be alive; to be a person. Anyone requiring herbs to increase their "sweetness" were "already failures", they were "finished" people.

The association between "blood" and sexual ability aligned it to a more general sense of productivity and contribution. This is highlighted in the name given for infecund men: *gojo*. The term translates as "impotent" but also "unproductive" more generally. Respondents' narratives alternated between discussing sexual and physical limitations. For example, asked what has changed in his own life, Fiskani first discusses his experience of declining strength for work ("I was cutting the wood, but now I can't") before moving discussion to talk about other older adults who experience declining sexual ability ("they are defeated in the house"). He notes that he has not experienced this himself ("I haven't been defeated in the house") despite his weakening body:

I What has changed now that you are getting old?

R I was strong in the past, I was dealing in curios[29]*. I was cutting the wood, but now I can't.*

I You were carving?

R No, I was getting the wood on which the carver would work, we used to fell trees like this one

I So you can't do it now?

R So, it has happened because, I am now old. My body is weakening, I can't manage to do that.

[…]

I What are the things that makes you feel you are an old person?

R Oh-ho, it's like when a person says they are defeated in the house [have sex]. When it comes to [bed]works, they don't work; they just stay like a child

I What works?

[29] Typically, wooden carvings sold to tourists at a site about 15 miles from the respondent's home at the intersection between the main road connecting Blantyre and Lilongwe and the road east to Lake Malawi.

R In the bedroom. You start behaving like a child, they tell you do this and that, people do things for you.

I Have you reached the age where people are doing things for you, and you are defeated in the house?

R No, I haven't been defeated in the house

[Fiskani, male, 61, married]

Although other respondents, particularly unmarried women, reported being "finished" sexually and instead were "concentrating on farming", Fiskani presents sexual ability as the 'final strength' – the behaviour that separates him from the very old. Declining sexual ability is presented by both Fiskani and the interviewer as an experience of older age – a future stage ("you start behaving" "have you reached the age"). This presentation was shared by other married respondents who noted decline in their ability to work. Echoing the narratives of adulthood documented in Chapter 4, men and women who could not perform sexually were regarded as being "useless" and "like children". In the following extract, Esnart questions her personhood in light of her changing body and the shift from both feeling sexual desire ("itch[ing]" for sex) and inciting desire in others (by "shaking" her body) to feeling little ("you just stay"):

OK, in the past - let me talk about the past. In the past when I was walking, I could shake my body properly, I was proud, every part was shaking. Yes, every part, I knew I am a person [laughs]. But now when I walk, I say better I reach where I am going. I don't shake my body. When I am sleeping my body doesn't itch that it needs a man. Because when you are fine[healthy], and you are sleeping, you wake up, and feel something itching to tell you, it needs a man. Then you know if I had a man, I would have done this [sex], but now it is not there, you just stay… I am just staying as a child.

[Esnart, female, mid-60s, single]

This questioning of personhood applied to men and women, but was most common from and about men who experienced erectile dysfunction or retarded ejaculation. Although interview narratives did not distinguish between the need for male and female potency and strength with regard to achieving pleasurable sex, my analyses

do suggest a somewhat gendered link between virility in sex and understandings of masculinity. Indeed, the Chichewa word *umuna* and Chiyao word *ulume* refer to both semen and manliness. Older men who experienced decline in their sexual functioning repeatedly questioned their status as "men" and were insecure about their abilities to maintain successful relationships.

The beginning of our first conversation with Wiski, introduced in Chapter 3 and discussed above illustrates this well. He has been asked simply "since that time you were born, up to this time, what has changed on this earth, in the world, but so too in your life?" He firstly agrees with his family's diagnosis that he is unable to farm and is hence childlike. However, unprompted, he continues to focus on his sexual ability. This, and his return to the subject throughout our three conversations, reflects the salience of this experience for him:

> *R The time I started realizing that the world is changing, was the time Muluzi was elected. During Kamuzu I was able to farm. But since Muluzi was elected, since that time, the time Bingu was elected, no.*
>
> *I What has really changed?*
>
> *R What has changed is that I am not able to do things. I am not a man enough. I am not a man enough. Even women, they are all like my sisters, or mother. Yes I am just like that.*
>
> [Wyson, male, mid-80s, single]

I therefore suggest that as with work (associated with physical productivity) explored in Chapter 3, the potential to give and receive sexual pleasure (associated with reproductive productivity) was behaviour associated with the identity of a valid person - an adult. Further, it was tied to understandings of being a "real" man or woman.

5.2.2 Sexual restraint and the idealised adult

Despite this linking of sexual ability and the essence of living (being a person), limiting sexual activities was associated with being wise and appropriately 'cool'. In particular, respondents talked of avoiding *chiwerewere* in older age. Although this

ostensibly accords with previous research regarding appropriate sexual behaviour for older adults (Van der Geest 2001), in rural southern Malawi, this did not reflect the much-documented idea of an asexual older age (Gutsa 2011; Nyanzi 2011; Owusu and Anarfi 2010). Instead, my analyses indicate that it was the positive attitudes to sex at all ages and the health implications of *chiwerewere* outlined above that underpinned this position.

Chiwerewere was dominant in respondents' discussions of sex throughout the life course and believed to be frequently practiced at every age. Since sex was regarded as natural and God-given, the desire for *chiwerewere* was widely understood to be a 'fact of life'. Polly notes that since sex is "nature, created by God. Everything has its own food. Eyes see, a mouth has a tongue, teeth. Everything was created for its purpose so every part of the body should do its work. That's why some old men do too much *chiwerewere* [laughs]. Some people attend to it [sex] very much, but others not" [Polly, Female, 60s, newly married]. For Patuma, sex outside of marriage was simply "unnecessary intercourse". Indeed, although male and female respondents who had experienced their spouses' adultery were vocal about the emotional pain it had caused, presenting their adulterous partners as underhanded people that used lies and witchcraft to manipulate others, two respondents (Madalitso, female, early 50s, single and Steven, male, 56, married) discussed the secret love affairs they were currently engaged in. They discussed their relationships openly with my research assistant, noting who else in their social networks knew about their affairs. Although they had ensured their relationships were hidden, their discussions were marked by a humour and light-heartedness that implied some level of social tolerance towards such 'weaknesses'. Interestingly, Steven was the most vocal respondent about the intense upset his deceased wife caused him when she had an extra-marital affair some years before her death.

However, despite some degree of tolerance towards those who engaged in *chiwerewere* in these data, there were a number of warnings about its dangers. The receipt of hotter blood could weaken the cooler blood of the older, married recipient, causing them to lose "power". It could also cause the death of the sexual partner receiving the hot blood, or the death of a family member through contamination. For

example, if a man engages in *chiwerewere* with a woman who has recently given birth, the commingling of their blood causes *chinyera/kanyera*, a potentially fatal illness if treatment is not sought from a *sing'anga*. Further, extra-marital *zibwenzi* could also harbour infections in their blood: syphilis, gonorrhoea and HIV were frequently mentioned. In the following extracts, Rhoda, discussing her co-wife, and Charles, talking about his recently deceased brother, assert both, that older adults engage in *chiwerewere*, and that they are at risk of these traditional (*mdulo*) and clinical diseases caused by sexual contact. Rhoda explains that she may be at risk of HIV infection through her co-wife's sexual activity outside of her martial relationship:

> *In nowadays it's different from the past, because as of now we have several diseases [in Malawi]. Some of them have no cure and are very dangerous. That is the HIV/AIDS disease, because in the past we had gonorrhoea, syphilis, and when people were affected, they were cured by medicine from the hospital and even the herbs from herbalists [2] And even I myself, I tend to worry about that disease [HIV], because my husband has polygamous marriage. I myself I can try to be honest to my husband, but I don't know about what my co-wife is going to do, since others they don't stop having* zibwenzi *even when they are old aged.*
>
> [Rhoda, female, 56, polygamously married]

Charles explains that his late brother died because he contracted some *mdulo*, possibly *chinyera* (usually associated with having sex soon after childbirth), after having sex with "different women" to whom he was not married:

> *I Were you also close to your late brother, Juma?*
>
> *R I was very close to him… I was older than him by maybe three years*
>
> *I It was him we had originally come to talk to[30] and we were so sorry to hear that he had died. What happened?*
>
> *R He was ill. God had sent him the illness. Then he died. […]*
>
> *I Oh, if possible take me through from his illness until when he died?*

[30] Juma was sampled from the MLSFH-08 respondent listing. He had died in the interval between our visit in 2009 and the MLSFH survey.

R He started complaining and he became ill

I What was he complaining about?

R He was complaining about his body and sometimes in his groin

I What did he say about his groin?

R He was feeling pain […]

I Did he not say how the pain started?

R It was the things from the women

I What about women? […]

R He slept with them and he got those diseases

I What was the disease he was suffering?

R I don't know if it was chinyera *or something else*

I Was it chinyera*?*

R I think it was.

I Did you not ask him privately so that he could express himself about it?

R No, his movements were questionable that time.

I When I asked you if you were close to him, you said very much close to him. If there was someone he could have told about the illness, I think it was you. So he did not tell you?

R I think he was ashamed of it… It has taught me to have self-control and avoid sleeping with different women.

[Charles, male, around 70, married]

Despite the dangers of *chiwerewere*, the joy of sex and naturalness of desire meant that refraining from it was difficult. The case is neatly illustrated by Robertson. As a *sing'anga*, more aware of the health consequences of *chiwerewere* than most, he goes on to acknowledge that since he is "a living person", there is a risk he may not resist the temptation:

R If you want to have a good life then you have to have a wife at a time. Again if you keep on marrying different women you will still face the bad blood. And you will notice that the woman will be growing fat

[having received ejaculate] and you grow thin [having given ejaculate], and this causes death in people.

[Interview 1]

R *The old men see that the private parts of old women are very old and they want to try fresh private parts. And when they are doing sex they say they are doing it with nice private parts, but they don't know* edzi *[HIV] is hiding in such private parts... when he reaches his home he starts feeling unwell."*

I *Do you have worries that you might get* edzi *in the future?*

R *I don't know if I will get it. I might get it by accident because I am a living person. I might travel and meet a lady whom I can fail to control myself with, I might get it through that. These ages are the ones having* edzi *[points at a teenaged girl walking by]. A man can be attracted by the straight breasts.*

I *Umm, have you ever done something to stop yourself getting* edzi*?*

R *I have done nothing. It might happen to me because I am still alive.*

[Interview 2]

[Robertson, male, 80s, recently married]

Previous studies have highlighted continued sexuality in older age against a backdrop of social-sanctioning of sexuality in old age (Gutsa 2011; Nyanzi 2011; Owusu and Anarfi 2010; Van der Geest 2001). These data suggest a more nuanced situation in rural Malawi in which fear of physical rather than social harm controlled sexual activity in older age. Sex with multiple partners was understood to be unwise, rather than socially unacceptable. Respondents reported that while being "movious" [promiscuous] was considered foolish, it did not necessarily make someone disliked or disrespected. Refraining from *chiwerewere* therefore demonstrated wisdom and sagacity. It could only be achieved by a model adult, the 'elder' introduced in Chapter 4. Interestingly, in these narratives it is *chiwerewere*, rather than sexual inability, that is consistently referred to as being "childish":

I *Meaning that even before you have never engaged yourself in* chiwerewere*?*

R *We just hear*

I Those time you were not doing that?

R No we were doing it, but when we reached a certain stage, like the way things are today, so we stopped there…

I So why did you stop such behaviour?

R I saw no importance in such behaviour... It was a youthful stage.

[Thomas, male, 60, married]

My analyses suggest that respondents aspired to the positive identities of the physically and biologically productive 'adult', 'man' and 'woman' set out above and in Chapters 3 and 4. However, the decline of bodily and sexual strength in older age challenged the relevance of these identities for respondents. These respondents could not align perceptions of their behaviour with the meanings of the behaviour required by this adult identity standard.

In light of this, the sexually-restrained elder outlined here presented older men and women experiencing (or expecting to experience) changes in their sexual capabilities with an alternative positive identity. This identity recast a lack of sexual activity, or declining sexual frequency, within a discourse of wisdom and socially-valued self-control. In doing so, ideas about what it meant to be an adult, and what behaviours are associated with that identity, shifted. As in the narratives presented in Chapter 4, the adult identity became dissociated from the body and its power. The identity standard instead included acting in ways that could perhaps be considered 'morally productive'. By demonstrating wisdom and restraint, these respondents presented themselves as 'model adults'.

Let us return to Fiskani as an example. The extract quoted above from our first interview with him saw him discussing his declining bodily strength for work, but continued sexual strength for sex. Although he talked about his morally- and socially-productive behaviour, this was not in the context of bed work: he was physically-productive 'in the house'. We visited him for a fourth time in 2010, nine months after our previous interview with him. This time his answer to the question is quite different:

I Ok, last year you told me that as you are getting older things have changed in your life. What is it really that you have changed?

R The way I was doing things in bed. They have now gone down.

In the rest of the interview, Fiskani discusses his increased wisdom as he has aged. The idealised elder emerges:

> *To stay without* zibwenzi *is good because you have a healthy body because you are not going somewhere else where you can lose your blood somewhere […] What I see at my age is that I now can keep myself [abstain]. I avoid a lot of things, I don't quarrel with people, so your life is better.*

5.2.3 Sexual identity in old age

Throughout the research conversations, men and women reported past or present behaviours in ways that aligned themselves with the physically-productive or socially-productive, idealised adult. I argue that respondents altered the perceptions of their behaviour in this way in order to maintain these identities when their bodies limited their behaviour. This analytical position makes sense of the respondents' contrasting, and sometimes contradictory, presentations of their behaviour during the research conversations. To illustrate these presentations and explore how they were enacted, I present three case studies: Winford, Nyuma and John. Of all respondents, these three most clearly demonstrate the presentation of behaviour in ways that fit with a positive identity. Both strategies - stressing sexual potency and stressing wisdom and sexual restraint - were used by male and female respondents.

5.2.3.1 Stressing sexual potency: Winford and Nyuma

<u>Winford</u>

We met Winford sitting at his house alone. He reported that his 6 children and 102 grandchildren and great-grandchildren were at school, their farms or resident elsewhere. Aged in his early 80s, he struggled to walk but could still farm. He

keenly showed us the area of his garden that he had cleared for planting maize that morning. He was a pastor of a Full Life Gospel Church of God chapel, a small mud building a few metres from his home.

Four years after the death of his first wife, around 2004, Winford had married a woman in her 50s. The marriage was arranged by friends who saw he was working alone and sought a wife to assist him, though he agreed to the match because he "had the [sexual] desire for a woman". The marriage ended quickly and badly; Winford reported that "she just wanted [his] money". In the end Winford left her, returned to his home and had started to think about marrying for a third time:

I Okay, when you left your second wife, did you have a desire to remarry?

R At the moment, if I want to marry, I can definitely get married… Ooh, yes, I can do that.

I What is preventing you from getting married now?

R I want to farm as I have done now, I just want to see how much I can make [from the sale of his cotton], then I can decide after knowing how much I have

I Suppose you have found the money you are looking for, will you find another woman and marry her?

R Aaah, yes, very much so. Very much so, very sure.

I There are other people who say that, when a person becomes old, sexual relationships are not important. What about you?

R [Laughs] It is the way one is born. It's one's strength. It depends on the person's strength. Some still want to have it [sex], but others don't, they just stay… My strength has not gone down

[Interview 1]

R There are two types of old age: the first one is where you do not have a desire for a woman, that's being old, then you are finished. There is another type where you still have a desire for a woman, it means you are not old yet.

[Interview 2]

In 2010 we visited Winford again to find out if he had indeed made enough money through the sale of his cotton to find and support a new wife. We were informed that he had died at the end of 2009, four months after we had last visited him.

Nyuma

We met Nyuma through her HIV support group and visited her four times for interview at her home. Her husband died five years previously. She lived with her daughter and grandchildren; her three sons all lived elsewhere with their wives. She lived in a small house of burnt bricks, above which a patchy thatched roof was very close to collapse. Nyuma knew her age to be 68 years old at the time of our first visit. However she looked considerably younger than other respondents and aside from her managed HIV infection, was in good health.

In our first conversation, Nyuma said that she did not want to marry again. Understanding that marriage necessitated sex, Nyuma reported that her "body parts are now dead… The desire for sex has died". When we met her a second time however, there was a subtle shift in Nyuma's narratives as she clarifies that it is only her and not a potential partner who had "written off" her body:

I People say a woman who has stopped menstruation also ages fast?

R No, she doesn't age fast. I stopped having menstruation after the birth of my daughter but I take care of myself. Do I look very old?

I No

R So it's not that you have stopped menstruation, but when you don't take care of yourself. I bath.

[…]

R On your own, you can't know you are cold. If there is anyone who says so they are telling a lie. As you are walking, you can't know that 'I am out of fashion'. But you tend to overlook yourself. You say 'the way I am, if I take my friend, aaah! Mmm I am tired of it [sex]'. You just underrate yourself, not that when a man comes, he will not do his work [have sex with you], only that you underrate yourself.

[…]

I You talked about men coming here to ask you for sex in the night, when was the last time this things happened?

R Last year and this year… Last month... There came a man, a very old man… When he came, he said, 'odi![31]Eee' I responded, thinking maybe he has something to say. Then I opened, and he said 'I want you'. I asked 'what do you want me for?'. He said 'I want to sleep with you'. I said no, then he took 20 kwacha and gave it to me, I said 'no, eee, okay you can go'. I took the money to his wife. I told his wife, 'your husband gave me this money, he says he wants to sleep with me but I don't want'.

At other times during our conversations, Nyuma returns to her previous desire and potency:

R The time when I was a young woman, when I sleep, I had a very big desire for sex. If I see a man passing by on the road, I would feel as I could go and grab him, wanting him to sleep with me. But now? Nothing. My desires are dead.

[Interview 1]

I When you were young you had the desire?

R Yes, I had it very much, I would even ask a man to sleep with me, if he refuses I was undressing him! […] I was a good looking woman… I had the desire

[Interview 2]

In the two case studies Winford and Nyuma present positive identities. Winford continually reasserts his virility and power. He is explicit about his sexual capabilities, forwarding these in ways that are compatible with the productive adult identity. He offers no prediction of declining bodily strength or life-force in his blood, noting that he will marry again in the following year.

Nyuma presents a more nuanced case. She does not have a sexual partner and initially reports that she does not want one since her body is "now dead". However

[31] A greeting called out while at the edge of a compound equivalent to knocking on a front door in the UK.

her narrative slowly shifts as she hints that the image of a declining, ageing body she had given previously was her own self-effacing presentation in which she had "underrated" and "doubted" herself. She goes on to suggest that she was extremely potent in younger adulthood and is still desired by the men who come to "propose" her.

My analyses suggest that both Winford and Nyuma, like other respondents, were motivated to discursively align their behaviour, or in Nyuma's case, potential behaviour, with the behaviour held as standard for the identity of the powerful and 'alive', adult.

5.2.3.2 Stressing wisdom and sexual restraint: John

John, aged in his early 60s, lived with his wife in a shielded compound in the heart of his village. Across our five interviews with him, John's narratives continually oscillated between his declining sexual strength and subsequent frustration, and his demonstration of self-restraint and wisdom in older age. Similar rhetorical strategies were used by female participants. For example:

I *That day you said that the heart never ages but //*

R *// the body ages… Because the heart, when you stay you think, you see a girl with good breasts. The heart thinks that had it been the past this girl, I could have slept with her. But because I have aged, you see that the body has aged but not the heart… It is painful because you think, 'aha', you think of doing such a thing but the body fails […] So a person like me, even if I see the girls I just admire and it ends there. Had it been not for my age [trails off].*

[…]

R *The youth of today… they grow fast but with no reasoning capacity… But we [older people] we are able to reason … If you are not careful you end up in problems. You can be careful if you don't go around with girls. When you are afraid of them, abstain and being faithful, even if we have the condoms the important thing is abstaining. But my friends [the young] do not abstain…*

I What qualifies one to be an old person?

R It is first that person accepts the situation that he is aged, because there some aged people who behave like children. Like children, look at that old man he is busy with girls. That is not [old age]. But when you accept yourself and start behaving like an aged person, stop doing some other things. Sometime you are tempted even at old age but you have to reason to be out of such situations.

[…]

I You said it's good to be careful with women as an aged person can you tell me more on this?

R Yes it is possible, it is possible if you reason and know that I am not supposed to do this because I am an aged person, because at times it happens that you are not of the same age and energy. When having sex when you are not energetic enough and you become a fool to that child. So you say 'I don't have to look like a fool'. Do you get me? I am aged, I will look like a fool, because by the time you produce sperms it happens that the girl is tired of the sex. And sometimes you are even told that [by the girl] since that time you are failing to release sperms so you look like a fool, so it's better to take yourself as an aged person, do you get me?

Although John reports declining sexual potency, like Winford and Nyuma he attempts to present a positive identity. He attempts to present his declining sexual frequency in response to his declining sexual potency as a proactive strategy that demonstrates his wisdom in "accept[ing] the situation", "reason" and avoiding becoming "a fool". By directing each conversation away from behaviour that is not compatible with the productive adult identity and towards behaviour that is compatible with the idealised adult identity, John is able to circumnavigate the possible self, here the asexual very old person, emptied of blood.

Narratives regarding his frustration at his failing sexual strength and continued desire for *chiwerewere* are eventually incorporated into those regarding his wisdom for abstaining from *chiwerewere* in his discussion of manpower. For John (in contrast to other respondents), *manpower* presented the opportunity for him to follow his heart and have *chiwerewere*, and for him to then abstain from doing so. In this, abstinence

became a proactive strategy informing his identity, rather than passive response to inability.

Winford, Nyuma and John discursively maintained positive identities during our conversations in which they were able to present themselves as 'valid' people – adults capable of productive or moral contribution. In doing so they were able to avoid the feared social imaging of a dependent, useless, childlike old age. In my analyses, sex is considered as a platform on which these age identities are both played out and constituted. For older men and women in this study therefore, sex was both, an essential - and often pleasurable - part of their lived experiences, and a salient part of how they understood and experienced growing old.

5.3 Summary

In this chapter, the first substantive investigation into sex at older ages in Malawi, I argue that understanding sex at older age requires reflection on the meanings of sexuality in the social, cultural and conceptual context of people's lives, as well as on experiences and understandings of 'being old' more broadly in this setting. The giving and receipt of sexual pleasure was considered innate and ostensibly universal. Primarily understood as a matter of strength, sex was on one hand beneficial to weakened older bodies, but on the other, not accessible to such bodies. Declining sexual frequency was associated with declining desire for sex, or frustration stemming from continued desire for sex. I have drawn links between these competing discourses by situating them within the understandings of ageing and adulthood outlined in Chapters 3 and 4. I have suggested that these discourses emerged from the way the ageing body was constructed as a weakening, failing body, incompatible with the adult identity, conceived as being productive.

I identified two responses to the subsequent dissonance, or potential dissonance, between behaviour and the desired identity. The first can be considered as an attempt to realign perceptions of (potential) sexual behaviours so that they fit with the adult identity. The second indicates a gradual shifting in respondents'

understandings of what it means to be an adult and which behaviours are associated with that identity. In this response respondents emphasised the separation of the body's "power" from the identity. Instead, the adult identity was associated with 'morally productive' behaviours such as wisdom and restraint, a more nuanced situation of social sanctioning of sex at old age than found in previous studies (and one that does not inadvertently perpetuate the much-cited stereotype of "asexual old age" (Scherrer 2009)). By forwarding these compatible moral behaviours, respondents aligned themselves with this alternative positive identity.

Chapter 6 | Neither foolish nor finished: Older adults' negotiation of HIV

Older adults in Malawi have witnessed two decades of the AIDS epidemic. Over this time local interpretations of "edzi" and responses to the epidemic have changed markedly (Watkins *et al.* 2007). At the time of data collection, prevalence of HIV among older men and women aged 50-64 using MLSFH data has been estimated as 8.9 per cent and 5.4 per cent respectively, compared to 4.1 per cent and 8.3 per cent among 15-49 years olds in the same sample (Freeman and Anglewicz 2012), and 8.1 per cent and 12.9 per cent in national 15-49 prevalence estimates for 2010 (National Statistical Office of Malawi and ICF Macro 2011). Data from the field site suggests that HIV prevalence is consistently over-estimated however (Anglewicz and Kohler 2009). When questioned as part of the MLSFH survey, over three quarters of all-

aged respondents in Balaka estimated that between 20 and 60 per cent of their communities were infected (MLSFH-08 survey data).

Messages about HIV prevention are widespread in rural Malawi, both from global and national actors, and at the local level (Tawfik and Watkins 2007). International messages, filtered through government and non-government agencies in the capital (Watkins 2004), were delivered to the rural field site through radio programmes, painted stone or wooden billboards on the main roads leading to it, and by religious leaders, village heads and visiting health workers. They focused on the 'ABCs' of prevention, calling on respondents to abstain, be faithful, use condoms – and in recent years, get tested. Interview data illustrate how these 'top down' messages both shaped and were reshaped in frequent gossip about HIV: who is - or was - infected, how they became so (via sex), how best to care for them ('with love'), who is at risk of infection ('everyone, if they don't behave') and how best to avoid to it ('self-control').

In 2005 free antiretroviral therapy (ART) became widely available in Malawi, transforming HIV from a debilitating fatal illness into a more manageable chronic condition. Its rapid scale-up changed the character of the epidemic dramatically. Ostensibly, an HIV diagnosis no longer implied an intensive but relatively short period of care leading to inevitable death. Adults infected with HIV in mid-life could now survive to be older adults, and with the possibility of regaining health, a whole range of responses to having HIV emerged. Uptake of HIV testing and the prevention of AIDS deaths showed rapid improvement and by 2006 could already be detected in mortality declines at the population level (Jahn *et al.* 2008). ART coverage has expanded significantly. By 2009 72 per cent of adults with CD4 counts of 200 cells/mm3 or lower were receiving treatment (UNAIDS 2010). However, access to ART remained limited by availability and accessibility (Angotti *et al.* 2011). Indeed, when Violet, healthy, fat and subsequently doubtful of the HIV+ diagnosis she had received two years earlier, asked me to take her to a clinic for HIV testing, we had to drive to two hospitals and a specialist VCT centre before we found

a practitioner with testing kits available[32]. Four years after initial roll-out then, the significance of ART for respondents' and non-respondents' (reported by respondents) understandings of HIV was inconsistent.

Conversations with older adults about HIV in the interviews represented the confluence of twenty years' of changing narratives about HIV, the longer-standing awareness and understanding of clinical and traditional diseases caused by, or transmitted through sexual contact, and the ethnophysiology of the body outlined in the previous chapters. Perhaps as a result, narratives were often contradictory. For example, respondents' positions on whether HIV was inevitable or preventable, whether treatments for HIV restored health or implied death "anytime", or whether or not the transmission of HIV involves blame differed within and across respondents.

In this chapter I explore the two most salient understandings of HIV for respondents' attitudes to infection in later life: that HIV is sexually transmitted, and that it weakens an individual's blood until they inevitably die. By piecing together disparate and often-contradictory conversations and thoughts about HIV, I suggest that these two interpretations have implications for the two dominant positive identities available to old adults: the physically productive adult and the morally- and socially- productive idealised adult (Chapter 4). The chapter then explores how older adults with HIV made sense of, and managed their infection in light of these constructions of HIV and adult- or personhood. In doing so it contributes to a sizable body of literature discussing how (all-aged) adults in African and non-African settings 'transition' from diagnosis and/or illness to living with HIV as a chronic illness (e.g. Frye *et al.* 2009; Russell and Seeley 2010; Tsarenko and Polonsky 2010).

[32] Even then I suspect Violet only got her test because it was a *mzungu* [white foreigner] asking on her behalf. We arrived at 11.55am, the counsellor had already locked-up for the day and was initially reluctant to go back to work.

6.1 Dominant understandings of HIV

In this study, conversations about HIV centred on its transmission and prognosis, reflecting other research in this setting among primarily younger adults and using different methods of data collection (Kaler 2004; Watkins *et al.* 2011). Interview narratives contained respondents' reports of their own and 'others'' attitudes and understandings, especially with regard to HIV in older age. Three themes are identified within these two understandings: that HIV is most frequently transmitted via socially unsanctioned sex; that HIV weakens the body, eventually causing death; and that HIV subsequently required intensive care.

6.1.1 The sexual transmission of HIV

When a body was returned from the hospital with a pair of protective gloves, the implications for cause of death and the importance of using the gloves when preparing the body for burial, was well understood in this population. The danger of "village injections" – herbal medicine dispensed using an unsterilized syringe – was discussed only in past tense. According to Patuma, "people are clever here for the razor blades". Indeed, the non-sexual routes of HIV transmission were well known, and considered easily surmountable. They were therefore largely absent in the dominant discourse about HIV transmission and risk.

Understandings of the sexual transmission of HIV shaped respondents' narratives and responses to the epidemic. *Chiwerewere* (illicit sex) and *uhule* (promiscuity) were at the crux of the epidemic. In respondents' narratives, individuals were infected most commonly through their *zibwenzi* (concurrent with a marital partner or not), though most respondents also recited stories about men and women who had left the village and "found HIV" in bars or trading centres (see (Tavory and Poulin 2012) for discussion of transactional sex in these settings). *Chiwerewere* also undermined the safety of marital sex by exposing an individual to the risk of HIV from their spouse's or co-wife's present and past *chiwerewere*, as well as, in the case of re-marriage, their new-spouse's former-spouse's *chiwerewere* (e.g. "So we heard

that a wife of [current husband] has been caught: She was having sex with other men in a bush [outside of the marital home]" [Mercy, female, 50s, married, HIV-[33]]). The growing insistence on HIV-testing before marriage reported by respondents indicated recognition of the relevance of past sexual encounters for those in monogamous contemporary relationships.

The centrality of *chiwerewere* for HIV transmission had implications for understandings of the inevitability of infection. This was frequently discussed in terms of "choosing" HIV. One set of narratives concerned the understandings of sex as both God-given and necessary in marital and *chibwenzi* [non-marital] relationships, as outlined in the previous chapter. Since sex could not be avoided, HIV risk was considered to be systemic in the context of (perceived) high HIV prevalence[34]. For example, faithful husband and wives who worked to satisfy their spouses sexually could still become infected if their spouse "spread [HIV] within the house". Moreover, even if individuals were able to abstain from sex completely, they could not avoid infection if it was God's plan for them. Nobody chose to have HIV:

> *[HIV] is from God ... because if you follow everything to prevent yourself from getting it, you can maybe have a complex situation, where you will need to help deliver a baby in an emergency, and there are no means of protection, you can get it, even though you have been very careful.*
>
> [Doris, female, 70s, single, HIV+]

In a second, more dominant set of narratives, the natural and near-universal desire for *chiwerewere* was superseded by the bombardment of HIV messages. In these

[33] Throughout the chapter, HIV status is included in the listing of basic characteristics of quoted respondents. HIV+ refers to HIV infection reported by respondents, rather than from MLSFH data. HIV- indicates the absence of respondent-reported HIV infection and therefore refers to respondents living as uninfected adults. There was no indication during fieldwork of any respondents who believed they had HIV not disclosing it to my research assistants.

[34] This discourse of "fatalism" has been identified previously among predominantly younger adults in the field site earlier in the epidemic (Kaler 2004)

narratives, individuals had agency with regard to acting on their sexual desires. Since "everyone" knew its transmission routes, HIV could be avoided by limiting sexual behaviour. Indeed, "lack of self-control" was frequently used as shorthand for *chiwerewere* in discussions about HIV transmission (in contrast to discussions about sex and ageing). Within this context, individuals who engaged in *chiwerewere* outside of their marital relationship had chosen to become infected with HIV, and often to deliberately infect their marital partner:

> *I think that if that person took heed of advice given about AIDS they would not have been in that situation [infected] because each time we go to the hospital even for* sikelo *[clinics for children under five] we are sensitized about AIDS. Even on the radio issues about AIDS are there too.*
>
> [Mercy, female, 50s, married, HIV-]

> *The first thing that [my wife] told me [when I told her I had HIV] was 'that is what you wanted, because I knew you were doing* chiwerewere*. You were leaving me here, and going out to look for other women, because of this you have what you wanted' [….] For me to tell my mother, it took- [2] I can say it took two years… A lot of people fail to tell their parents, because three quarters of us [Malawians] think that if you have it [HIV], it's like you chose to get it. And people say 'that is what they wanted, they got it from what they were doing'.*
>
> [Daniel, male, early 50s, married, HIV+]

Significantly for understandings of HIV in later life, an individual's ability to control their innate sexual urges was considered to be typically age-related. According to respondents, younger adults frequently engaged in chiwerewere despite being aware of the risk of HIV infection. They were more likely than older adults to employ narratives about the inevitability of HIV:

> *Young people can get* kachilombo *[literally virus, used to refer to HIV] easier, because they take things for granted. Like in the case of* kachilombo*, they just take it as a plague. They say everybody will die anyway, so they are very negligent about their life. But with old people we know we had similar disease before, like smallpox, which was later*

ended. We still believe one day edzi *will be no more, so if you take care of yourself you can have a chance to live on.*

[Patuma, female, 58, married, HIV-]

I In your village, how many edzi *deaths have there been?*

R There are very many like down there. The girls- girls they can number up to thirty. Thirty, all gone.

I Should we say the ones dying more are the girls or old people as well?

R The old people somehow, but mainly the girls…They don't listen when we tell them to go and get tested. They say 'what for? Let us all die', that's what they say. 'Let's all die'

[Stella, female, 70s, single, HIV+]

This reflected physiological differences between the temperature of old and young bodies (Chapter 5). Since sexual desire was concomitant to the heat of one's blood, and blood cooled with age, respondents reported that it was more difficult for younger adults to resist the natural call to chiwerewere:

When it's [HIV] found with a young person, they [say] 'let's put that aside'. They say with young people 'how could they keep themselves? They need to eat each other [have sex], that's nature.

[Esnart, female, mid-60s, single, HIV+]

[When younger adults are infected] people say it's obvious. Because at that age you have to do sex with a number of girls, and we used to do that too during our time.

[Youngson, male, 70, married, HIV-]

Nevertheless, respondents warned that times had changed. Despite the prevalence of other potentially fatal sexual illnesses in the past, HIV was recognised as having redefined the profile of acceptable sexual behaviour. Even younger adults could, and should, abstain from sex in ways that had not been necessary in the past. Some respondents (though there were exceptions) expressed sympathy for younger adults who could not enjoy the sexual freedom they themselves had had. This attitude has

previously been documented in this setting in data collected using ethnographic journals (Watkins 2004). Rhoda and Ethel explain:

> *Had it been that there is no disease we could have been allowing them to enjoy the way we enjoyed, but nowadays because of the disease that is no such enjoyment. There is* edzi *so there is a need to take care.*
>
> [Rhoda, female, 56, polygamously married, HIV-]

> *It's [HIV] a big problem unlike those days… People were engaged in immoral behaviour, but there was not this disease and people were not aware of the disease. Even during our time. There was not this disease [so] we were just playing freely.*
>
> [Ethel, female, late 80s/early 90s, married, HIV-]

Older adults were better placed than younger adults to recognise and act on this changed sexual landscape. Drawing on the identity of the fully matured, idealised adult – the elder (Chapters 4 and 5), respondents presented older adults as restrained and wise in their sexual behaviours. By limiting their sexual contact, older adults protected not only their own health, but that of their spouse(s), thus demonstrating compassion and love by providing for and protecting their family.

However, rather than reflecting a "cooling" of older adults' sexual desire as discussed, in respondents' narratives, older adults' restraint reflected their good judgment. In the following example John, categorising himself as part of the in-group of older adults, discusses his self-control in light of the danger of HIV. He explicitly distinguishes between older adults and younger adults ("those born in 1961"[35]) on the basis of their cognitive ("they don't even think"), social ("in turn they infect the wife at home") and sexual ("they do everything") behaviours. Throughout the interview John proposes that it is his wisdom that has awarded him (and implicitly his wife) a long, HIV-free life:

[35] These adults would be aged between 58 and 37 at the time of the interview. However my analysis of other data from interviews with both John and other respondents suggest it is unlikely John has made these calculations to refer to these chronological ages. Rather, I suggest he is making reference to 'prime aged' adults, distinct from teenagers or elderly.

This time [of AIDS], the one who was born in 1950, you cannot compare them with me. Those born in 1961 or 71 you cannot compare them with me. I am much stronger than them. Because they… don't abstain. They don't even think that they are married the time they are going to watch video shows - they go there to do everything [have extramarital sex], do you understand? They go there to do everything after getting to the video show, they don't think of the wife [left] behind. So there are prostitutes there, so they get infected from that lady from Blantyre, in turn they infect the wife at home… The youth are the most infected because they don't abstain but we [older adults] are able to stay with our wives.

[John, male, 60s, married]

On one hand, older adults were therefore not expected to be at risk of HIV. Anecdotes about "people's" surprise when an older person requests an HIV test, tests positive for HIV or arrives at an HIV support group, lace across respondents' interview narratives. A dominant theme in these anecdotes is that the older person must have acquired HIV non-sexually:

*When the hospital had come to our village to test blood, my mother was among the first people to test her blood. My mother is very old. When she went to test her blood, people were laughing at her, saying '*agogo *like you? Why are you testing your blood?' My mother said… I lost my children to* edzi*, it could happen when I was taking care of them I got* kachilombo.

[Kondwera support group member, 50s, male, HIV+]

On the other hand however, almost all respondents conceded that some older adults *do* engage in *chiwerewere* and subsequently contract HIV. Although only few respondents without HIV spoke of specific individuals they knew of, there was little doubt of their hidden existence:

But nowadays the disease is not only the youth but even the aged… the youth are mobile [sexually promiscuous], but there are also some other aged people doing the same secretly… and they are getting infected and they are dying.

[Rhoda, female, 56, polygamously married, HIV-]

In failing to act in ways defined by the elder identity standard, these HIV-infected older adults were defined by its opposite: They were foolish, rash and therefore childlike. In the following extracts Polly and Rabson discuss these older adults who have refused "to grow" – to mature. The older adults in their stories lack the wisdom of their years, naively failing to appreciate the consequences of their behaviour in Polly's example. Their concern for their appearance is depicted in both examples as inappropriate, and for Rabson, deserving of ridicule. Both older men and women were discussed in this way.

> *I You also said that the old people who get the disease do not control themselves? Did you say that?*
>
> *R Um-hm [Nods in agreement]*
>
> *I I would like you to explain that to me further*
>
> *R It's because there are other old people [aged] like myself who refuse to be called* agogo. *They stay because they manage to wash, bath and wear ironed clothes. And other old people have many* zibwenzi. *Then they can start becoming ill frequently and when they decide to go to the hospital, there they will be found with* kachilombo. *Despite being old. Then she will start to think about her many sex partners [yet] sometimes she can start accusing her husband that he has a* chibwenzi.
>
> [Polly, female, 60s, newly married]

> *There are two groups of adults. Some can manage to control themselves - it's difficult for these adults to get* edzi. *But the other group behave like young people - sometimes the young ones are better [behaved]. These adults can get* edzi *because of their behaviour. They don't control themselves. They even refuse to be called* agogo *but uncle or brother instead [laughs]… They are the people who cling to wearing bras instead of leaving their flat breasts bare… They refuse to grow [laughs].*
>
> [Rabson, male, 75, married]

In conversations about HIV therefore, presentations of sex at older age differed from those given within the context of conversations about ageing and sex (Chapter 5). Only sexual restraint is offered as the behaviour associated with the role identity of

the fully developed adult; sexual ability and frequency, so central to respondents' discursive responses to the challenges of the ageing body, are entirely absent.

Non-marital sexuality among older adults was subsequently 'out of place'. Without the 'heat' of youth, such sexual behaviours were not socially sanctioned, by any respondents. In their narratives, sexual behaviour that was expected and "obvious" for younger adults was "promiscuous" for older adults. In the following excerpts, Nyuma, diagnosed with HIV while aged in her 60s, discusses the response she expected from both her HIV-uninfected peers, as well as HIV-infected younger adults:

> *I Do people react the same when a young person has* kachilombo, *as compared to an old person?*
>
> *R It is not the same. People speak a lot of bad things.*
>
> *I Who is talked about more?*
>
> *R They talk bad about us [older people], more than the young people. Because we are old. They say 'an old person is found with this disease? Eeee! They are big prostitutes'*
>
> *[Interview 1]*
>
> *I You said if the [support] group was composed of young people, you would be ashamed. Why would you be ashamed?*
>
> *R Because I would have been thinking that out of all the group, I am the only old person. The youth would have been saying 'but that woman [tuts and shakes her head], arrh! It's better us, the young people'*
>
> *I So you mean, being promiscuous [as respondent said earlier]? It's fitting for young people?*
>
> *R Yes*
>
> *I And not you old people?*
>
> *R Yes, it's not our size. It's not our size.*
>
> *[Interview 3]*
>
> [Nyuma, female, 68, single, HIV+]

As a result, older adults with HIV forfeited the respect traditionally awarded to the elder - the fully developed adult. This was illustrated most clearly in respondents' narratives about advising their children and grandchildren. While the elder was recognised as the custodian of wisdom and the giver of respected advice (Chapter 4), HIV infection in old age indicated that the elder did not possess this wisdom and their advice could not be respected. Winford's description accords with those given by respondents with and without HIV:

> R *The old person [with HIV], it means he was not careful, and people will not take him serious, when he wants to advise children*
>
> *[Interview 2]*
>
> I *You said that an old person, who has* kachilombo *and wants to advise young people, they can't listen to them, because they have it? I want you to say why it is difficult for an old person to advise the young people.*
>
> R *The problems will come because the youth will say 'this person is troublesome'. They will say 'we were thinking they were respectable old people, but they are not, they have the* edzi*'. So can you advise the young people? It can't happen… It is hard because, you also have the disease, and you want to advise them against* edzi*, [but] they will say 'why is he advising us when he himself has it?' They will say 'if he knows it was a bad thing, why did have it himself?' So you just keep quiet.*
>
> *[Interview 3]*
>
> [Winford, male, early 80s, recently divorced, HIV-]

Respondents who had been diagnosed with HIV in later life discussed their initial response to HIV testing in terms of shifted perceptions of their behaviours. In their narratives, HIV at old age (unlike at younger age) is presented as a social identity involving not just an individuals' body, but their character. Their accounts suggest internalisation of these perceptions. For example, in contrast to illustrations offered elsewhere in the interviews, respondents gave generalised accounts of the perceptions of unidentified "others" rather than specific individuals or incidents in which the ideas had been communicated. When Esnart was diagnosed with HIV

when aged in her 60s, the change in "people's" perceptions of her was the most salient element of her experience.

> *I was very worried, when going there [to the clinic following HIV testing]. I was crying; I spent the whole day on Tuesday and Wednesday crying. When Thursday came, I was also worried – 'How can an old person like me have his disease?' I still went to the hospital. I took courage that let me meet the doctor… My worry came because when a person has been found with the disease, people take them as foolish. So I said, 'should people know, I am sick like this?' I will be a foolish person, I will be like a lost person. I will be a nobody. When I used to be someone who was respected. I was crying on that… I was crying for this story, the whole of my crying centred there.*
>
> [Esnart, female, mid-60s, single, HIV+]

Esnart's narrative, as those of other respondents, closely accords with the theoretical understandings and practice of role identity formation set out in Chapter 4. The social situation of a research conversation about HIV in older age 'activated' respondents' 'mature adult' identities (that is, they focused on this identity, rather than other identities they possessed, such as 'mother' or 'comedian'). When diagnosed with HIV, the meanings associated with an individuals' behaviour were understood to be at odds with those prescribed by the morally- and socially-productive adult identity standard. My analyses suggest that respondents experienced or expected to experience HIV as a threat to identity. When Esnart expects others to perceive her behaviour as foolish, she anticipates that her own perceptions will follow suit ("I will be a foolish person"). Since foolishness was held in opposition to the set of shared meanings held within the identity standard of the adult, Esnart's expects her identity will also shift towards the corresponding opposite identity: that of the 'non-adult', or 'non-person' ("I will be like a lost person. I will be a nobody").

6.1.2 The prognosis of older adults with HIV

6.1.2.1 HIV at old age means death "at any time"

Conversations about HIV oscillated between the routes to infection, and the prognosis of those infected. HIV pathogenesis reflected the centrality of blood in the Chewa and Yao ethnophysiology of life (Chapter 3) and was understood as the rapid degradation of the body's finite power or life force. Respondents conceptualised HIV as a distinct force in competition for power with the body, or "feeding" on the power contained in the blood. When the body contained a lot of blood, it was able to defend itself against the virus and slow the pace of degradation. When the body contained less blood, it had less power to withstand the virus. Regardless of the quantity and strength of blood at the point of infection, HIV eventually caused blood to weaken, and through ubiquitous chronic diarrhoea, eventually flow from the body.

Respondents warned that infected individuals should avoid activities known to cause bodily weakness that would allow the virus to "multiply". Sex (Chapter 5), work and stress were widely acknowledged to 'use up' the body's finite supply of blood and thus weaken the body. For example the messages respondents recited that called for communities to "love" those with HIV or for infected adults to "live positively", were in their narratives, underpinned by the understanding that distress would cause the blood to weaken, the body to become "malnourished" and HIV to gain power more quickly. In contrast, "good food" (meat, eggs, cooking oil, *ufa woyera*[36]) was considered to add power to the blood, strengthening it and its defence against the virus.

However, even a restrained individual could only preserve their power for a limited time. Eventually the virus took all the power from the body, leaving an infected individual without blood. Death was therefore inevitable. Robertson's assertion "if I would be found with *edzi*…I would just say I am a dead person" was widely shared among HIV-uninfected respondents. Time from infection to death was widely

[36] Maize that has first had the outer kernel shell and seed germ pounded off before being milled.

regarded to be short among these respondents: "after a year, but not as long as 2 years".

Building on understandings of ageing as a trajectory of declining strength and blood (Chapter 3), HIV was understood to be more potent in older, already weak, bodies. HIV was presented as the ultimate challenge to retaining blood, "complicating the situation" of ageing and signalling that the body "has now been finished" [Esnart, female, mid-60s, single, HIV+]:

> *R The younger one has fresh blood while the older one has finished blood…The older one can die easier. The younger would remain but later he will also die because the disease is* edzi.
>
> *I Umm, why did you say the older one would die quicker?*
>
> *R Because he has no blood… it is finished .*
>
> [Charles, male, around 70, married, HIV-]

The following excerpts illustrate the cumulative force of HIV and ageing in weakening older adults' blood. Blood weakened by old age offered inadequate defence against the virus that would further weaken it. At the same time, it offered inadequate strength to secure food that would add power to the blood to improve its defence:

> *So the aged will die fast [from HIV] because their bodies are already weak, whereas the girls are strong, and they are able to get help and they eat nice food. Because they say there is need to be eating nice food. So when you are aged, where are you going to get them? You die the same month. You become sick because of the lack of food in the body. Whereas the girl will be able to buy meat, cooking oil, chickens and eggs. So she will be gaining the strength, when you [an old person] are only eating the vegetables, so can it work?*
>
> [Rhoda, female, 56, polygamously married, HIV-]

> Edzi *can bring a problem [to older adults] because the body has already lost strength. So when they are sick more often they can't work, so those are the problems... because the body has no power. Each and every*

disease is against the power which is in our bodies. So it's a combination… You die fast as compared to those who are young.

[Polly, female, 60s, newly married]

The implications of HIV-related blood loss for an individual's ability to work were dominant in respondents' discussions. In both younger and older bodies, HIV was understood to weaken blood to the extent that physical production was impossible. John for example, is confident that despite being slim, the HIV+ test result he received in 2006 was a mistake[37] because of his ability to work:

Look at my body. Any person who has not known me he will say that I am suffering from edzi, *but the one who knew me from childhood, they know that this is my body. John is slim…But I am able to work - I am able to farm.*

[John, male, 63, married]

As discussed in Chapter 3, inability to work was discussed as the end of possibility and development. This was often represented in the phrase that without HIV a person 'could have become the president'. While most frequently used in reference to younger adults, it was also used by respondents with regards to older adults. As Daniel explains, like John Tembo, a central figure in Malawian politics since the 1960s and at the time of fieldwork, the leader of the first opposition party, older adults also have plans and possibilities "to do more" that are limited by HV infection:

The honourable John Tembo, he is still working and he is around 80, is he not aged? So it's just the same with the aged, they still want to do more and they do come up with plans.

[Daniel, male, early 50s, married, HIV+]

Moreover, it prevented HIV-infected adults from attaining resources to secure their own and their families' survival:

[37] When, at his request, we took John for testing at the local hospital, he was told he did not have HIV.

> *I would have a painful future [if I had HIV] because I would fail to work for my family. Nowadays I am managing to work and buy food. That could not happen if I fell ill. I would suffer… I would be serious [seriously ill] and fail to wake up. I can fail to go for piecework and would fail to get money to buy food. I would be waiting for other people to do everything for me.*
>
> [Jane, female, 54, recently married]

The social imagining of older adults with HIV as non-workers was evidenced by HIV-infected respondents' reports of being overlooked for paid work (for example, Fiskani reported experiencing drastic decline in demand for his house building business following public disclosure of his HIV diagnosis) or not receiving the coupons for subsidised fertiliser distributed by village heads on the grounds that the limited and valuable coupons would be "wasted" on them[38]. Although this situation was not unique to older infected adults, respondents argued it was more common in old age. Members of the Kondwera HIV support group discussed this perception animatedly:

> *The village heads do not understand us. Like with the piecework [typically offered by Government contractors and coordinated by the village heads] where people get K200 a day, we are not considered. They think we can't* work*: we just want to get free money… Other people are not open to come and join [the support group] because they feel if they do that… they will be taken as people who have* edzi *[and] as a result, will not be able to get a loan, they can never be employed… The reason why they say this is because when someone has HIV or* edzi*, they think they are people who get sick very often, and that they are weak. They are not useful. They feel if they give them a job to do, they will not do it properly… That is why we are side-lined, and left behind.*
>
> [Kondwera support group member, 50s, male, HIV+]

Narratives around not being able to work mirror those explored in Chapter 3. As in the case of old age, the inability of weakened HIV-infected bodies to work for

[38] See (Dorward and Chirwa 2011) for details and discussion of Malawi's agricultural input subsidy programme.

resources to strengthen their blood, or generally provide for themselves or families, challenged their identities as physically productive adults. As Esnart (above) discussed and internalised the perception of her as a non-'adult' based on her apparent lack of morally productive behaviour, Susan also presents herself as a non-adult in the context of declining physical production:

> *I have become weak in the way I do my work. I get tired very fast. I can't even carry heavy things, I fail to carry heavy things as I used to do it the past…I don't pound, I fail, but I want to eat* ufa woyera. *In the past, I would pound any time I wanted, after that I would carry the maize to the mill, but now I can't. Even going for fetching firewood, I can't carry a big bundle, I just carry a small bundle, like a child.*
>
> [Susan, female, mid-60s, widowed, HIV+]

However, my analyses suggest that for respondents, HIV in older age provided an even greater challenge to maintenance of the adult or person identity. The understandings set out (that HIV weakened the body, and was more progressive in older, already weakened bodies; that weakened bodies couldn't be physically productive; and that the period between HIV infection and death is short) bore a further understanding of older adults with HIV as liable to die at "any time". Old adults with HIV were "weak and unhealthy" [Estina, female, 55, single, HIV-]. They were subsequently expected to be vulnerable to very small threats to their health. Even "bumping a tree stump" could result in death [Mercy, female, 50s, married, HIV-]. Accordingly, the very physical viability of older adults with HIV was questionable.

The availability of ART had done little to alter these understandings. Narratives about ART, particularly at old age, were confused and contradictory, as both infected and non-infected respondents weighed experience or stories about the success of treatment against the funerals they had attended over the years. On one hand, referred to as *chitetezo* (protection, immunity), ART was understood variously to strengthen the blood, or provide a protective layer "which the disease feeds on, instead of feeding on person's body" [Lyness, male, 68, married, HIV-]. On the other hand however, longstanding public health messages that "HIV has no cure"

were difficult to disavow. Non-infected respondents acknowledged that infected adults now grew fat and so appeared healthier, but were sceptical about whether this signalled improved strength. Instead, ART was presented as providing a bodily mask that hid the on-going weakness of blood beneath. In a discourse that mirrored that documented twenty years earlier in the USA, being infected but healthy was "a contradiction in terms" (Sontag 1988, p. 32). In the following excerpt, Mercy relays the conversations that occur at the borehole, recognised in previous research in rural Malawi as an important location of collective meaning-making in this setting (Watkins and Swidler 2009):

> *A person who is suffering from malaria, and the other one who is suffering from* edzi*… They are different because a person who is suffering from* edzi, *although a person will suffer and recover, the body is still weak… So that is what people say at the borehole, or anywhere they will meet. They used to say when they see a person who suffered [of another illness], when that person arrived [at the borehole] they start to talk to that person that, 'you were serious [seriously ill] but now your body is back to normal', like praising them. But to others who suffer from* edzi *we just greet them. We don't joke with them. We know that although a person has recovered, the body is still weak, so we don't talk more to them, so people just gossip on them [when they have left].*
>
> [Mercy, female, 50s, married, HIV-].

Even among HIV-infected respondents, there was some doubt about the efficacy of ART in old age. When blood had already decreased and weakened from age, it seemed unlikely that ART could strengthen it sufficiently:

> *With the medicine, we see people taking them, then they die after sometime. So we say maybe when we take the medicine, maybe it weakens us so that we die earlier? This is not from counselling, it is what I think on my own. The young people do die also, but mainly it's us old people who die faster. Maybe we have insufficient blood in our body… Maybe for an old person, their life is already weak, they take the medicine and within a short time, they are gone. But for a young person maybe their bodies are still strong.*
>
> [Stella, female, 70s, single, HIV+]

I argue that it was the perception that older adults with HIV were unable to sustain their physical survival through production, were likely to die suddenly because of already weakened blood, and were provided only a façade of health by ART, which underpinned HIV-infected respondents' report that "others take us as *maliro* [dead bodies]". Older respondents, younger focus group participants, key informants and others confirmed that this perception of infected bodies was directed towards all-aged adults with HIV. However, my analyses suggest that understandings of the ageing body outlined in Chapter 3 served to produce a social construction of older adults with HIV in particular, as the "living dead". They were consistently described as being "already finished" by respondents and those they reported on. HIV therefore presented a greater and more explicit threat to older adults' personhood than provided by their ageing bodies alone. Although contextually different, this experience of a 'double burden' of HIV and ageing accords with the experiences of older adults with HIV facing age and HIV-related stigma documented in the USA (Emlet 2006).

6.1.2.2 HIV requires intensive caregiving

Before inevitable and rapid death, old, infected, and weakened bodies were understood to require intensive personal care during a period of bodily decay. These understandings were grounded in respondents' experiences of their own severe HIV-related illnesses prior to receiving ART, or of caring for or visiting (usually younger) HIV-infected adults before their deaths over the previous twenty years. In their vivid illustrations, the infected adult, with limited access to primary healthcare that might have alleviated their symptoms, suffered intensely painful deaths.

As with non-HIV-related illness, care for infected older adults was typically provided in the home. Spouses or same-sex siblings were understood to be the most appropriate care providers, followed by a same-sex adult child in their absence. Narratives about HIV-care strongly echoed those of old aged care (Chapter 3). They focused on the burden on the carer and the emotional implications of receiving personal care.

Firstly, reflecting the understandings of weakened bodies' need for protein- and calorie-rich food, concern about the financial burden of caregiving and "finding chicken" was frequently cited within these discussions. This was strongest when the carer was expected to be an adult child with their "own family" to feed. In addition, providing intensive care took the carer away from their fields and contributed to further decline in the household's resources:

> *"If I can get a virus, it will mean that I have put my children in troubles, because they have got their children who are relying on them. Their children are struggling; they don't have enough food. So if they want to give you an assistance, to satisfy you in your body, it will not be enough.*
>
> [Patuma , female, 58, married]

Secondly, as with old age care, providing intimate care was considered to burden the familial carer and embarrass the patient. Within the context of HIV, care was expected to centre on inevitable diarrhoea and bathing. Both necessitated the carer "seeing the private parts" of the patient. This was considered especially humiliating if the carer was a child rather than spouse, and too difficult to contemplate if the carer was not a child of the same sex. Further, although some respondents spoke confidently about the availability of plastic gloves, other respondents' were fearful that such tasks would expose their potential carer to HIV infection:

> *I am afraid that I can also infect my child. The child suffers to take care of you sometimes. You are not even able to go to the toilet - you do the toilet anywhere so the child is busy removing them so I get worried.*
>
> [Jane, female, 54, recently married, HIV-[39]]

The significance of receiving personal care for ill adults has been documented previously with regards to ageing (Schröder-Butterfill and Fithry 2010; Twigg 2006; Van der Geest 2002b) and to HIV at younger ages (Thomas 2006) in a variety of

[39] At the time of this interview, Jane was very scared that she had HIV. Her previous husband had been diagnosed with TB and was expected to have died of AIDS. She understood from friends that if he had, she too would be infected. (When, at her request, we took her for HIV testing, she left the clinic beaming and reported to have been tested 'negative'.)

settings. While it was discussed much less frequently by respondents than other implications of HIV (perhaps because of the similarities of aged-care and the perceived inevitability of that), similar themes emerged from my analysis of respondents' narratives to those identified.

The situational meanings of intimate physical dependency and bodily exposure held by respondents were incongruent with the most basic meanings they held within the adult identity standard. As frequently noted with regard to aged care, needing help to wash and toilet were ultimately infantilising (Twigg 2006). For example, HIV-related illness was defined as the experience of having "diarrhoea like a child". Being cared for by a child represented the reversal of behaviour and therefore, role identities. This is neatly illustrated by Rhoda. She reported that if ill, it would be her daughter who cared for her (despite being polygamously married). However:

> *R It is not good be cared for by your child when you have this disease. Yes, it is not good. The children should be sick and you should be taking care of them. Yes, because it is a very bad disease. Somebody down there [gestures to elsewhere in the village] she was wearing napkins like a child*
>
> *I Who was helping that person wearing the napkins?*
>
> *R The mother. Yes, and in the morning they could dry them. So should your child be doing that for you? Is that good? No, it is not good. It's better to die of another disease. Yes, but not* edzi. *You lose respect because it brings very bad illnesses… The other bad thing is that the child is even able to see your private-parts which is not good… It is supposed to be you cleaning the private parts of the child… but not the child doing that…if you are still alive you still feel ashamed: my own child cleaning my private parts! Mmm. When you are nearing your death you no longer feel shy*
>
> [Rhoda, female, 56, polygamously married, HIV-]

Thirdly, although less discussed by respondents, my analyses suggest that "burdening" the family with caregiving tasks and risk of HIV infection was also considered to be incongruent with the meanings held within the adult identity standard. Individuals who required care took from their families, rather than gave.

Following understandings of HIV pathogenesis, the patient used-up all of their family's material resources but inevitably died. The meanings of their behaviour (selfishness, lack of love) contradicted those held within the identity standards for the morally- and physically-productive adult. Such people could not be respected. In the following excerpt Ruth explains that in asking for "everything" from their family until the family is left with no resources ("nothing remaining at home"), infected adults die "disrespectfully":

> *To those who don't suffer from disease of AIDS, when they become sick, We bathe them. If it is me, children bath me, making me clean… But AIDS, people go disrespectfully. Disrespectfully. Everything, everything [points to imaginary food]: that egg. The egg of a chicken. The remaining eggs after incubation. Those eggs, they broke the egg, and take the chicken and put on fire and chew it. Chew it. Nothing remaining at home. Nothing.*
>
> [Ruth, female, late 70s, married, HIV-]

6.2 Older adults' navigation of HIV infection

I have argued that interview narratives of older adults with and without HIV present HIV in later life as a challenge to individuals' identities as morally or physically productive adults. This challenge occurred when perceptions of an individual's behaviours no longer corresponded with the set of meanings respondents (and those they reported on) held for these identities. Challenges to identity were two-fold, mirroring the dominant discourse about HIV in later life in the interviews. This discourse was situated within the understandings of ageing (Chapters 3 and 4) and sexuality (Chapter 5). Firstly, corresponding to transmission narratives, HIV infection implied unwise and impulsive behaviours that were incongruent with the meanings held within the identity standard for the morally productive adult. Secondly, corresponding to prognosis narratives, HIV infected old bodies were incapable of the intimate independency, self-sufficiency or familial provision associated with the identity standard for the physically productive adult. What is

more, based on understandings of HIV and older age more broadly, infection in later life questioned an individual's physical viability, the core definition of personhood.

However, older adults with HIV did not identify with being foolish elders or the walking dead. Rather they discussed behaviours and roles that were aligned with the meanings held for the adult identity standard. As argued with regards to ageing (Chapter 4), I further argue that respondents (consciously and unconsciously) did this to maintain positive identities in light of identity challenges presented by HIV infection, in-line with Identity Control Theory.

A number of discursive strategies can be identified in respondents' interview narratives, representing their responses to each of the two identity challenges. Respondents typically employed a combination of these during the interviews. The availability of (re)constructed positive identities was shaped by respondents' pre-diagnoses identities as morally-productive or physically-productive adults. The identities they performed following infection influenced their experiences of HIV.

6.2.1 Responses to the foolish non-adult identity

Just as HIV-uninfected respondents, respondents with HIV also distanced themselves from the young adults and foolish old adults who infected themselves and their families through their sexual behaviours. In 'othering' those who were not sexually restrained, respondents reaffirmed that they were members of the 'in-group' of wise and thoughtful matured adults. For some respondents, this involved stressing continuity in their pre-diagnosis morally-productive behaviours. For others it involved emphasising change in their behaviours from physical to moral production following HIV diagnosis. Both sets of respondents discussed living with HIV in ways that were congruent with the shared meanings and expectations associated with the 'matured adult' role and its performance.

6.2.1.1 Continuity of behaviours

Across their interviews, Stella, Ellia, Susan, Zione, Madalitso and Arnold all stressed that they had contracted HIV through non-sexual routes. They had therefore not chosen HIV:

> *[People] joke about people with* edzi*, so I ask them 'where did you see the market for* edzi*? Or PTC? Or Chipiku*[40]*?, where did I buy it?' ...I did not choose to have it.*
>
> [Esnart, female, mid-60s, single, HIV+]

Instead, they reported that they had been infected when caring for someone sick with HIV (informally within the household, or formally as a *sing'anga* [healer]), delivering the baby of someone with HIV or preparing the body of someone who had died of AIDS for burial. These non-sexual behaviours were not foolish or irresponsible. Moreover, they were understood to imply wisdom and considerable knowledge, social responsibility, selflessness and compassion: attitudes and characteristics also associated with the role of the matured idealised, morally-productive adult. In their narratives it is their social roles and behaviour as mature adults that put them at risk, making them the most 'innocent' infected of all:

> *You know I prepare dead bodies. When they hear a cry, they say go and get* anganga [*older person*] *to come and help in preparing dead bodies.* Chisoni chinapha nhwali *[mercy lost a person's life]. Now it has cost me.*
>
> [Stella, female, 70s, single, HIV+]

These respondents stressed continuity in their pre-diagnosis behaviours and associated identities. My analysis suggests that their narratives reflect their motivation to maintain their sense of self.

[40] PTC refers to People's Trading Centre, a national chain of small grocery stores found in towns. Chipiku is a national wholesale retailer, selling goods like fertiliser and seeds, and found in trading centres.

6.2.1.2 Discontinuity of behaviours

Other respondents emphasised change in their behaviours following HIV diagnosis. These respondents, all male, do identify sexual routes of their infection. However, during their interviews they discursively challenge the association between the meanings of these sexual behaviours and the non-adult identity outlined above.

Some respondents reported that their infection dated from sexual behaviour that occurred before they knew of the risk of HIV transmission. Since it was not sex in general that was foolish, but sex when there were known health-risks to an individual, their partner and their children (Chapter 5), such sexual behaviour was therefore not associated with being unrestrained or irresponsible:

> *That time [of HIV testing], I did not expect that I will have* kachilombo*, no. … Because the cause of the disease I had, I did not know that it can be* kachilombo*…I did not know very well, about* kugonana *[sex outside marriage, lit. sleeping together], touching one's blood, and other means, I didn't know about them.*
>
> [Fiskani, male, 61, married, HIV+]

Other respondents discussed their sexual behaviour as now-rectified mistakes. Older age and HIV are presented as being morally cleansing, inspiring a change in behaviour. For example, Steven blames "Satan tempting" him for starting an extra-marital *chibwnezi* relationship around the same time as remarrying, and having made "a mistake" in failing to insist both women went for HIV testing before starting their relationships. Although Steven's affair is on-going and remains a secret from his wife, he presents himself as caring and wise: as morally-productive. Throughout our conversations he redefines his *chibwenzi* relationship as a morally and socially-justifiable marital love relationship, he emphasises the steps that he had taken to prevent HIV infection, and offers the steps he plans to take to protect his health and that of others:

> *I very much fell in-love…When I am not home then it means I am with that woman at her home… I take her as my second wife… even if she will be found HIV positive I will never leave her, she will still be mine.*

[Interview 2]

This positive [HIV result] is coming when I had put a limit: I said 'I will not go out to other woman apart from these two'… Then you find that, while I am concentrating on these two women, I am found I am like that [...] [Now HIV positive] I should continue with this life. I have two women, I should continue with them. This other one is part-time not full-time, so it should remain like this.

[Interview 3]

[Steven, male, 57, married, HIV+]

All respondents who suspected having been infected with HIV through sex distinguished their past behaviours (and the associated meanings of being uninformed and sexually impulsive) from their current behaviours. However, the meanings associated with both past and current behaviours were aligned with the wider adult identity. Past sexual behaviours were set within the discourse of sexually-capable adulthood, while current behaviours were presented in ways understood in the shared culture of the interviews and respondents as demonstrations of wisdom, provision for family and restraint. Their narratives therefore reflect a change in the definition of the identity standard of the 'adult', from physical-productivity to include moral-productivity.

In the following passage, Steven uses the change in his behaviour to illustrate a change in his identity from sexually capable adult to still-capable, but sexually-restrained, adult. He emphases the authenticity of this identity by stressing that not only does he recognise himself in this role ("I am"), but that others also recognise him as occupying that role ("my friends call me"), reflecting role identity theory (McCall and Simmons 1966):

I had been doing a lot of youthful life, including having many women - though I was not very promiscuous: I would only have one at a time, [although] I did have a lot of girlfriends… Now from [aged] forty-something, we put a target of 15 women. It means I was having sex with two or three women every 10 years. So, in short I can say, every 3 years

I was sharing [blood] with one woman, but if you compare with the youth of today, they can do it as they wish, maybe every week, change. With me it was not the case... I still maintain my target: I am still going at every 3 years, I am having one woman. This time I am 57 years, but I have been with 17 women… I used to chat with girls, but now I just see them as my friends, even my friends call me 'friend of girls'.

[Steven, male, 57, married, HIV+]

Their narratives fit within a broader discourse, (re)produced in HIV advice and counselling delivered in the field site and support groups' discussions, in which HIV offered a "new life" for infected people. In this new life, individuals took on healthy behaviours that were understood to imply wisdom and self-restraint:

You went to get tested, instead of your dying, you have been given a chance to live… So you now have a new life… we have changed some of the things we used to do… There is a change in diet, the things which are destructive to our health we stop. Also the way you used to live as husband and wife you change it, you now have to be using the condoms… I have changed, no I can't do chiwerewere*, or do some other things which would risk my health, like drinking and smoking.*

[Fiskani, male, 61, married, HIV+]

6.2.1.3 "Living positively"

Whether emphasising continuation of pre-diagnosis behaviours or changed post-diagnosis behaviours, all respondents with HIV discussed managing their infection as "living positively". As "starting a new life", this discourse was embedded within HIV advice and counselling, mutual-support and advice circulated in HIV support groups, as well as within international health promotion materials. Locally it involved "accepting" one's HIV diagnosis to gain access to the treatment and care available, strengthening the body's blood by eating a varied, protein-rich and higher calorie diet, and preserving the body's blood by limiting vigorous marital sex, avoiding *chiwerewere* altogether, limiting physical work in the field, and making sustained efforts to reduce stress by thinking 'positively'.

The importance of the positive living narrative for maintaining emotional well-being following diagnosis and transforming personal and social attitudes to HIV has been noted in a number of settings (e.g. Levy and Storeng 2007; Liamputtong *et al.* 2012), and was the reason for its inclusion in HIV counselling and support, according to my research assistant Jonathan and other HIV counsellors I spoke with. However, I argue that older adults used the discourse in different ways in order to negotiate a set of age-specific meanings of HIV.

Respondents with HIV explicitly differentiated themselves from younger adults with HIV in their 'positive' behaviours. For example:

> *The young people hide that they have* kachilombo. *They are shy. But with us old people no. As a result they die faster… They think maybe to have* kachilombo *is shameful, but we do expose ourselves, we tell people how we are.*
>
> [Nyuma, female, 68, single, HIV+]

Moreover, for respondents, living positively involved behaviours and attitudes that mirrored those recognised as being associated with the matured adult. In general, respondents reported that older adults were more successful in managing HIV because, unlike younger adults, they followed the advice given to them by HIV counsellors at testing centres and hospitals. In doing so, respondents demonstrated to interviewers their respect for advice more broadly as well as their wisdom in their recognition of good advice.

> *I am an old person. I was told I have* kachilombo. *I do follow what I was told at the hospital, so I stay and have sat down. But the young women do not want to believe it. They just say it [death] has its time. So they continue to do what they were doing… For old people, they believe what they have been told. They say let me sit down, and be taking care of my children. That's it. […] I got* kachilombo *a long time ago but I am still alive because I listen to what I get from the hospital, what I get from the support group.*
>
> [Susan, female, mid-60s, widowed, HIV+]

Similarly, respondents reported that older adults were more successful in managing HIV because unlike younger adults, they attended HIV support groups. Indeed the majority of members of the support groups I visited were mid- and older-aged. For respondents, this demographic composition reflected older adults' attitudes and behaviours: they were "not proud" [self-important], were comfortable with their HIV status and were not interested in pursuing *chibwenzi* [lovers] – all of which they suggested prevented younger adults from attending the groups.

> *I In your group, who are many, the old people or the younger people?*
>
> *R …[The youth do not come] maybe they are ashamed… They feel they will be looked down upon by people, they want people to respect them… but with us we just walk freely, without pride, we don't mind anything.*
>
> [Esnart, female, mid-60s, single, HIV+]

The activities of support groups encouraged 'positive living' through a range of activities, including growing nutritious fruits and vegetables and medicinal plants (such as *chamwamba* (moringa), known for its immune boosting properties) in communal gardens, receiving training and advice, providing mutual emotional and practical support as well as encouraging non-members to get tested for HIV:

> *We live positively by coming together and sharing experiences. Because sometimes you may think that, what you are going through is the worst thing, and when you share it with your friends, they can tell you how to go about it. You may also have other people who have gone through similar situations, or even worse than the one you have, and they can encourage you to go on. We also learn how to make good meals, which can help improve our immunity.*
>
> [Fiskani, male, 61, married, HIV+]

Observational and interview data indicate that the support groups constituted tight knit communities. Respondents discussed them as functioning on a level of model citizenship involving hard work, cooperation, mutual respect, consideration, wisdom and love –qualities that were reflected in the names of the support groups. In short, support group members were presented as making idealised moral and physical

contributions to their group, families and communities. The discourse is neatly highlighted in the following excerpt from a group interview with support group members.

> R *We work together here in all activities. I will give you an example: we were filling those tubes with soil. Both old and new members worked together. We worked together; we worked in sowing and transplanting the tree seedlings. The old members had grown groundnuts; they also gave us some to plant in our gardens. They didn't show any selfishness!*
>
> I *You are 63 years and he is 35 years. How do you interact with each other?*
>
> R *Here we live as a family. It's like* Kondwera Support Group, *we do not consider age when we are doing things, we do things as a group.*
>
> [Two males, 35 and 63, Kondwera support group]

Older adults reduced stress, understood to weaken the blood, by being "courageous" about HIV infection, framing it positively, and not entering into conflict with those who would speak badly of them. In discussions about ageing more broadly, these characteristics – and their shared-meanings of self-restraint, wisdom and coolness – were linked to 'elderhood' by respondents.

> *It's really a big problem to get* edzi *when young, we really become worried to see young people having* edzi*... It is better for us get it, because even if we have it, we are courageous enough to live on.*
>
> [Kondwera support group member, older age]

> I *Do you think that you have changed as a person, since finding out you have the virus?*
>
> R *I have changed. I don't want to get in conflicts with people; The moment you pick quarrels with people, they say the medicines are making her mad, so I don't want people to have a wrong conception of people who have HIV.*
>
> I *People talk about living positively with HIV*
>
> R *Yes*

I What does it mean to live positively?

R It is when you have made up your mind, so that you will not get worried about having kachilombo*, there you have to safeguard your life. You have to make sure that you are happy.*

[Nyuma, female, 68, single, HIV+]

Finally, as also noted by non-HIV infected respondents, older adults with HIV reported that they were more able to resist having sex in order to preserve their blood and protect others from infection:

I can think, as for me, to be found with kachilombo *like this one, which disturbs your body it is better for an old person … Because we old people do take care of ourselves [laughs]… These young women, they haven't finished chatting* [having sex]*, the young men they haven't finished chatting …Eee! Concerning* chiwerewere *they are not finished with it. They are still sleeping together, but for us the* agogo *as you see us, not sleeping with each other, and other things…We just say my life should continue, so that I can do this job and that, you can't think of a man.*

[Esnart, female, mid-60s, single, HIV+]

I argue therefore that the positive living discourse and narratives around successful management of HIV were used by respondents as vehicles through which to resist the dominant meanings of HIV in older age outlined above, and set out behaviours that reaffirmed their identities as non-foolish, matured valid adults.

6.2.2 Responses to the "finished" non-adult identity

If not foolish, respondents with HIV certainly did not perceive themselves as "finished". Instead their interview narratives can be viewed as performances of a more positive identity: that of 'adults' – viable and contributing members of the social world. As observed in the narratives of all respondents with regard to the ageing body (Chapter 4) these performances centred on discussion of behaviours and attitudes that emphasised realised or potential productivity, here in the context of transformative HIV. Three responses were identified in which respondents

emphasised their potential return to productivity, continued productivity, or new productivity. Often respondents used all three responses across their narratives.

6.2.2.1 "It is only the disease which has weakened me"

The loss of blood and the decline of the HIV-infected older body was not a wholly-unsubstantiated stigmatising discourse forwarded by non-infected respondents and others. Rather it reflected the lived experience of some respondents, even following initiation of ART. Some respondents could not conduct physical work as they had previously, endured periods of short-lived and prolonged illness and disability, and struggled to collect their ART from the dispensing clinics that were a day's walk away.

Across our conversations, these respondents stressed that their limited physical productivity was not really 'them': their behaviour did not reflect their identities. A dominant narrative for these respondents was to discursively separate themselves and their 'real' bodies from their HIV infection and their HIV-infected bodies. When asked why they thought they were unable to work as they once had, respondents were unanimous that it was HIV infection and not their advanced age that limited them:

> *I was strong in the past… but my body is weakening… I am an old person, but not very old, it is only the disease which has weakened me… If I did not have* kachilombo *I would have been working a little bit.*
>
> [Fiskani, male, 61, married, HIV+]

My analyses suggest that in attributing declines in productivity to HIV rather than age, respondents were able to distance themselves from being "finished". HIV, once managed with ART, provided the possibility of future physical productivity. Ageing however was a linear trajectory and could not be managed (Chapter 3). In the following example, Esnart make sense of her present behaviour ("not doing anything") and previous behaviour ("I was able to work") by drawing on her identity as an independent adult ("I used to be a person who would help myself, I did not rely

on someone, no, not that.") and the possibility of behaviour that would reaffirm that identity ("one day I will be strong"):

> *In the past I was strong. I was able to work. I was pounding, fetching firewood in the mountain, drawing water. Before I was sick, I was very strong. But since 2003, I was not doing anything. Better this year, I can do a little bit…Even though I am weak now, I know one day I will be strong as I used to in the past… I used to be a person who would help myself, I did not rely on someone, no, not that... I was working in my garden and feeding myself, I could do a profitable business, I could do piecework, but now when I started becoming ill, all these things have changed.*
>
> [Esnart, female, mid-60s, single, HIV+]

The narrative of 'blood loss but identity continuation' is highlighted most strikingly by Daniel. Daniel lived on the edge of a tarmac road, a short distance from the closest rural trading centre. This was some miles from the other respondents whose homes were much less accessible. He was one of a few male respondents to have a business outside of the agricultural production that almost all rural Malawians engage in. He owned a tea room; a small building with a tin roof containing a wooden table, a broken plastic chair and a wooden bench from which he and his wife served tea sweetened with milk and sugar to wealthier passers-by. There were no customers during any of our visits.

Asked to describe himself at the beginning of our first interview with him, he answers:

> *OK, at the moment I am married. My main occupation is farming, but I love to do business. At the moment my business has gone down, because of the disease. I started becoming sick in 2003, 4, 5, is when I started receiving the ARVs. The child that I have in this marriage is only one son, but I found my wife with 4 children, I found them very young, it's me who has brought them up.*
>
> [Daniel, male, early 50s, married, HIV+]

In the passage, the use of "but" implies that despite his current occupation, Daniel is really a businessman – this is his identity. He implies continuity in that identity by stressing that he is only unable to work "at the moment" and highlighting his past work in business and bringing up children. In doing so, I argue that he stresses that the dissonance between his behaviour and his identity are temporary and that change in his behaviour does not reflect a change in his identity.

We next saw Daniel two weeks later. Asked what he had been doing since our previous interview, his answer can again be understood as an attempt to distinguish his HIV-related behaviour from that of his identity: the 'real' him:

> *This week the most time was spent on my illness. So, but I really wanted to be farming. So that my wife should be left here [at the tea shop] and I start farming little by little. So this week I can't say I have done this and that, no. Yes I spend much of my time in bed. I have spent all the two weeks in bed. Previously I was trying to do some other things; small-small things.*

He presents this period of illness within a framework of work and productivity. The time he spent in bed is time he would have liked to have spent working ("I really wanted to be farming") and time he would previously have spent working ("trying to do some other things"). In doing so, I suggest he highlights to the interviewer what kind of person he is: being in bed is not typical behaviour for him. As in the previous interview, he suggests the continuity of his productive behaviour over time: he was working previously and through emphasising "this week", implies that inability to work is not permanent and he may return to work the following week.

Later in the interview he emphasises that he is a business man. He stresses the size of the plot for his tea room and that due to his business acumen, the tearoom is still functioning. As Fiskani, above, he stresses that it is "only the disease" that has challenged his productivity. Although he lacks capital investment, like Esnart, he has the potential to be productive: he is in "a good business place":

> *This place belongs to somebody but all this part here is ours. Yes I have a big place even behind here… All this yard from the fence to that end is my place… The problem is the capital… The business is there, if one can*

have a good capital then you can be able to gain a lot. But with our small capital and the illness has also consumed part of it… So there are a lot of problems but we are at a good business place the only problem is that we have no one to help us [provide capital].

6.2.2.2 Continuing productivity

Interlaced with these narratives of future possibility, respondents emphasised their present ability and practice of physical productivity. With the exception of one respondent who had recently been diagnosed with HIV and had not experienced any illness ("as of now I don't have any problem… I just feel normal life as before" [Steven, male, 57, married, HIV+]), respondents forwarded both future and current productivity narratives simultaneously across their interviews. Their discussions can be seen as a direct response to the identity challenge presented by the perception of HIV infected older people as non-adults.

Narratives about hard work – and in particular returning to hard work following infection – were embedded within understandings of the transformative nature of HIV, and the discourse of a new, "positive life". For some respondents, self and familial provision through work reflected their moral cleansing through HIV. In the following example, two HIV support group members talk of both, having been enabled to work through the wisdom of being tested and receiving treatment, and "learning" the importance of "hard work" following their moral transformation. In the second excerpt, the group member forwards their attitudes to work (their 'commitment' to work) as a direct response to the discourse of "finished" infected older adults:

[Before HIV testing] I was worried [but], I became courageous… I made up my mind that being with kachilombo *is not the end of life, because you can learn more things, and the strength I have now is greater than the one I had before I got tested. Because now I can work and be dependent on my own. Not depending on other people to help me, this is what I have learnt that belonging to a support group, is one way of learning things, and making life have a meaning through hard work.*

[Kondwera support group member, 50+, HIV+]

> *The coming of the support groups have changed people's mind. In the past we used to think when a person is sickly, we used to say they have* edzi, *the* edzi *people were not working, they were only waiting to be assisted… But here we are encouraging each other to be committed to doing work and depending on ourselves. But we feel other people have not known this truth, we feel people should be sensitized that a person with* kachilombo *is just as good as the one who does not have it."*
>
> [Kondwera support group member, 50+, HIV+]

For others, work presented a continuity of their pre-infection behaviours, made possible by the initiation of ART. In the following example, Zione discusses how her life has improved now that she is able to work following treatment:

> *Last year I had problem, I was not good. I was reduced to a beggar. This year I have problems but they are not that much... I am happy [now]. When you rely on people to give you food, they can give you anything they want. But if you have your own food, you can cook anything you want, or any time you want. I am also able to give it to my grandchildren, they come here and have food, they feel more accepted and welcome. You also have people looking at you as a someone, who is not here to be a burden to others... Life has changed so far, I feel my daughter will be relieved of the burden that she had in the past. She also has a big family, so when she was supporting me it was an added burden to her. I am now fine. I can now do the things which I was not doing… At least [when] I can do something to support myself, I feel I am someone.*
>
> [Zione, female, late 70s/early 80s, widowed, HIV+]

For both groups, physical productivity was understood as constituting the adult identity standard. Zione notes that now she can support herself she is "someone". The support group member notes that "the person with *kachilombo* is just as good" as a person without.

6.2.2.3 New productive roles

Finally, HIV and the possibility of "living positively" in a "new life" discussed above, gave infected respondents opportunity to occupy new, positive social roles. They were actively involved in HIV prevention and care efforts, "sensitising" others to the needs and experiences of people with HIV and encouraging testing, particularly among the very ill. Despite their grounding in HIV infection, otherwise considered to undermine respondents' social identities as mature and productive adults, these roles shared the meanings associated with this identity standard.

In the anecdotes and reports, offered by almost all infected respondents, older adults with HIV appear as hero-like figures. They are - in-line with the matured, idealised adult identity standard - wise, selfless and caring. In the following excerpt, Daniel talks of his role as 'mouth piece' for the members of his support group. In direct contrast to the meanings of weakness and non-contribution associated with the 'non-adult' identity, he presents himself as an integrated member of a community ("all my friends"), a contributor, and a "strong" force to be reckoned with ("tell them that Daniel Mhango Mstogoleri has said so"):

> *I really want those with the virus here at [sub-traditional authority place name[41]] to be helped. I am representing them all here at [place] … the radio has announced the allocation for those with the virus but we will not get that allocation which is in billions not millions, but it will end up in some other people's pockets in the offices and buying cars… Where is the help? They are not helping us. Go and tell them that Daniel Mhango Mstogoleri has said so. We are not helped here: [Place] in Balaka Group Village Headman [place]. There is a strong support group, you have trained them but they are not supported.*
>
> [Daniel, male, early 50s, married, HIV+]

In a second example, Nyuma, in a familiar story among infected respondents, discusses how she has visited sick people and advised them to seek HIV testing and

[41] Districts are sub-divided into rural traditional authorities (TAs) or urban administrative wards. Some traditional authorities are further sub-divided into areas that encompass a number of villages.

treatment. In similar narratives to those produced by the support groups, she "encourages" these people, and receives thanks from their families. In doing so, Nyuma fulfils the roles of an 'elder': She is both caring and wise. Moreover, in contrast to the advice of infected non-elders discussed above, her advice is respected and followed. Like Steven (above), her identity is affirmed through her own perceptions of her behaviour and that of others:

> R *She came from her home, coming here. She was sick, and she came here and slept here. When I asked her 'what is the problem?' she said 'my mother is not caring for me very well'. I said 'okay'. I took her to [name] Hospital. I said 'Agnes, this is your patient', that's my doctor… She was well received and helped. It's there where they told her, you have* kachilombo*… Then I took her to her mother, I told them, 'here is your child, we are coming from the hospital'. They said 'thank you very much, you have done a very good thing'… I told them, I said 'the hospital says, she has* kachilombo'. *Their mother started crying, I told her, 'no, this is not death, nor the beginning of death. This* kachilombo *is just there, but she will be okay, perfect good'*
>
> I *When you took this person to the hospital and caring for her, how did you feel?*
>
> R *I was feeling happy, I knew I was taking care of my friend. I had to show my love to her. I gave her water to bath, and then took her to the hospital.*
>
> I *When you took her back to their parents, what//*
>
> R *//They were very happy, happy indeed, they said 'thank you, thank you very much. Our daughter when leaving here didn't tell us she was coming there, thank you very much, you have helped us a lot', they said so.*
>
> [Nyuma, female, 68, single, HIV+]

I argue therefore that the respondents were motivated to reaffirm their physical and moral-contributory behaviour. I have suggested that in doing so they managed their identities as adults, rejecting the accusation of being "finished" non-people. As set out with regard to responses to the foolish non-adult identity, respondents navigated these challenges by using the narratives around successful management of HIV.

6.3 Summary

In this chapter I explored older adults' understandings and attitudes to HIV. I argued that these were anchored in discussion of the sexual transmission of HIV and the poor prognosis of those infected. I suggested that these two narratives had important implications for the way HIV at older age was understood.

Since respondents frequently contracted the time between infection and HIV diagnosis, both those with and without HIV discussed infection in older age as following from recent 'risk' behaviours. (This has been discussed elsewhere as a "misconception that matters" (Watkins *et al.* 2011).) In the dominant narratives reported, HIV in older age therefore demonstrated a lack of wisdom. To have HIV in older age was to dangerously and fatally weaken an already weakened body. Older adults with HIV were therefore perceived to fall short of both sets of meanings held in the identity standards of the adult: moral/social and physical productivity. Previous chapters (3 and 4) argued that this identity - conceived as a physically-productive adult or the morally-productive, 'elder' adult - was intimately linked to personhood, and as such was the core identity respondents aspired to.

However, older respondents with HIV did not identify with either the foolish or finished non-adult identity. Rather, I have suggested that their interview narratives represent discursive strategies to align perceptions of their behaviour and the meanings held within the identity standard for an adult. In discussions with my research assistants and me they presented themselves as wise, caring, restrained and physically capable, now or in the future.

I presented their narratives as a menu of response options. I suggested that older adults with HIV utilised combinations of these response options based on their perceptions of their behaviours and the meanings they held within the adult identity standard before their HIV diagnosis. For example, when the sexually-capable and physically-productive adult identity had been most salient before HIV diagnosis, the redemptive 'cleansed' and matured adult identity became more salient afterwards.

Although respondents reported new behaviours, the identities they forwarded were not new. By looking at the meanings and perceptions of behaviours, rather than just the behaviours themselves, I identified considerable cogence between the meanings of the post-diagnosis behaviours stressed by respondents and the meanings held in the identity standard for pre-diagnosis adult identity (as originally defined, or as redefined).

Chapter 7 | Ageing and HIV in Lilongwe

This chapter contextualises the experiences of ageing and HIV infection explored in the thesis (Chapters 3-6) within the policy and programme environment. This environment is primarily situated in the capital Lilongwe. It has been stimulated and shaped by its small number of actors' understanding and construction of both, the experiences of older adults in rural Malawi and the international discourses on ageing and HIV infection at older age outlined (Chapter 1).

Although there was some cross-over with regard to the actors, the policy and programmatic contexts surrounding ageing and HIV infection at older ages were essentially discrete. An old age policy context in which HIV infection was a small topic was just being established in 2010. Meanwhile tentative acknowledgement of HIV after age 49 was just being added to the pre-existing, well-established and

considerably better-funded HIV policy and programme context. Reflecting their separation, in this chapter I will review the policy and programmatic contexts of older age and HIV at older age separately. I will then explore the understandings of older adults that underpin these contexts.

The chapter provides an impressionistic, but analytical account of these contexts. As noted in Chapter 2, it is based on less in-depth analyses of data constructed from typically single interviews with key informants, from my observations of all stakeholders during a national conference on ageing, or collected in documents during my fieldwork.

7.1 The development of a policy context for ageing in rural Balaka

7.1.1 Introduction: constructing my review in 2010

This study was conducted at a time of change. There was an emerging recognition in Lilongwe of older adults ("the elderly") as a distinct "vulnerable group". A policy and programmatic context for ageing was in the process of being established. Between 2004 - when a governmental policy focus on old age appears to have begun - and 2010, "sensitizing", mapping and consulting were dominant activities. A series of mostly unconnected meetings over this period aimed to take stock of the ageing "problem", identify the stakeholders and their activities - especially the small group of civil society organisations who had been developing a programmatic context over the previous decade - and decide a way forward. On one hand, progress was being made: all key informants recognised new and essential political will, for which President Bingu wa Mutharika was held personally responsible. On the other hand, some civil society stakeholders spoke quietly of being stuck in a quagmire of meetings and workshops, as well as their fears about the sustainability of the ageing

agenda following the end of the President's office[42] and in the context of funding constraints.

Despite the frequency of meetings, key informants were typically unaware of the activities of other actors. In November 2007, the Food and Agriculture Organization of the UN (FAO) and the Bingu Silver Grey Foundation for the Elderly (BSF) held a large, well-attended meeting entitled *Population Ageing in Malawi: Understanding Challenges, Responding to Opportunities*. The proceedings of the meeting concluded that it had "revealed, once again, that there are many institutions in Malawi engaged in ageing-related activities, but that coordination among them is poor or non-existent – and this fact is not explainable just by limited resources. The poor coordination of ageing-related activities is exemplified, for instance, by the numerous policy training workshops taking place every year that, however, rarely result in new initiatives being actually developed and implemented." (BSF and FAO 2008, p. 13)

The existence of the FAO/BSF meeting proceedings is unusual; the outcomes of training workshops, meetings, consultations and policy and programme decisions taken have typically been undocumented or at least, not disseminated. Despite full bibliographies in the few documents available, almost all key informants from all sectors reported being unable to access the materials referenced. After our interviews, they were rarely able to find the typically-hardcopy internal documents they reported wanting to share with me. The communication system shared by all stakeholders was reliant upon calls to personal mobile phones and expensive dissemination meetings and workshops in the city's hotels[43]. Although UN

[42] Having served the maximum three terms, the President's leadership was due to end in 2014. However President Mutharika died on 5 April 2012.

[43] These meetings are typical throughout the development 'industry' and the academy in Malawi. Key informants described them as being essential for the dissemination of information and ideas, such as a research paper or report. An academic working in a university demography department described how the expensive events were 'costed' into research budgets: "As you know, it is typical for research that dissemination is a source of big budget on its own, because you have to cost and cost and so on, provide them [participants] accommodation because some of them come from different places, and so on and so on, so if you don't have that provided for in the budget it's very difficult, because you get results and good studies and they just print the reports but they don't get disseminated so

employees had UN email addresses, all other stakeholders used personal email accounts, but irregularly, consistent with patchy and intermittent internet provision in the country. Only the UN and government stakeholders have websites. The latter continues to contain very little content: The Ministry with responsibility for ageing (The Ministry of Persons with Disabilities and the Elderly) has an entirely blank webpage (Malawi Government 2012b)[44]. The postal service was used infrequently for sharing documents and letters. The newness of "the ageing issue", the perceived skills-shortage with regard to work on ageing, and the insecurity of organisational funding were evidenced in chronic staff shortages across almost all organisations, and considerable un-staffed periods. As a result, continuity of ideas and institutional knowledge was limited. Very few key informants could elaborate the history of their organisation's activities with regard to ageing or provide any overview of the policy and programme landscape.

Participants at the FAO/BSF meeting noted the need to review and document the ageing policy and programmatic environment (BSF and FAO 2008). This chapter begins with my attempt. It is pieced together from disparate key informant interviews and documentary data collected in Malawi. This documentary data collection includes that found by searching the internet for events, authors and organisations that key informants mentioned vaguely but could not elaborate on, such as Help Age International's involvement. These sources are referenced in the text. The outcome is a slight hazy picture of the history and development of ageing

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you wouldn't know what's going on." [Senior Academic] They were designed to be attractive to participants, typically involving meals, per diems, travel allowances and opportunities for networking. For NGO volunteers in particular, these per diems were a vital source of income. Swidler and Watkins document another face of this culture of workshops in their discussion of the sustainability discourse in donor-funded AIDS programmes in Malawi (Swidler and Watkins 2009, p. 6)

[44]Although the Government of the Republic of Malawi website referenced here was updated considerably in 2012 following the death of President Mutharika and the succession of Joyce Banda, the webpages from 2007-2010 (no longer accessible) were similarly sparse. On the current website the Ministry of Persons with Disabilities and the Elderly contains no description of the Ministry's role, in contrast to all Ministries. However, from 2007-2010 the page contained a single link that connected users to the Ministry of Social Development and People with Disabilities, established in 2004 and disbanded in 2006. Elsewhere on the website, the National Disability Policy was included in a list of Government Policies from across the Ministries. There was no reference made to the elderly anywhere on the website.

policy and programmes in Malawi that should be read with caution. Not all the documents referenced by key informants were available to me to read.

Individuals discussed by name reflect their personal influence in shaping the ageing policy and programmatic arena in Malawi. Their dominant roles and activities were corroborated by key informants from every sector and did not appear to be contested. Their dominance in the history I constructed and present here reflects their roles, but moreover the length of time they have been involved in ageing policy and programmes in Malawi. However, it does not represent the privileging of data from interviews with these individuals in shaping my analytical account.

References indicate the primary source of data on which I constructed each stage in the development. However, each stage was rarely constructed solely on one source of data. Aside from the exceptions I note, there was little disagreement among key informants regarding who the main actors were or what they were responsible for. For example, between 1992 and 1999 my construction is based predominantly on the description given by one key informant since few others were active in Malawi at this time. Nevertheless, in 2010 his account appeared to constitute accepted history, as government and civil society key informants reiterated his involvement and referred me to speak to him in order to construct my account. I detail his involvement in order to illustrate how understandings of ageing and old age in Malawi in 2010 have been shaped by individuals exposed to international discourses on African ageing.

7.1.2 A patchy history

For 92 per cent of Malawians not employed in the formal sector (National Statistical Office of Malawi 2009) there is no form of social protection in old age. The policy context emerging in Malawi centred on its provision, either as a universal social pension, or as part of a wider social protection programme targeting all vulnerable households, and the development of a national policy specifically focused on older adults. Programmes targeting older adults consisted of ad hoc and irregular small-scale distributions of goods and geographically-limited advocacy projects

encouraging communities to care for their elderly members. Such projects reflected stakeholders' shared understanding that although limited facilitates might be required for "destitute elderly", institutional care for older adults was not culturally-appropriate "for Africa". This understanding was explicitly tied to experiences in neighbouring Zambia where Government policies have sought to move away from the institutional care that formed a significant part of the welfare policies inherited at independence since the 1980s (see Brooks and Nyirenda 1987). Stakeholders suggested that primary strategy for improving social support for older adults ought to be the facilitation of informal systems of familial or community care [field notes on *Ageing in Africa: Sensitizing the Nations* conference].

The activities of one international and three inter-connected national NGOs, three UN agencies, academics at the University of Malawi, three Government Ministries and the President's personal foundation, had been central in shaping the policy and programme landscape that had emerged in 2010. Although other actors were involved or had carried out ageing-related activities, (some of whom were interviewed, see Appendix F) their influence did not feature in the majority of key informants' narratives. Those frequently absent from the history constructed by key informants include the small number of NGOs and religious groups carrying out work with older adults as part of a wider remit or within single districts or regions (such as Elder People Association, discussed briefly below), the Ministry of Health, which struggled to respond to the challenge of the absence of geriatric training in the public health service [MoH key informant], and not least the elderly themselves, groups of "prominent" older adults, typically well-educated and English-speaking former public sector workers ("those who are able to say something"), selected by the key actors to attend large conferences and consultation meetings [Ministry for the Elderly and PUSEPA key informants]. These actors are subsequently less represented in this Chapter.

The skeleton history of the burgeoning ageing policy and programming context I present is hung around the activities of these most prominent actors. I include some of the key events in the development of parallel general social protection provision. Within Malawi, general social protection has been much more fully documented than

age-related provision and its development has been subject to a number of critical reviews (see Chinsinga 2007; Devereux and Macauslan 2006; Maliro 2011; Slater and Tsoka 2007). Events are chronologically ordered as far as possible.

1992

- A small-businessman named Richard Jagali returns to Malawi from a period living in South Africa. There he had visited NGOs caring for the elderly and was impressed by what is achieved. From his home he begins to conduct research, making visits to older adults in his own and surrounding villages. He finds that the elderly are "voiceless" and cannot communicate their problems. He drafts a document about the situation of old people in Malawi and the kinds of policies that would be needed to address "their plight". [Interview with Jagali]

- Jagali establishes 'Elderly Clubs' in rural villages around Lilongwe based on those seen in South Africa. Working with the village heads, he identifies "active" older adults in each area and invites them to form a committee. He returns to register the committee and holds two-day workshops[45] to train the committee to recruit other older volunteers to sensitize their communities on the importance of elderly care, and to make visits to less active older adults to identify areas of need. Jagali encourages committee members to engage in income generating projects, such as weaving mats, to raise funds to assist the vulnerable older adults identified. Larger problems are reported back to Jagali who seeks external funding to assist them [Interview with Jagali]. This model will be repeatedly used by stakeholders over the next eighteen years [Interviews with NGO stakeholders].

- This is the first initiative any key informant mentioned. Jagali's efforts are the earliest indication of policy or programmes focusing on older age in Malawi I could identify.

[45] For which lunch is provided. As noted above [2], and by the NGO stakeholders operating in rural areas, transfers made during these workshops are central to their functioning. These stakeholders provided detailed descriptions of the refreshments they provided at various workshops over twenty years, reflecting their perceived importance for recruiting and sustaining volunteer-run projects.

1994

- Bakili Muluzi wins Malawi's first multiparty presidential election.

- The Public Pensioners Association of Malawi (PUSEPA) is established to assist former public service employees who receive a non-contributory pension. The NGO will negotiate between the Government and the 30,000 (in 2010) retirees. By 2010 the organisation will have successfully campaigned to have pensions linked to inflation and the salary of the employment position held[46]. [PUSEPA key informant]

1995

- Jagali takes his document on the plight of Malawi's older adults to the new government's Ministry of Gender. The Ministry's remit includes focus on 'vulnerable groups'. Jagali argues that this includes the elderly. The Ministry responds that old age is not a priority area for Government since the elderly are cared for by their children. This is corroborated by UN stakeholders in 2010 and observations on other African settings (Apt 2005).

  On the Ministry's advice, Jagali applies to register an NGO so that he can address ageing issues on his own. He uses money earned from his private businesses (selling buildings and crops) to establish the **Aged Support Society of Malawi (ASSOM)**. It is the first organisation to specifically focus on old age in Malawi. He recruits a board of unpaid trustees. [Interview with Jagali]

[46] During Hastings Banda's rule (1961 to 1994), pensions were paid inconsistently, if at all. In 1994 when PUSEPA was formed, they lobbied the government, then Bakili Muluzi's (1994-2004) to raise the pension from the blanket 11MK in-line with inflation, length of service and position held. In 2010 they accused the government's Finance Ministry of calculating pension provision arbitrarily and unfairly. Retirees who had worked as civil servants for central government in Lilongwe received 30,000MK (~£128) per month, a significant payment. Retirees who had worked as cleaners for example, received the minimum pension of 2,300MK (£9.80) per month. Although PUSEPA argued that pensions were insufficient, they were widely considered enough to live on by other stakeholders, especially those keen to see non-contributory pensions extended to all older adults. [PUSEPA key informant]

1996

- The **United Nations Development Programme (UNDP)** recognises societal changes associated with changing demography of Malawi (growth of the older population, mortality and migration of younger adults) as an area of requiring focus. Since ageing is not a priory area for Muluzi's Government, the UNDP begin to fund ASSOM to carry out ageing-related activities. Between 1996 and 1997 they fund Jagali, its Director, to attend international conferences on ageing in Germany[47], Singapore[48] and Malta[49] with the aim of building capacity in Malawi. [Interviews with Jagali and UNFPA].

- UNDP funds ASSOM to conduct a small workshop in Lilongwe on health and hygiene for the elderly based on lessons learnt from the international visits. It is attended by old people in the area. [Interviews with Jagali]

1997

- The board of trustees and Jagali quarrel: They have been working unpaid while Jagali's extensive international travel suggests he is profiting from the NGO. Jagali leaves ASSOM and establishes the **Aged Welfare and Development Association (AWEDA)**. He is the Executive Director and only member of staff. [Interview with Jagali]

- ASSOM's most prominent trustee becomes the organisation's Director. **Thomas Mbewe** is employed as Head of Programmes. ASSOM's mission, aims, objectives and programmes (including elderly clubs) do not change from Jagali's initial vision. The organisation aims to develop and support programmes that empower older adults, advocate for the rights of older adults and care for orphans under the care of older adults. [Interviews with Mbewe and Jagali]

[47] Probably the 4th International Congress on Health Ageing, Activity and Sports, August 27-31 1996, Germany.

[48] Probably the World Congress of Gerontology, August 17-19 1997, Singapore.

[49] Unknown.

1998

- **The Elderly People Association (EPA)** is established in Blantyre by a female banker. According to Jagali, she has been inspired by ASSOM's work. By 2010 EPA works across nine districts in Malawi's southern region. [Interviews with Jagali and EPA]

- Jagali's second NGO AWEDA begins to operate small scale ad hoc projects. He rents an office and begins to re-build a network of contacts in organisations concerned with ageing for his new organisation. He visits villages around Lilongwe working with village heads to identify areas of need and encouraging younger adults to look after the elderly in their communities and plan for their own futures. He recruits volunteers in the village to build a small shelter for the elderly and elicits a donation of blankets from the Red Cross. Private companies in Lilongwe donate items for him to distribute in the villages. His advocacy work continues. [Interview with Jagali]

- The UNDP funds Jagali as AWEDA to celebrate the International Day for the Elderly with a workshop at Civil Stadium in Lilongwe.

- **HelpAge International** has no permanent presence in Malawi. However AWEDA is approached by **HelpAge UK** to attend workshops and international meetings they were organising. They fund AWEDA to carry out a short programme [Interviews with civil society stakeholders]. No details of this programme were available in 2010 and the extent of the organisation's activities in Malawi is unclear.

1999

- The UNDP funds AWEDA to host a second celebration of the International Day for the Elderly in Blantyre. It coincides with the UN International Year of Older Persons. [Interview with Jagali]

2002 – 2003

- A food crisis affects much of southern Africa, including Malawi's southern region. EPA receives funding from HelpAge UK and technical assistance from HelpAge Kenya to distribute food, repair homes and support vegetable production. Four day care centres are established to provide food for especially vulnerable older adults and encourage their participation in income-generating activities. (Help Age International 2002, 2003) [Interview with EPA]

- The **United Nations Population Fund (UNFPA)** replaces the UNDP as the UN body concerned with ageing in Malawi. Under its *Care Support Empowerment of the Aged* project, the UNFPA provide funding to ASSOM to increase public awareness of the needs of older adults, especially with regard to their role as carers to adults with HIV and orphaned children. ASSOM carries out a volunteer-run civic education programme for traditional and civic leaders aimed at "community sensitisation and mobilisation on the rights of the aged and on the need to care and support the aged" (UNFPA 2004) [Interviews with UNFPA and ASSOM]

2004

- **Bingu wa Mutharika** is elected President. All key informants accredit his personal interest in care for the elderly for the development of a policy context around old age in Malawi.

- Under the new government, the Ministry of Persons with Disabilities is replaced by the **Ministry of Social Development and People with Disabilities**. The Ministry of Gender is replaced by the **Ministry of Gender, Children and Community Development**. As within Muluzi's government, gender is (and in 2010 continued to be) considered an overarching lens through which to examine

all types of vulnerability. Reflecting Mutharika's interests, the Ministry begins to include ageing and old age within its policy remit. [Interviews with UN and Government stakeholders]

- AWEDA (Jagali) and ASSOM (led by Mbewe) begin to advocate for greater inclusion of the needs of the elderly in development planning, the instituting of policies and appropriate legislation to address the needs of the elderly and the need for a ministry specifically focused on ageing. [Interviews with Jagali and Mbewe]

- UNFPA commissions ASSOM to conduct research on the situation of the aged in Malawi, with support from the University of Malawi (Department of Population Studies) and the Ministry of Economic Planning and Development (Population Section). Mbewe designs the research study. [Interviews UNFPA, ASSOM, Department of Population Studies and Ministry of Economic Planning and Development]

- **UNICEF** in Malawi begins advocating for social protection for vulnerable children. [Field notes on 'Ageing in Africa: Sensitizing the Nations' conference] (UNICEF Malawi Unknown)

2005

- ASSOM's director and board of trustees quarrel with Mbewe: Mbewe objects to their unauthorised redirection of UNFPA programme funds to other, unfunded ASSOM activities. Mbewe leaves ASSOM and establishes his own NGO, **Hope for the Elderly (HOPE)**. The organisation operates in the central region (Lilongwe and Mchinji). The aims, objectives and programmes of Hope are very similar to those of ASSOM, including the Elderly Centres. Jagali's ideas now underpin the three ageing focused NGOs in Malawi. Mbewe is one of Malawi's only social gerontologists and he is quick to establish the organisation. UNFPA cease funding ASSOM. [Interviews with Jagali, Mbewe and UNFPA]

- The **Malawi Growth and Development Strategy (MGDS) (2006-2011)** is adopted in July. It provides an overarching framework for all Government activities. Valid for five years, it is considered a medium term operational strategy for attaining Malawi's Vision 2020 (Government of Malawi 2006), an all-party agreement made in 1998 to become "secure, democratically mature, environmentally sustainable, self-reliant with equal opportunities for and active participation by all, having social services, vibrant cultural and religious values and being a technologically driven middle-income economy" by 2020 (p. 3). Social Protection and Disaster Risk Reduction for the most vulnerable is the second of five key themes. The elderly are included in the Strategy both as those most vulnerable to disasters (p. 35), and as those who may be excluded from Malawi's economic growth and development, "due to their inability to actively participate in the development process". The Strategy states that the "Government has put up plans to provide social protection to these marginalized groups of people." (p. xvi)

- UNICEF continues to advocate for the provision of social protection for vulnerable children. They argue that social cash transfers should be integrated into the Malawi Growth and Development Strategy (MGDS).

- ASSOM completes its research *The Aged Persons in Malawi: Towards Understanding their Situation and Challenges*. A meeting is held to disseminate the report. The deductive quantitative study conducted in each region aims "to identify the physical, psychological, social, sexual and financial abuses against old age persons" (executive summary). As well as considerable poverty, the report identifies significant prevalence of abuse, nearly half of the respondents having heard of incidents of elderly abuse. Among its recommendations, the authors suggest the formation of a policy on old age to guide programmes and the provision of social security to all older adults (Aged Support Society of Malawi *et al.* 2005).

- The Ministry of Gender, Children and Community Development begins to draft a national policy on ageing. [Interviews with government stakeholders]

- The President launches the **Bingu Silvergrey Foundation (BSF)** as a "nongovernmental, non-religious and non-political organisation that promotes and safe-guards the interests and welfare of retired and elderly persons above the age of sixty years". Without any staff, the Foundation's activities are limited. [Interviews with BSF]

2006

- The Ministry for Persons with Disabilities and Elderly (Ministry for the Elderly[50]) is established, replacing the Ministry of Social Development and People with Disabilities and subsuming the Ministry of Gender, Children and Community Development's ageing remit. It is designed to operate as separate disability-focused and elderly-focused divisions, overseen by the Principle Secretary. With regard to ageing, the Ministry is mandated to "promote the quality of life of older persons and ensure that they participate fully in all spheres of socioeconomic development of the country" (Mwale 2010). Its role is to coordinate, monitor and evaluate elderly-related legislation, policy and programmes being carried out by all stakeholders [Interviews with Ministry for Elderly]. Its key areas of work are described as "policy formulation, provision of nutritious food to those in need, civic education and awareness-raising about the elderly, collaboration with BSF, and production of printed materials" (BSF and FAO 2008, p. 12). In addition, the Ministry has an unpublicised fund to provide small-scale direct "public assistance" to individual older adults in response to requests [Interviews with Ministry for the Elderly].

- No personnel are recruited into the elderly-focused division due to the perceived shortage of skills in the country with regard to the "new elderly issue", expected to involve the need for health and medical expertise. However, the disability division begins to work with the Ministry of Gender, Children and Community Development to continue drafting a national policy on ageing. In addition, the department division begins to administer ad hoc direct assistance to elderly individuals. [Interviews with Ministry for the Elderly].

[50] As it was referred to by ageing-related stakeholders.

- The first preliminary Draft Policy on Social Protection[51] is written by the Social Protection Steering Committee. The Ministry of Economic Planning and Development coordinates the Committee, but receives input from, among other stakeholders, Ministries involved with "vulnerable groups" including the Ministry of Persons with Disabilities and Elderly and the Ministry of Gender, Children and Social Welfare. It is intended as a medium term policy to contribute towards the reduction of poverty and vulnerability, in line with the MGDS. The draft does not meet the approval of civil society, donor agencies or parliamentarians (Chinsinga 2007). Subsequent drafts will be written over the coming years.

- In July the **Mchinji Pilot Cash Transfer Scheme** is started with UNICEF's financial and technical support. The Scheme aims to reduce poverty and food insecurity, and increase school enrolment and attendance among children living in beneficiary households. It is designed to target 10 per cent of households that are both "ultra poor" (the poorest 22 per cent of the population) and "labour constrained". These are expected to include the elderly, disabled, AIDS affected, women and orphans and vulnerable children. Improving children's welfare is at the heart of the project (Schubert 2007).

- **The Food and Agricultural Organization of the UN (FAO)** commission a study investigating the situation of the elderly in rural areas, within their mandate to consider equity in rural livelihoods. The work was carried out under the project *Building the Capacity of Agricultural and Natural Resources Sectors for Effective Implementation of the Malawi Growth and Development Strategy (MGDS), with Special Focus on HIV and AIDS*. The FAO Representative in Malawi interviewed in 2010 understood that the rationale for activities regarding old age was through the indirect impact of the HIV/AIDS epidemic on the elderly, and reflected the "individual rather than institutional interests" of her colleague responsible for the commission, based at the FAO headquarters in

[51] I could not access this draft.

Rome. The study, *Rural Ageing and Livelihood Challenges*[52] is conducted in rural Zomba between December 2006 and April 2007 by the Centre for Social Research, University of Malawi.

2007

The BSF employs an Executive Director to run the Foundation in consultation with Mutharika, formally launching its activities. The Foundation is funded by donations in cash or kind from national and international (recruited by Mutharika during trips abroad) businesses and private individuals directly, or through fundraising activities such as an annual golf tournament for Lilongwe's wealthy population. Its activities consist of making occasional and relatively small-scale (e.g. targeting 200 elderly) distributions of donated goods such as plastic buckets, blankets and food. Targeted areas are selected at random. The police accompany the distributions which are made using State House vehicles. The Foundation's promotional materials show crowds of older adults organised into rows and seated on the floor waiting to receive these hand-outs.

The Foundation commences plans to construct centres for the elderly in each of Malawi's three regions, and eventually all districts[53]. The centres will provide meeting places for the elderly where they will be provided with a meal, healthcare, skills training and visits from schools and speakers. Some centres would be residential to provide shelter for the destitute. [Interviews with BSF]

- The organisation is precariously placed. Its Executive Director fiercely defends it as "non-political" foundation that is unconnected to the Government (BSF and FAO 2008) [Interviews with BSF]. Meanwhile the Ministry for the Elderly describes collaboration with the Foundation as one of its key areas of work (BSF and FAO 2008). In 2010 other government stakeholders will describe the BSF as part of the Government's work on ageing [Interview with NAC].

[52] A short presentation about the research is given in 2007 but a report of the research was not available in 2010 and little discussed by stakeholders interviewed.

[53] These permanent structures to act as centres for the elderly are not similar to Jagali's Elderly Centres, despite the name.

- The preliminary results of the FAO-led study on population ageing and rural livelihoods in Zomba are disseminated in July at a meeting in Lilongwe. Based on survey data and four structured focus-group discussions, the report identifies significant poverty. Participants discuss the need to bring together key stakeholders working on ageing in Malawi to map the dynamics of population ageing and its impact of food security, livelihoods and rural development, and discuss a way forward. The convening of a national meeting on population ageing in Malawi is recommended. (BSF and FAO 2008)

- The Mchinji Pilot Cash Transfer Scheme is extended to three additional districts (Likoma, Machninga and Salima). The Global Fund to Fight AIDS, TB and Malaria Round 5 begins to fund the Pilot Cash Transfer Scheme starting from July. Consultants financed by UNICEF report that by November 2006, 65 per cent of the 3,094 households in receipt of cash transfers in Mchinji are elderly-headed (Schubert 2007). Preparations are made to extend the pilot to three additional districts in 2008.

- In November the FAO, together with the BSF, host a national meeting Population ageing in Malawi: understanding challenges, responding to opportunities in Lilongwe. The proceedings of the meeting will be one of very few documented outputs in the process of developing a programmatic and policy context to ageing in Malawi. Perhaps as a result, the proceedings become a key document over the coming years. By 2010, stakeholders, and government stakeholders in particular, will refer to their annotated copies repeatedly during interviews. In contrast, although reported on at the meeting, the FAO research study that led to its development is very rarely mentioned.

  Participants at the meeting made several recommendations. Key among them was the need for mapping and coordination of stakeholders' various ageing-related activities and the consideration of a non-contributory pension scheme. (BSF and FAO 2008)

  In 2010 NGO stakeholders will question the utility of the meeting. They report that participants were invited for political influence, rather than interest in ageing.

As a result, they contributed little during or following the meeting. With so few 'real' stakeholders and an un-staffed Department for the elderly at the Ministry of Persons with Disabilities and the Elderly, the ageing agenda is not developed. Indeed, many of the 13 recommendations of the meeting will not be taken further, including the coordination of ageing activities, an annual meeting for knowledge exchange on ageing or the development of policy-relevant research on ageing.

Despite the Ministry of Persons with Disabilities and the Elderly's personnel shortage, writing of a national policy for older adults by the disability department and the Ministry of Gender, Children and Community Development gains momentum. [Interviews with government and civil society stakeholders]

- HelpAge International fund Jagali to attend a 2-year training programme in South Africa on Organisational Management. [Interview with Jagali]

- The UNFPA's Programme Manager leaves, ending the organisation's direct activities with regard to ageing programmes and policy planning. [Interview with UNFPA]

2008

- The Ministry of Persons with Disabilities and the Elderly begins a series of consultation meetings with stakeholders with regards to the national policy. Large meetings are held in the first cities of each of Malawi's three regions (Lilongwe, Blantyre and Mzuzu). Donor agencies, international organisations, ageing NGOs, academics, Members of Parliament, various (unnamed) government stakeholders, District Commissioners (DCs), village heads and "prominent people in the village" and "eloquent elderly" selected by the DCs, are all invited to attend.

  The Ministry continues to provide piecemeal assistance to older adults in response to requests made by individuals, or by families, village heads, community based organisations or MPs acting on their behalf. According to

quietly critical NGO stakeholders, this includes the building of a MK 10 million[54] house complete with electricity and running water for a rural centenarian, and the purchase of coffins at the request of the family of deceased elderly. The activities are understood by NGO stakeholders as wasteful of resources, inappropriate, and in the case of the electricity, dangerous to the intended beneficiary. [Interviews with Ministry for Elderly]

- In 2007 the national FAO-BSF meeting on Population ageing in Malawi had recommended the establishment of a Technical Working Group on Ageing, coordinated by the Ministry of Persons with Disabilities and the Elderly and comprising various government, NGO, and UN stakeholders. This group is convened. Mbewe is made a member. In 2010 he describes his role as being a limited informal advisor to the Ministry on their activities rather than a member of a collaborative group that exchanges ideas. There is no mention of the group by other stakeholders. [Interview with Mbewe]

- The Mchinji Pilot Cash Transfer Scheme is extended to Chitipa, Mangochi and Phalombe. An evaluation of the Mchinji Pilot is carried out by the Malawi Vulnerability Assessment Committee, a consortium committee of government, NGO and UN agencies chaired by the Ministry of Economic Planning and Development. It finds that while the transfers assisted beneficiaries and increased school enrolment, the targeting of payments was unsuccessful. Less than a quarter of the households selected for receipt of the transfers were from the poorest, "ultra poor" quintile and 11.8 per cent were from the wealthiest quintile. Further, only 55.9 per cent of beneficiary households met the "labour constrained" criterion (Seaman *et al.* 2008).

- The feasibility of public pensions starts to be explored. HelpAge International (UK) plays a key, but largely undocumented, role in initiating these discussions. They fund a tour of low and middle income countries with social pensions for key government stakeholders. At the request of the Ministry for the Elderly,

[54] Around in £37,000 in 2008 (£47,600 in 2009 following significant deflation of the Kwacha).

HelpAge UK carry out a pension feasibility study. The study concludes that pensions are affordable and outlined an implementation strategy. Building on the Malawi Vulnerability Assessment Committee's poor evaluation of the Mchinji Cash Transfers Pilot, the feasibility study argues that the training and implementation of community-based targeting, along with the need for constant reassessment following receipt of transfers, make the scale up of the pilot untenable and ineffective, in contrast to universal cash transfers to older adults. [Interviews with civil society stakeholders]

With the support of the Ministry for the Elderly and BSF, HelpAge UK and the Economic Policy Research Institute (South Africa) produce a concept paper for a universal social pension scheme for submission to the Social Protection Steering Committee responsible for drafting the social support policy. The paper recommends the scheme as a way of meeting objectives outlined in the MGDS (2006-2011) to provide social protection to the most vulnerable, the draft National Social Protection Policy and the draft Nation Policy for Older Persons (Pearson *et al.* 2008)[55].

- A series of media reports suggest that the decision to develop a pension scheme has been approved. For example, a number of sources claim that Clement Khembo, Minister of Persons with Disabilities and the Elderly opened the southern region consultative conference for the draft policy by announcing that plans for a monthly pension scheme are underway and funding for the first phases is being sought (Help Age International 2008; Mizere 2008; Nyasa Times 2008).

- The Stephen Lewis Foundation (Canada) begins to support Hope for the Elderly. HOPE extends its volunteer-run outreach activities in rural areas. Slightly different from the Elderly Clubs of AWEDA and ASSOM, the activities involve recruiting all adults to attend awareness-raising workshops based in their village. Volunteers to monitor the wellbeing of elderly members of their village are

[55] I could only access a draft of this concept paper from the first author, which was missing the recommendations.

recruited with the lure of t-shirts and refreshments. In return for a hectare of land, HOPE provides agricultural inputs to the village so that younger adults can farm the donated land to produce food for the village's elderly. This is monitored continually by the volunteers recruited as HOPE's "eyes" in the village, and sporadically by visits by HOPE. The construction of a large office and community centre is begun in rural Lilongwe. [Interview with HOPE]

- Jagali returns from South Africa. Without funding, he cannot make the payments on the rent of his office. The offices are closed and all AWEDA's documents are destroyed by the landlord. AWEDA's box at the Post Office is also closed ending his ability to communicate with the organisations that had funded AWEDA's projects. Over this period Jagali attempts to operate AWEDA from his home but without communications or money for transport to the villages, many of the programmes AWEDA was carrying out end. However Jagali continues to make visits to the elderly clubs every year to encourage the committees of older adults to continue running them. [Interviews with Jagali]

2009

- The Ministry for the Elderly continues with its series of consultation meetings on the national policy. Civil society stakeholders (privately) accuse the Ministry of dragging their feet with regards to the development of the policy and their assessment of pensions. The Ministry attributes the lengthy pauses between each consultation meeting to delays in acquiring the significant funding required to host the meetings. The draft policy appears to be continually revised during this period. A fifth draft is produced, entitled *National Policy for Older Persons* in Malawi: Older Persons, New Power for Development. Re-writing of this draft appears to be frequent, and uncoordinated. Two different undated versions are given to me by different members of the Ministry in 2010 (drafts [a] and [b]). [Interviews with Ministry for the Elderly and civil society stakeholders]

- Subsequent (un-numbered) drafts of the National Social Protection Policy are written. The inclusion of the elderly among the "ultra poor" is stated prominently in the Minster of Economic Planning and Development's forward (p.

3). Ultra-poor households are later described as "those that have few or no assets, little or no land, limited or no labour, are chronically ill and are child/female/elderly headed with high dependency ratios" (p. 12) and increasing numbers of elderly-headed households is identified as a constituent of Malawi's "demographic vulnerabilities" (Republic of Malawi 2009, p. 13).

- Attempting to keep AWEDA functioning, Jagali solicits donations from well-wishers to distribute to small numbers of rural elderly. He receives packages of soap, sugar and blankets. In 2010 he comments that these hand-outs are unhelpful and unsustainable. [Interview with Jagali]

- ASSOM are invited to the Central region national policy consultation by the Ministry for the Elderly. The per diem from that meeting is their only income. [Interview with ASSOM]

7.1.3 The situation in 2010

The situation in 2010 was one of restricted progress. On one hand, stakeholders were generally positive that after periods of lethargy between the events outlined above, the development of a policy and programmatic focus on ageing was gaining momentum. On the other hand however, lack of funding, lack of personnel, and the fragility of the democratic governance system - or at least, a culture of opacity following non-democratic rule – was understood to challenge the sustainability this development [civil society interviews]. My analysis of interview and observational data indicated there was strong motivation to develop policies and programmes to help the "vulnerable elderly" from well-meaning individuals, but that this wasn't always echoed at the organisational level.

It resulted in a sort of impasse. Almost all stakeholders from government and civil society commented that progress was slow. The situation was well-highlighted towards the end of my fieldwork. The BSF, the Ministry for the Elderly and the Community of Sant'Egidio (an Italian NGO that had not been a major stakeholder in the development of a policy and programmatic context in Malawi), held a lavish two-

day conference entitled *Ageing in Africa: Sensitizing the Nations*. It was opened by President Mutharika, accompanied by Press and the fanfare of national army band. However, presentations and discussions at the conference appeared little changed from the last large meeting in 2007. A key informant, although impressed by the conference that "would not have been possible" twenty years previously, commented:

> *You are just talking and talking and then everyone leaves for their homes and there's nothing. There is just nothing! Like myself. I was there [at the conference] and I saw people are just talk-talk, talking about ideas that were there in 1995… Without money it can't happen! You know, you can have a very good plan [the national policy], but if the funds are not there, arh! It's dead.*
>
> [Civil society key informant]

Government stakeholders

Between January and March 2010 the elderly-focused division of the Ministry of Persons with Disabilities and the Elderly had employed its first members of staff: a Deputy Director, recruited from the 60-strong disability department, and a Chief Awareness Officer. Civil society stakeholders were optimistic that having dedicated elderly-focused personnel to communicate directly with would lead to progress in the development of the ageing agenda, while technical skills of the new staff were expected improve the appropriateness of the Ministry's activities. UN stakeholders commented that this indication of political will with regard to ageing would place them in a better position for supporting these activities. However, with just two staff, some ageing activities were still carried out by the Ministry of Gender, Children and Community Development and the Ministry of Economic Planning and Development. It was not clear from my conversations with the Ministry for the Elderly whether they were aware of these other activities.

The Ministry for the Elderly's direct "public assistance" had proceeded with no formal procedure in place. They described having sent cement and roofing to a village community to assist them in making repairs for an old woman whose mud

brick house had collapsed. Occasionally the Ministry was invited to visit a village to assess a situation and send assistance accordingly. It was unclear whether this reflected a change in the Ministry's assessment of need since earlier projects, or their presentation of more successful transfers during our interviews. The Ministry described the need to develop a more systematic approach that targeted the most vulnerable older adults:

> *At the moment we are just, as I said, we are not systematic we are just demand-lead, so it depends on who knows [they can ask the Ministry], what about the other people who don't know?... We really need something that would be targeting the right people, like there are some very old persons, who are very poor, but they are not targeted because no one has identified them, but if there was a systematic identification then we would be able to assist those in need.*
>
> [Interviews with Ministry for Elderly]

The consultations on the *Draft National Policy for Older Persons* had been concluded. A meeting had been scheduled to begin to cost an accompanying Action Plan. This would be attended by other government stakeholders, including the Ministry of Gender, Children and Community Development, as well as the five active NGOs working on "elderly issues" (ASSOM, AWEDA, HOPE, EPA and PUSEPA). It would then be submitted to the Ministry's Principle Secretary, and eventually to the Cabinet for approval. The Ministry was confident the policy would be passed in light of the extensive consultation process. Once approved, the role of the Ministry of Gender, Children and Community Development in implementing ageing policy would end.

However civil society stakeholders questioned the extent to which the *National Policy* would shape action when passed. One key informant commented on the low priority awarded to ageing within "recent" Sector Working Groups (SWG). These groups were intended to guide implementation of the country's second Malawi Growth and Development Strategy (MGDS II), operational from 2011/12 to 2015/16. This Strategy shaped all Government activities, and the groups comprised

government and non-government stakeholders working on the thematic issue, chaired by a lead Ministry and co-chaired by a development partner.[56]

The SWG guidelines placed the Ministry of Persons with Disabilities and the Elderly within the Sector Working Group on Vulnerability, Disaster and Risk Management. Other Government Institutions in the SWG were the Department of Disaster Management Affairs, the Malawi Council for the Handicapped and the National Youth Council of Malawi, while development partners and civil society organisations included DfID, World Bank, UNICEF, UNDP and Save the Children (Government of Malawi 2009). None of the ageing-focused actors that had shaped the ageing policy arena were included.

Civil society key informants were concerned that the ageing policy and agenda would be overshadowed by the much stronger, better funded and more capacitated emergency relief and social security actors in this group. For example, DfID and the World Bank are widely accredited with driving the social protection agenda and policy in Malawi (Chinsinga 2007; Devereux and Macauslan 2006). Stakeholders expected that DfID would be named as the co-chair of the group.

The relevance of their concerns rested on the inclusion of pension provision within a wider social protection plan. At the time of research, this was a central debate.

The *National Social Protection Policy* was at an advanced stage, but had not yet passed to the Cabinet approval (Jeke 2010). The Cash Transfers scheme remained in its pilot phase, and discussions about the feasibility and shape of instituting a national scheme were underway. With regard to ageing, discussions focused on extending and reorganising the scheme as a centralised vulnerability programme that would incorporate schemes that might otherwise have been instituted by the Ministry of Persons with Disabilities and the Elderly, Ministry of Gender, Children and Community Development or Ministry of Youth Development and Sports. This

[56] Sector Working Groups were in fact announced on 20 November 2008 (Government of Malawi 2009). The key informant's reference to them as being "recent" is likely to reflect slow progress instituting the Groups. By June 2010 members of only four of the sixteen proposed Groups had made any steps towards communicating with each other to build the network.

coordinated system was understood by government stakeholders to be more cost effective in targeting the most vulnerable citizens. The scheme would therefore take the place of a universal social pension, and, they argued, offer a fairer and more holistic way to tackle extreme poverty:

> *The issue of the pensions, I understand that it is not really viable for Malawi. But this one [an extended cash transfer programme] I don't know what they will call it, maybe a grant or whatever, but I think the idea is the same, that it will be cash to an elderly person, or a household with orphans, or maybe with a person with disability… If you give, universal pension to all the elderly whether rich or poor, but you neglect maybe a person with a disability who is poor, or maybe you neglect some orphans who are poor, but you are giving money to elderly persons who are at least doing better. So it's like morally, people were debating that, they are still debating that, I don't think there has been a conclusion.*
>
> [Interviews with Ministry for Elderly]

When asked, no other key informants corroborated this debate. However, a decision to abandon plans to introduce elderly-specific social security measures was also confirmed by an anonymous key informant. They commented "off the record" that HelpAge UK "came in too strong and too soon, when Malawi wasn't ready" in their advocacy for pensions. According to the informant, although HelpAge UK's feasibility study was well received, their arguments for pensions centred on examples that the Malawian government could not relate to: Delegates came from the London rather than Kenyan office, giving pensions a "white face"; the key example used was South Africa, widely considered a middle income country with more in common with Europe than the rest of Africa. At an undated time, stakeholders from the Malawi Government are believed to have visited HelpAge Kenya to report that they would not be pursuing the 'un-African' concept of pensions. During the time of my fieldwork, the influence of HelpAge International in the pension debate appeared to be sensitive: the organisation was little discussed and information about their role was difficult to elicit during interviews with the relevant government stakeholders, perhaps confirming this anonymous report.

However, any such decision had not been formally announced. Rather, the Ministry for the Elderly appeared to be avoiding discussion of pensions. At the Ministry/BSF-led *Ageing in Africa* conference, pensions were barely mentioned during either the invited presentations or the limited and heavily chaired discussions. The few presentations focused on other African countries focused on "the role of traditional family systems and community level structures" in expanding social protection for older adults (Doh and Bortei-Doku Aryeetey 2010), or made brief reference to universal social pensions as a challenge (Ntegyereize 2010). The presentation about South Africa, the only country represented that has a universal pension, made no reference to them (Kay 2010). The only Malawi-based presentation to mention universal pensions stated that Malawi needed to assess whether they could be afforded (Chiwona-Karltun 2010), making no reference to HelpAge International's 2008 feasibility study. According to civil society stakeholders, exclusion of pensions was deliberate:

> *You know, at the conference there was a problem. The Ministry were defensive. The presentations on pensions were all vetted by the Ministry before the conference. When the abstracts were selected for presentation, the ones about pensions were not accepted. They were allowed to attend at their own expense but then they were silent – they just watched.*
>
> [Civil society stakeholder]

Similarly, many conference participants commented during the breaks how little time was dedicated to discussion in the programme. Comments from the floor were heavily chaired and dominated by the feedback on the conference given by each of the 40 'prominent elderly' selected to attend. With very little variation between them, elderly participants introduced themselves, named their district, thanked the conferenced organisers, and stated that the lesson they had learnt from the conference was that communities need to "love the elderly" [field notes on 'Ageing in Africa: Sensitizing the Nations' conference].

During interview, the Ministry key informant presented previous indications of the Government's plans for pensions as misunderstandings. Asked about Clement

Khembo MP's speech announcing the Government's intentions to adopt a universal pension, they reported that pensions had never been approved and the media just "takes what[ever story] they want". I asked the key informant about the *Draft National Policy*, noting that two the versions of the fifth draft I had been given suggested that the Government would be providing unconditional social support for all adults aged over 60[57]. They answered only that they "would be surprised if there was anything so specific in the policy". It was not clear whether the suggestion was that I had misunderstood, or whether subsequent drafts would remove these statements.

Nevertheless, at the *Ageing in Africa* conference that followed these conversations, the Deputy Director of the Ministry described the extended Social Cash Transfer scheme as providing "interim relief" for older adults in her presentation (Mwale 2010). The suggestion that elderly-specific social transfers were still being considered was not missed by stakeholders. Indeed, civil society stakeholders were aware that pensions appeared less likely now, but understood that they had not been ruled-out. For example, in response to complaints during the conference that there had been no opportunity for discussion, conference organisers said that participants

[57] Undated fifth draft [a] p.26 states (emphasis added):

4.9 Social Security and Employment

[…]

4.9.1 Objective

To establish and implement formal and informal social security systems.

4.9.1.0 Strategies

4.9.1.1 ***Provide universal and unconditional social cash transfers responsive to inflationary trends to older persons above the age of 60 years.***

Undated fifth draft [b] p.15 states (emphasis added):

3.9 Social, Employment and Income Security

[…]

3.9.1 Policy Statements

The policy will ensure that formal and informal employment and income security are established by:

- ***providing unconditional social support transfers to older persons above the age of 60 years;***

could send them a statement to be incorporated into the conference proceedings[58]. Statements submitted by both AWEDA and HOPE requested that universal social pensions were implemented [AWEDA and HOPE key informants].

Civil society stakeholders

Funding and personnel significantly shaped the role of civil society stakeholders with regard to ageing policies and programmes. The sustainability of the organisations involved and their roles were variable.

Shortly before my fieldwork in 2010, the UNFPA had employed a new Programme Manager. It had been three years since their predecessor had left. During this time the organisation had not carried out or funded any ageing-related activities, nor had they contributed to the wide consultations on the *Draft National Policy*. However, the recruitment of a Programme Manager signalled a new era for the UNFPA's involvement: "with [the Programme Manager] on board we should surely find ourselves part of it, and in fact we should even initiate the dialogue ourselves considering that we have a stake". UNFPA key informants reiterated through our interview that the political will demonstrated by the Government's establishment and staffing of a Ministry dedicated to ageing, combined with their own increased human resource capacity, meant that the organisation was now ready to play a greater role.

At the same time, the FAO were losing personnel, and contracting their role within the ageing policy and programmes arena. Unlike the UNFPA, the FAO had been consulted on the *Draft National Policy*. They understood the policy's focus on nutrition and livelihoods to have been informed by the FAO-commissioned research and dissemination meeting. They were satisfied with their contribution, which had intended to stimulate rather than guide focus in this area. However in 2010, the FAO were no longer active in the area of ageing. Their representative in Malawi, who at the time of fieldwork was reaching the end of her short term contract, explained that this reflected shortages of FAO personnel in Malawi to implement the interests of their colleague in Rome.

[58] At the time of writing in August 2012, I understand that conference proceedings have not been produced.

Charitable organisations were in similarly contrasting positions with regard to their continued focus on ageing. At the time of fieldwork, only Hope for the Elderly had a regular source of funding. Investment from the Stephen Lewis Foundation and a small tuckshop in the centre of Lilongwe had secured seven paid members of staff. The organisation was in the final stages of constructing a tin-roofed multi-roomed office in rural Lilongwe. The building, which would have electricity and running water, would be used by community groups for HOPE projects. The organisation reported that they were supporting 4,200 older adults in rural areas through their volunteer outreach programme and had secured further funding from the Stephen Lewis Foundation to build eight homes for "destitute elderly". In addition, the organisation had been commissioned by the Ministry of Economic Planning and Development to work with the Department of Population Studies at the University of Malawi to produce a series of leaflets to distribute to older adults about "human rights and HIV". The Ministry had received the 2.8 million MK (around £12,700) for the project from the UNFPA. No key informants were able to offer further details about the forthcoming project during our interviews.

Now with two members of staff, an Executive Director and a part-time administrator, the Bingu Silvergrey Foundation was also making progress towards its programmatic goals. At the time of fieldwork the BSF had begun the development of a centre for the elderly in Luchenza in the south of Malawi. However, the sustainability of the organisation was questioned by key informants. Although the BSF asserted that as a personal foundation, it would continue to function following the end of Mutharika's office, other civil society stakeholders doubted this was the case:

> *R Ah! If it wasn't the government, it wouldn't be called by the President [have his name], it would have some other name. But if it's called by the President, now maybe the President is not there and the government somehow changes, so they will not even continue. That's the fact... even their [organisational] structure, you see their structure is the President's– the new person there is Mrs Mkandawire, and she's alone*
>
> *I You mean that all the board is Bingu's family?*

> R *Yes, yes, as directors. So is it an NGO? No, it isn't. Which means that if something changes, maybe the government changes, which means that the organisation also changes. Yeah, (laughs).*
>
> [Civil society key informant]

All NGO stakeholders, including the BSF, commented that funding was difficult:

> *I don't think [any NGOs are effective] because each and every organisation of elderly people, I don't think there is an organisation which is fully funded, we are all struggling. Even Blantyre people, [Director of EPA], also struggling. Even ASSOM. Ah! That's a problem. Everybody. They just keep pushing themselves to do this and that, and maybe do small-small, just small-small activities. But there is nobody who is on a payroll.*
>
> [Civil society key informant]

ASSOM and AWEDA suggested that the initiation of a Ministry concerned with the elderly meant that donors such as UN organisations were less likely to work with, and fund, NGOs directly. The Ministry were therefore considered a competitor in bids for funding. No NGO stakeholders knew of the money for direct assistance the Ministry had told me about, and based on their past experiences, believed there was no point applying to the Ministry for funding for their programmes.

Despite five years without funding and the death of its director, ASSOM continued to exist and was run by a Pastor. Its small office in Lilongwe's suburbs was staffed for a few hours each day by six volunteers. Although they were all unpaid, they described the per diems received for attending the occasional meetings run by the Ministry and others as income. The organisation still had no institutional funding and was not actively seeking funding, perhaps unaware of the process for doing so. With small donations from well-wishers they were able to make visits to the elderly staying close to their volunteers in Lilongwe, Mzimba, Kasungu and Nchyeo. They still had some of the Elderly Clubs established by Jagali. However, without any central funding to assist the elderly identified by the village committees, they reported that their volunteers were "dropping". [ASSOM key informant]

A programme manager, an officer, and "two volunteers" had been recruited for AWEDA. However no personnel received a salary. Jagali continued to the run his personal businesses and AWEDA from his home. A solicitor allowed AWEDA to use his office address and PO Box for their correspondence. The organisation had no funding. The Elderly Clubs continued in name only. AWEDA planned to move the organisation towards advocacy work. At the time of fieldwork, the organisation was seeking funding to "train trainers"[59] to sensitize younger adults towards the needs of older adults, encourage those who can afford to support their elders to do so, and encourage communities to raise money to support elderly whose families cannot support them. [AWEDA key informant]

Lack of funding did not just limit NGO's programming. It also limited their ability to critically engage with the Ministry for the Elderly's activities. They reported being dependent on the Government for funding, either directly, through commissions using donor money or the per diems received at meetings they were invited to, or indirectly, through the Government's perceived ability to damage the reputation of the organisation with potential funders. Therefore, while on one hand AWEDA saw its role as moving from programmes to advocacy, arguing that they were well-placed to hold the government accountable for implementation of the National Policy once passed, on the other hand, they were limited in their ability to challenge the Ministry's activities. They understood that more older adults' lives would be improved if NGO stakeholders remained in the Ministry's favour, and the running for funding to initiate their own projects.

One key informant described the nuanced ways their charitable organisation engaged with the Ministry. Despite calling NGOs "cowards" for their minimal advocacy work, the key informant was clear that their organisation was careful in how they communicated with the Ministry, focusing on older adults' needs - "real issues" - and not the content of the *National Policy* or the Ministry's activities. The key informant reported that by situating discussion on "uncontroversial topics" such as the plight of

[59] See (Swidler and Watkins 2009) for an interesting critique of this development approach in Malawi.

vulnerable and frail old people, ageing NGOs had avoided the conflicts and challenges experienced by other NGOs:

> *You know Ministry and NGOs we are two different [groups]. We work together because the issues that we talk about are not sensitive issues. But when they are sensitive issues you cannot sit together with the Government… For example, those who are actually doing human rights issues, direct human rights issues, they will always be at loggerheads with the government… Like now, there is a group of NGOs that the government is threatening to deregister. You see?*
>
> [NGO key informant]

7.1.4 Post fieldwork: a note on 2012

In 2010 President Mutharika had won a second term in office, was Chairperson of the African Union, and was highly regarded in the national and international media. By 2011 the President's popularity was very low, both inside Malawi and internationally. After accusations of aid mismanagement and increasing autocratic crackdowns that resulted in the shooting of 19 anti-government protestors, there were calls for his resignation. Vice- President Joyce Banda defected from Mutharika's Democratic Progressive Party to form the People's Party. However, on 7 April 2012 Mutharika died. Banda succeeded him to become Malawi's fourth President.

The intense unpopularity of the Mutharika in 2012, and the death of the Executive Director of the BSF sometime in 2011/12, has led to the abandonment of the former President's personal foundation. The Ministry of Persons with Disabilities and the Elderly, so associated with the former President's personal interests, still exists but appears to show no activity. The *National Policy* does not appear to have been passed. According to my research assistant, contacted in August 2012, "nothing is happening on the ground".

7.2 The inclusion of old age in HIV policy in Malawi

The HIV policy arena in Malawi is well-established and comparatively well-funded. In sharp contrast to ageing policies and programmes, developments in HIV policy and programmes are well documented and easily accessible (e.g. Malawi Government 2012a). As policies and programmes globally, it has typically focused on reproductive aged adults and children infected during birth or via breastfeeding. Discussion here centres only on the inclusion of older adults into these policies.

Triangulation of interview and documentary data indicated the very tentative recent inclusion of adults aged over 49 in HIV policies and programmes, and HIV infection in ageing policies and programmes. Prominent documents explicitly stated the need for research, policies and programmes to prevent sexually-transmitted HIV in older age. However with the notable exception of UNFPA, who were not directly engaged in the issue[60], such statements were at odds with the way stakeholders discussed HIV in older age.

The inconsistent, and at times contradictory, focus on HIV at older age is illustrated in the 2005 report carried out by ASSOM, the University of Malawi and the Ministry of Economic Planning and Development on *The Aged Persons in Malawi*. According to the report, one of the key objectives of the study was "to identify the general and reproductive health needs of the aged persons" (p. i and again p.5). However there is no mention of aged person's reproductive health in the following 35 pages of the report. General health is explored without mention of reproductive health (pp. 21-23). The risk or experience of HIV infection are not included within the list of eight effects of HIV and AIDS on older adults, suggesting it was not a possible answer on the quantitative data collection tools used (p. 14). The focus on reproductive health rather than sexual health for this population, defined as being aged 60 and older, is also unclear. Oddly, the report concludes that "sexual and

[60] Key informants from the UNFPA noted that their work focused on sexual health across the life course, and that programmes were needed to increase women's access to reproductive health services post childbearing because of the risk of cancers related to reproductive health in later life.

reproductive health (SRH) needs of the aged persons" should be investigated in the future (p. 34). However the authors do not justify why this is an area of interest, why it was not discussed within the report, or the inclusion of sexual rather than just reproductive health (Aged Support Society of Malawi *et al.* 2005).

Nevertheless, by 2010 the *National Policy for Older Persons* contains a prominent statement about HIV in old age that recognises older adults are at risk of infection. Both versions of the fifth draft of the policy given to me state:

> *In communities affected by HIV and AIDS, older persons are the primary carers of the sick and of the large numbers of orphaned grandchildren, yet they have no means to do so. Moreover, some older persons are still sexually active and need to be included in STIs prevention messages.*
>
> *3.10.1 Policy Statements*
>
> *The policy will ensure that Government provides support to older persons affected and living with HIV and AIDS and other opportunistic infections by:*
>
> - *reviewing policies relating to HIV and AIDS and other epidemics to ensure that they include issues affecting older persons;*
> - *conducting public awareness and prevention campaigns on HIV and AIDS, and other sexually transmitted infections include older persons;*
>
> *[…]*
>
> - *providing access to older persons to have HIV and AIDS services such as HIV Testing and Counselling, Anti-retroviral Therapy and psychosocial services which are age-friendly; and*
> - *providing prevention information to older carers PLHA to avoid accidental exposure during care giving.*
>
> (Government of Malawi 2008, Undated fifth draft [b] pp.16-17)
>
> (Very similar wording is used in undated fifth draft [a] pp.27-28)

Like the silence in the middle pages of the ASSOM report, no ageing stakeholders discussed this part of the policy with me. There was no mention of sexual health at the large *Ageing in Africa* conference in 2010. However, the policy was written

following wide consultation. The inclusion of the sexual transmission of HIV may reflect the input of HIV-focused actors rather than ageing-focused actors.

In 2010 the National AIDS Commission (NAC) (working in collaboration with the Ministry of Health's Department of HIV and AIDS, and the Office of the President and Cabinet's Department of Nutrition, HIV and AIDS) represented the central HIV-focused actor. While the Government was ultimately responsible for the *Malawi National HIV/AIDS Policy*, NAC provided technical assistance, resource mobilisation, monitoring of the epidemic, and overall leadership and coordination of the national response to HIV and AIDS. Indeed NAC had begun to consider HIV after 50 in 2008. The key informant interviewed noted that while they believed HIV after age 50 was low, prevalence was increasing. There was therefore a need to include older age groups in data collection and prevention efforts:

> *The graph for them was very very low, you know, so even within the analysis, we were not capturing them much. But now, we need to ask the districts, that they need to be reporting 50 plus. But the data was just small, the graph was very very small indeed, but now at least you can see a slight increase, so before things get out of hand, we need to do something so that we maintain the graph. It is not alarming figures, no, but only that at least we are seeing a trend of an increase, but it's not all that erm, big. But we still feel we need to do something before things get out of hand.*
>
> [NAC key informant]

The *National HIV/AIDS Policy* (as the *National HIV and AIDS Action Framework* (NAF) and the *National HIV Prevention Strategy*) contained no specific reference to HIV after age 49 in 2010. Interest in older age groups was recent and followed an (unnamed) conference in Nairobi in 2008. Presentation of Kenyan data had inspired NAC to consider adults aged over 50 in their own data. Drafting of a second edition of the *National Policy* had started and was likely to include older ages. In 2012 at the time of writing, this second edition does not appear to have been passed (Malawi Government 2012a).

However there was considerable disconnect between the assumptions of the *National Policy for Older Persons* and those likely to be included in the new *National HIV/AIDS Policy*. While the former focuses firstly on the sexual transmission of HIV at older age, the NAC key informant discussed only non-sexual transmission of HIV through caregiving. Further, reflecting the emphasis given to the need for empirically-based research in underpinning HIV responses, the key informant noted that there was no evidence for sexual transmission; evidence for non-sexual transmission could be taken from the prevalence of caregiving roles in older age:

> *I So where has the focus on older people come from, from the Kenyan data [presented in Nairobi]?*
>
> *R Yes. Carers! They are the carers… I mean you can't answer those questions unless you do research, otherwise I will be biased if I tell you through sex, because there is no evidence. But we assume it is because of the roles that they are playing. And even the children, the orphans who they are taking care of, some of them are already infected, because of …mother to children transmission of HIV. So if the mum dies, she leaves an infected child, then the grandmothers take care of this child, but if- she doesn't even know, that this child is also infected. So she's going to take care of her grandchild, but in the end get infected. So us, we think it is from there, the angle of the carer. Beyond that I don't have data to verify and document that it is through sex. Because I don't have the data to back us up, but our assumption is through the carer. Because that is the way we are seeing it: that there is a huge burden of care with the women and usually the elderly. Because it's attacking the reproductive age group. So for example me, I am of reproductive age, so for sure, my parents should be old, so if I'm sick they are the ones who take care of me.*
>
> [NAC key informant]

Only one NGO, Hope for the Elderly, mentioned HIV infection in older age. For HOPE too, caregiving was the only discussed transmission route. In 2010 a key informant discussed wanting to develop a programme to educate older adults about the risk of transmission when caring for infected patients. Although no details were available regarding HOPE's collaboration with the Ministry of Economic Planning and Development and University of Malawi to produce information for older adults

regarding "human rights and HIV", it is therefore likely that these would also focus on non-sexual transmission of HIV.

During the period of fieldwork, adults over 50 were not included in any HIV programmes or policies. The inclusion of this population in future HIV policy was likely to be based on prevention of non-sexual transmission of HIV. Further, the absence of HIV from the dominant discourses of the ageing-focused policy and programme actors suggest that it was unlikely to be a priority area for implementation after the *National Policy for Older Persons* was passed.

7.3 Dominant understandings of old age and HIV at old age in Lilongwe

The "lament discourses" on African ageing noted in Chapter 1 dominated the policy and programmatic data constructed and collected. They are documented explicitly in the proceedings of the FAO/BSF-led meeting on *Population ageing in Malawi: understanding challenges, responding to opportunities* in 2007. Demographic change and associated 'modernisation' is at the heart of the "challenges". Increasing numbers of older adults, urbanisation, rural-urban migration and HIV are associated with stagnating rural development with implications for older adults' health and nutrition, the weakening or loss of traditional care and support systems for older adults, and, at the same time, increased care and support requirements from older adults. The "opportunities" of population ageing centre on the contributions increased numbers of older adults can make as caregivers, "guardians of traditions" but most dominantly in the proceedings, as "sources of knowledge and experience" for communities (p. 5), that is, as 'wise elders'. The counterweight provided by these opportunities does little to readdress the balance however. The "bank of wisdom [and] experience" (p. 8) contained in the older population is hampered by their illiteracy, social isolation, limited participation and empowerment. The bank would remain closed without intervention of the meeting's participants.

The challenges and opportunities, and the weight awarded to each, are very closely mirrored in the *National Policy for Older Persons*. Here too, older adults are elders with "expertise, knowledge and experience [to] positively contribute to the economic, social, cultural and political development of the country". However, in the policy they are more regularly vulnerable old people, who "remain on the margins of [Malawian] society" suffering problems "ranging from abandonment to ailing health… [and who] despite chronic and disabling diseases, have to work into very old age - not by choice but from the sheer necessity to survive" (Government of Malawi 2008, Undated fifth draft [a] p. 1 Presidents' Forward).

This dire situation of older adults is presented as the rationale for the policy. Readers are informed that "in most cases, older persons have been subjected to loss of dignity, respect, love and victims of difficult circumstances. In general the rights of the older persons have been violated". Further older adults are "unable to generate their own income. Their bodies become frail due to health ailments and as a result their productivity levels deteriorate and therefore become dependent for their survival and well-being." (Government of Malawi 2008, Undated fifth draft [a] p.9 and [b] p.3) The challenging situation of the elderly is offered as a barrier to their inclusion in society as "useful citizens". The purpose of the policy is "to improve the quality of life of older persons and issue a new lease of life and bring hope to them". In sharp contrast to the dependency and un-productivity of older adults' outlined in the preceding paragraphs, the policy firstly aims to do this by "harnessing their proven capacity for productivity, independence and active involvement in the development of their communities." (Government of Malawi 2008, Undated fifth draft [a] p.10 and [b] p.4)

The diffusion of lament discourses in, and between, international and national understandings of African ageing is neatly illustrated by the coverage awarded to a paper presented at the 2007 FAO-BSF meeting by former employee of the UN Economic Commission for Africa, Zifa Kazeze. The short review paper entitled *Social Protection and Ageing in Malawi* is included as an appendix to the proceedings (Kazeze 2008). It begins by briefly recounting the findings of the 2005 ASSOM-led research *The Aged Persons in Malawi*, before presenting the

international policy context for ageing and the Mchinji Pilot Cash Transfer Scheme as the emergence of a Malawian policy context for ageing. It concludes by examining social protection programmes in other countries and the author's recommendations for Government provision of social protection. The weight of evidence presented in the report is non-Malawi focused.

A year later in November 2008, the Kaiser Network (now Kaiser Health News) circulated a report on Kazeze's paper to its large body of international subscribers. The "recent government report" is described as having shown that older Malawians receive less care from their children and communities in light of HIV and changing family structures associated with a weakening economy. ASSOM's alarming research finding that around half of respondents are aware of elder abuse is recounted, along with the need for their social protection (Kaiser Network 2008). Addressing an international health and development audience, the news report presents these experiences and understandings of old age as evidence coming from Malawi.

However, the ASSOM research itself was deductive. Based on understandings of African ageing documented in international health and development literature (presumably contributed to by some of Kaiser's audience), the study sought to test these assumptions: "The first stage of the study involved a desk review of existing literature on the aged… These background documents did [*sic*] set out the context of the research and also informed the design of the structured questionnaire" (p. 7). The only Malawian literature detailed in the report's bibliography is that used to introduce the Malawian context: the Malawi Demographic and Health Survey (DHS) and census reports, the *National Population Policy* and the *HIV/AIDS Strategic Framework* (Aged Support Society of Malawi *et al.* 2005, p. 35)

Although the research tools used are not accessible, some of the questionnaire wording is included in the report. This suggests a heavy hand in the construction of the data. The importance of gossip in ideational diffusion and the motivation to present experiences in ways that are most likely to attract assistance has been previously documented in Malawi (Miller *et al.* 2001; Watkins and Swidler 2009). I

suggest therefore that it is hardly surprising that 48 per cent of older adults interviewed reported to have "known or heard of the existence of" a case of elderly abuse. The proceedings of the FAO/BSF-led meeting also note that the report's findings are "similar to those reflected in the 2002 Madrid International Plan of Action on Ageing (MIPAA) and the 2002 African Union (AU) Policy Framework and Plan of Action on Ageing" (BSF and FAO 2008, p. 10). However, the Kaiser Network report does not reflect this deductive research design. Instead, in the implicit presentation of them as inductively-generated evidence from Malawi, the study's findings can be conceptualised as feeding back into and propelling the international discourses that shaped them.

All ageing and HIV stakeholders noted that the evidence-base for policymaking and planning on ageing and HIV in older age in Malawi is scant. The key informants discussed only the 2005 ASSOM-led study, the 2006 FAO study and Malawian DHS and census data. The ASSOM study was explicitly shaped by international discourses. The FAO study, also based on a deductive research methodology, is rarely referred to. The DHS collects data only for women aged 15-49 years and men aged 15-54 years. Although ageing was one of twelve thematic areas set out internationally that the National Statistics Office (NSO) planned to use to analyse the 2008 census data, in 2010 they commented that it was not a priority area for the country, despite the recommendations of the meetings on ageing.

Further some available evidence appeared to be under-utilised by government and NGO stakeholders. For example, the evaluation of the Mchinji Pilot carried out by the Malawi Vulnerability Assessment Committee in 2008 was not raised by any of the stakeholders interviewed. This included government stakeholders who were both heavily represented on the Committee that authored the report, and concerned to improve targeting of poverty alleviation programmes to the most vulnerable. Similarly, a key informant from the Ministry for the Elderly commented that research based on data collected from small or statistically unrepresentative samples was of little use for planning policies and programmes:

> R *There was a small survey that was done, a small one, a situational analysis of the elderly. But… I really have ignored it because really*

when you look at the sample size, this and that, it's not something you can take as representative of a nation.

I So you only look at research that has a nationally representative sample?

R That is why I haven't taken it seriously. So for example yesterday I went to a dissemination meeting. Chancellor College, Department of Population Studies they did a small survey also on the current and expected trends in Demography... the sample size is not really, anything we can. Anyway the trends are the same so there is some truth in what they were saying there, but unfortunately it is a bit [trails off]

[Interviews with Ministry for the Elderly]

The research referred to is based on data collected from 1,200 households across six geographically diverse districts. In contrast, government and NGO stakeholders regularly referred to anecdotes from their own (urban, relatively wealthy) lives as evidence.

7.4 Summary of ageing and HIV in Lilongwe

There was no specific age-related policy and programme context to the experiences of older adults in rural Balaka for the period this thesis focuses on. However, in Lilongwe there was emerging recognition of both older adults as a "vulnerable group" in need of social protection, and HIV infection at older ages. Within this embryonic policy and programmatic context, the situation of older adults was understood to have worsened over time. Macro-level demographic and social changes, including the HIV/AIDS epidemic, were expected to have eroded the venerated position of older adults and the familial care once received. This produced contrasting images of old age. On one hand, older adults were vulnerable, unable to work, and subject to abuse. On the other, they were bastions of wisdom and a vital resource in the care for younger adults and children infected and affected by HIV and AIDS. They were at risk of sexually-transmitted HIV infection in some documents, but only at risk of non-sexually-transmitted HIV in others. Across all

understandings, older adults had little control over their experiences. My analyses of the data constructed and collected suggest that these understandings of old age reflect international discourses on ageing in Africa.

Chapter 8 | Conclusion

This thesis is timely. As demographers and their cross-disciplinary colleagues recognise both African ageing and the increasing HIV epidemic in older populations as a priority for academic enquiry, it provides one of the very first in-depth considerations of older adults' experiences of becoming old, sexuality or living with HIV in Africa. At a time when discussion among demographers interested in the complexities surrounding demographic behaviours and events is focused on the promotion of rigor in qualitative studies (Coast *et al.* 2009; Hennink *et al.* 2011; Hutter *et al.* 2009), this thesis demonstrates the contribution grounded theory and repeat dependent interviews can make to achieving high quality in demographic data collection and analysis.

The study aimed to explore older adults' experiences of ageing and HIV in rural Malawi. Using an interpretive approach that drew on theoretical and empirical insights from a range of disciplines, I identified a set of meanings surrounding old age and ways of discussing ageing that taken together, formed an analytical framework. This framework concentrated on the importance of maintaining a positive 'adult' identity. It was used to interpret older adults' experiences of ageing, as well as their understandings and experiences of sex and HIV infection at older age.

The account produced is centred on the experiences of ageing and HIV that were most salient to respondents. It is grounded in their interview narratives. By recognising these narratives as identity performances given to a specific audience, the account incorporates my influence and that of the interviewers and research process on the data produced. Further, it acknowledges and captures more of the complexity of respondents' experiences of ageing, sex and HIV infection than has been documented in existing research. In doing so it highlights unexplored issues and non-reductionist ways of understanding these experiences.

This chapter summarises the analytical account I produced (Chapters 3 to 6). I discuss the contribution of my account to understandings of sexuality and HIV in

later life. I then explore the potential of identity for the understanding of demographic behaviours and events.

Following this, I outline the dominant analytical account of old age identified in the academic and policy arenas. I discuss how it fits with the inductively-generated analytical account presented in this thesis. I then offer tentative suggestions for policy in light of this comparison. The chapter concludes by examining some of the limitations of the study and highlighting directions for future research.

8.1 Summary of findings

The body was the dominant and overarching theme across older adults' discussions on a wide range of topics. Its social construction was central to how older adults made sense of ageing. Respondents presented their body-centred ageing experiences in a variety of contrasting ways. Discussion of "phasing out in strength" and the struggle to continue carry out farm, house or bed work was juxtaposed with discussion of continued or even increased strength, self-sufficiency, familial provision and sexual prowess. These contradictions existed not just between respondents, but also within individual respondents' narratives.

Through physical productivity the body was understood as the embodiment of identity. Within the specific context of rural Malawian livelihood systems based on self-sufficiency and familial support networks, able bodies (that is, those with sufficient "blood") were necessary for social and personal recognition of an individual as an adult. Adulthood was conceived as a marker of social validity, aligned to being a person. It constituted a role (Burke and Reitzes 1981) and social ('group') identity (Campbell 1995).

Reflecting the social construction of identity, the adult identity was understood to be dynamic and to change in response to the body's ability. Old age was understood to dramatically lessen the body's ability and was associated with declining physical productivity and increasing dependency. Neither unproductivity nor dependency was compatible with the meanings of the adult identity for respondents and their

communities. The ageing body was therefore associated with the loss of this most salient identity.

However, regardless of their body, no older adults presented themselves as having the identity of a non-adult, or non-person. Rather, this socially un-valid position presented a feared "possible self" (Markus and Nurius 1986) – an identity they may possess in the future. Older adults were motivated to avoid this possible self.

This thesis argues that ostensibly contradictory narratives about ageing experiences can be understood as rhetorical strategies respondents employed to avoid the possible self and maintain positive 'adult' identities. Using Identity Control Theory (Burke 2006), I identified two sets of strategies. In the first, respondents attempted to practically or discursively (re)align their behaviour with the behaviour they associated with the adult identity. For example, respondents focused on their continued physical productivity or drew the interviewers' attention to external causes for the limited outputs of their productive endeavours, such as poverty. In a second set of strategies, respondents presented altered understandings of the meanings held within the adult identity standard in order to improve congruence with their current behaviour. For example, respondents directed research conversations away from declines in their physical productivity to focus on their past self-sufficiency and care for dependants, or on highly-valued qualities that were not based on bodily strength (such as wisdom, emotional 'coolness' and self-restraint). I argue that this reflects a broadening of the meaning of productivity held within the identity standard to include physical productivity as evaluated over the life course and social and moral productivity.

A central tenet of the thesis is that the adult identity (and its childlike counter identity) influenced older adults' broader experiences and behaviours. Reflecting the study's research questions, I have focused on two: sexuality and HIV infection.

I explored older adults' experiences of sexuality by reflecting on the meanings of sexuality in the social, cultural and conceptual context of their lives, as well as on experiences and understandings of old age and the adult identity.

Sex was understood as an innate part of being an adult. Sexual pleasure depended on the giving and receiving of sexual fluids. These fluids contained and constituted a person's strength, or life force. Ability to have pleasurable sex was evidence of being alive. Sexual pleasure therefore remained salient in old age. Since old bodies had less strength, sex was on one hand beneficial to weakened older bodies, but on the other, not accessible to such bodies.

Respondents discussed their sexual behaviours, desires and abilities in ways that enabled them to maintain positive identities as adults. Some respondents stressed their continued or increased capacity to give and receive sexual pleasure. Sometimes this was a response to the interviewers' questions about sex; at other times respondents turned the conversation to their sexual ability when discussing their decreased ability to carry out other kinds of 'work'. These narratives can be understood as an attempt to focus on productive behaviours that aligned an individual with the adult identity.

Other respondents reported having less strength for sex as they aged. However, rather than challenging their adult identities, these respondents presented their behaviours as demonstrative of wisdom and self-restraint. These narratives can be understood as respondents' redefinition of the behaviours aligned with the adult identity from physical to moral or social production.

Finally, building on understandings of ageing and sexuality, I explored older adults' understandings and experiences of HIV infection. I demonstrated how these were anchored in discussion of the sexual transmission of HIV and perceptions of the poor prognosis of infected individuals.

HIV infection in older age was understood to result from foolish sexual behaviours. To have HIV in older age was to dangerously and fatally weaken an already weakened body. Older adults with HIV were therefore perceived to be neither socially and morally nor physically productive. Their behaviours could not be aligned with either definition of the adult identity presented in these data. These understandings shaped older adults' experiences of HIV. They were accountable for

respondents' perceptions of the greater social exclusion of older infected adults than younger infected adults.

However I illustrated how respondents with HIV controlled perceptions of their behaviour so that they were considered neither foolish nor finished. Instead they employed narratives in which they featured as both wise, caring, restrained adults and physically capable adults. For example, they stressed routes of HIV infection that highlighted their physical and moral production, such as bathing the bodies of those who had died from AIDS. Alternatively, mirroring responses to the ageing body, they stressed the externality of the causes of their decreased working by separating their 'real' selves, which were physically productive, from the effects of the virus. Others discussed how their behaviours had changed following HIV diagnosis. For these respondents, age and HIV had 'cleansed' them and encouraged the adoption of new morally productive behaviours. Always 'adults', these respondents redefined meanings held within the identity standard from physical productivity to social and moral productivity.

I suggested that respondents with HIV utilised different combinations of the potential rhetorical strategies presented based on their pre-diagnosis adult identities. For example, when the morally productive adult identity had been most salient before HIV diagnosis, the continuation of this identity through the stressing of non-sexual transmission routes and caregiving and HIV advocacy roles following diagnosis was most salient.

This analytical picture developed in the rural field site was presented against a backdrop of African ageing and the HIV epidemic as documented by the academe and the policy and programmatic context developing in Malawi. This was outlined in Chapters 1 and 7 and is explored below.

8.2 Contributions of the study's findings

8.2.1 Understandings and experiences of sex in later life

The thesis presents one of very few in-depth qualitative examinations of sexuality in later life in Africa (Chapter 5). Many of the texts on which our understandings of later life in Africa are based omit sexuality (e.g. Apt 1995; Cliggett 2005; HelpAge International and Africa Regional Development Centre 2001), an important element of human experience (Gagnon *et al.* 2002, p. 622).

Among the existing attempts to understand sex at older ages in Africa, (Freeman and Anglewicz 2012; King *et al.* 2010; Todd *et al.* 2009) have quantified sexuality in terms of sexual partners and encounters, (Gutsa 2011; Owusu and Anarfi 2010) have qualitatively described some sexual behaviours, while (Lee 1992; Nyanzi 2011; Van der Geest 2001) have offered more in-depth ethnographic descriptions of ideas about sex and sexual experiences. Much of this existing research has identified social and cultural norms that limit older adults' sexuality after childbearing and presents continued sexual desire and activity in light of this (Gutsa 2011; Nyanzi 2011; Owusu and Anarfi 2010; Van der Geest 2001).

For example, in culturally more conservative Ghana, Van der Geest identified considerable censorship of sex at old age. Sex was considered to be incompatible with "the beautiful image of old age" represented by the 'elder' – as in Malawi, a figure that ought to show restraint and control in all areas of life. Elderly respondents reported declining strength for sex. For men this was connected to the more general strength needed for courting, while for women, sex was a "tiresome" physical task from which they derived minimal pleasure. Women additionally reported declining desire for sex while men's desire was understood to continue until death (Van der Geest 2001). In contrast, Lee's 1960s research among the !Kung of Botswana documented increasing boldness and ease of presentation of sexuality among post-menopausal women, including the initiation of sexual relationships with younger men outside marriage. Lee traces this to increasing free time following

intensive work throughout younger adulthood and increasing acceptance of extramarital affairs that do not have implications for resource sharing for the woman's family. Nevertheless, only women aged 45-65 occupied this sexualised position and the very oldest (the "old –dead") were disregarded sexually (Lee 1992).

This body of literature is limited in size and geographical coverage, but moreover, scope. All of it descriptive, some presents sexual behaviours at older age in isolation of any social or cultural context, instead presenting evidence of continued sexual activity as somehow surprising (Gutsa 2011; Owusu and Anarfi 2010). Of the three studies that do situate sexual experiences, (Nyanzi 2011) focuses exclusively on the experiences of widowers in an urban setting, (Lee 1992) documents social and sexual roles across the life course but does not give voice to individual experiences or attitudes towards sex, and does not comment upon sexuality among women after age 65 or upon men, while (Van der Geest 2001) provides only an impressionistic insight into sexuality at old age and how it may connect to wider understandings of old age.

Although the findings of this thesis cannot be generalised to all older men and women in rural Malawi, they do provide an in-depth understanding of the ways constructions of ageing and sex can influence complex experiences of sexuality in older age. Since levels of divorce and remarriage are high in the sample (Reniers 2003), as in Nyanzi's (2011) research, the data presented here offer an opportunity to consider experiences of sexuality beyond and outside of marriage. Further, I respond to recent criticism of writing on sex in old age globally. This work has typically focused on asserting continued sexuality and has subsequently positioned sexual disinterest as negative or as evidence of "unsuccessful" ageing (Scherrer 2009). My account of sex and sexual desire at older ages in Malawi has explored and accounted for alternative, less-sexualised positions without problematising these older adults' experiences, giving them a much needed voice within the nascent debates on sexuality in the gerontological literature.

8.2.2 Understandings and experiences of HIV in later life

The thesis provides one of the very first qualitative considerations of older adults' experiences of HIV in Africa (Chapter 6). Only one other study, recently published, has focused on what it is like to become old with HIV in Africa. Stuart Wright and his colleagues consider the psychological wellbeing of older adults in rural and peri-urban Uganda (Wright *et al.* 2012). In their descriptive longitudinal study, they identify significant but fluctuating experiences of despondency among older adults. As identified in the thesis, Wright *et al.* found contradictory narratives within and between respondents. On one hand, respondents reported significant health or business difficulties, but on the other, reported having "no marked problems". Associating fluctuating and differing experiences with changes in social isolation, lack of familial support and the experience of poverty over time, the authors highlight the importance of considering context for understandings and experiences of health. This accords well with the account presented in this study in which understandings and experiences of HIV were heavily context-specific, tied to livelihood systems and the ethno-physiology of the body.

However, although the authors account for changes in individuals' narratives between interviews by pointing to temporal changes in their personal, social and economic contexts, they do not account for contradictory statements from individuals during one interview. In this thesis I account for similarly contrasting narratives by considering the presentation and maintenance of identities. This use of identity theories represents one of the thesis' major contributions to understanding experiences of HIV at older age, and understanding the link between identity and HIV and chronic illness more broadly, not just in Africa and not just at old age. The thesis responds to calls to extend and deepen our analytical understandings within health research globally by the use of such theories (Lively and Smith 2011). In the following discussion, I therefore set my findings within the broader literature on identity and HIV at all ages, within both African and non-African settings.

Similar responses to HIV infection to some of those identified in this thesis have been documented among all-aged adults with HIV in a variety of settings. They have

been presented as facilitating either "acceptance" of an 'HIV/AIDS identity' (that is, being 'HIV positive', 'person living with HIV', 'person with AIDS') (Baumgartner 2007), or, following the increased availability of ART, of living with HIV as a chronic condition (Russell and Seeley 2010). For example, in rural Uganda, "working hard" in economic pursuits following HIV diagnosis has been interpreted as being important for individuals' sense of control over their life and return to normalcy (Russell and Seeley 2010). Likewise, the 'positive living' social activism identified here fits within a global discourse that has shaped similar response behaviours in a wide variety of sub-populations in different African and non-African settings (e.g. Guarino 2003; Robins 2005). Working and 'positive living' have been interpreted as rendering "new identities" for infected adults by providing empowering social work, expanding their social networks following their shrinking in relation to illness and/or disclosure (Robins 2005; Russell and Seeley 2010; Seeley *et al.* 2012) and encouraging the "incorporation" of an 'HIV identity' (Baumgartner 2007).

The thesis offers a different interpretation of these responses among older adults with HIV in rural Malawi. This interpretation is born out of data constructed and analysed using grounded theory, and subsequently the integration of Identity Control Theory. I argue that respondents with HIV were motivated to maintain their positive pre-HIV identities as adults. Contrary to previous research on HIV and identity therefore, I suggest that although respondents reported new behaviours, the identities they forwarded were not new. By looking at the *meanings* and *perceptions* of behaviours, rather than just the behaviours themselves, I identified considerable cogence between the meanings of the post-diagnosis behaviours stressed by respondents and the meanings held in the identity standard for pre-diagnosis adult identity (as originally defined, or as redefined). That is to say, what changed for respondents was the meaning of the adult identity standard, which shifted in response to their changed behaviours and situations. They were always 'adults'.

Previous work on identity and HIV, and work on identity and chronic illness more broadly, has typically viewed HIV as an identity 'disruption', or as an identity 'spoiler'. The first body of work presents illness as a "biographical disruption"; a

bodily failure that profoundly disturbs daily activities and relationships and subsequently their realities (Bury 1982). For Juliet Corbin, this necessitates "biographical work" which involves the "review, maintenance, repair, and alternation" of an individual's biography in light of their changed reality (p. 264). This includes identifying and accepting which aspects of "the self" have been "lost", which can be recovered and which aspects have been added. This results in the redefinition of the self or the creation of a new or partially-new conception of self around the limitations (Corbin 1987). Subsequent research on HIV and identity has focused on the processes by which the disruption caused by HIV diagnosis or illness has become integrated into an individual's life, behaviours and subsequent identity (Baumgartner 2007; Russell and Seeley 2010; Tewksbury and McGaughey 1998).

In the second body of work, often overlapping with the first to include biographical disruption, HIV is presented as creating a spoiled *social* identity, and subsequently a spoiled *self*-identity, as once labelled, individuals internalise stigmatising discourses. This has focused on the processes by which an individual comes to terms with having a stigmatised HIV identity (Baumgartner 2007; Flowers *et al.* 2006; Seeley *et al.* 2012) and how these identities influence health-relevant behaviours – for example, by limiting disclosure of HIV infection (Bond 2010) or by encouraging 'positive living' (Liamputtong *et al.* 2012).

Much of this work on HIV and chronic illness draws on insights from symbolic interaction, but it does not incorporate existing sociological and social psychological theories of identity and identity construction. As a result, many of the nuances of controlling salient identities are missed. Conceptualisations of identity and the self in more recent work tend to be limited, often focusing instead on personality or health markers; for example self-esteem, mastery, agency or simply 'HIV identity' ((Corbin 1987) is an exception and does detail the self as distinct from self-esteem). Often, the pathways between biographical disruptions (such as failed performances) or stigma and the "loss" or subsuming of pre-HIV diagnoses are not explored; use of Role Identity Theory would have elaborated the relevance of the disrupted behaviours to identity. Similarly, the work has tended to employ purely content-based analysis of data, focusing on reported behaviour and feelings, but overlooking

the discursive responses individuals employ. For example, Asbring's study of identity-transformation among women with chronic fatigue syndrome and fibromyalgia notes that depending on their health some women "maintain more of the activities important to their identity than others" (Asbring 2001, p. 315) but does not discuss the way women reported these activities or how or why these identities were important. Insights from Identity Control Theory in this study of HIV and ageing in Malawi highlighted the importance of perceptions of activities for identity construction. Here, perceptions of activities (the way activities are presented and discussed in the interviews, rather than the absence or presence of activities) facilitated more nuanced exploration of the parallels between the pre- and post-diagnosis identities.

Finally, given the role of ART in increasing the prevalence of HIV at older age, I have examined its role in understandings of and responses to HIV at older age. ART enabled older respondents with HIV to participate in physical and social or moral production that could be aligned with redefined positive adult identities. These responses challenge earlier research on the incorporation of HIV into identity. In this work, adaption to having HIV only occurs when an individual recognises their changed bodies and subsequent behaviours and reformulates their identity. When effective treatments are available, these altered identities may be displaced, but do not return to the "baseline identity" (Tewksbury and McGaughey 1998, pp. 225-226). In the analytical account presented here, ART enabled respondents to engage in behaviours that separated their "baseline" identities as adults from their changed bodies, and thus maintain these identities.

It has been suggested that ART allows people to re-establish positive social positions following infection (Castro and Farmer 2005). Analysis of data constructed in rural Balaka paints a less optimistic picture. In their narratives, respondents' self-perceptions of their 'adult'-like productive behaviours were not mirrored in others' perceptions of their behaviour. In line with the Identity Control Theory (Burke 2006), my analyses suggest the existence of continued dissonance between so-called "situational inputs" (how an individual perceives themselves in a situation, based on how others perceive them in a situation) and the identity standard, result in continued

frustration, as well as struggle to realign other's perceptions. As one respondent reported, non-infected people needed to be "sensitized". This finding supports and extends that of recent work among all-aged adults enrolled on ART programmes in Zimbabwe (Campbell *et al.* 2011) by drawing on the narratives of non-infected adults. These narratives confirmed that despite high awareness of ART, its availability had done little to alter understandings of HIV. Infected adults on treatment were understood to remain weak and unhealthy behind a mask of strength. These meanings continued to feature in the way older adults with HIV experienced and made sense of their infection.

8.3 The importance of identity for demographic understanding

Finally, this thesis argued that identity was of central importance to older adults' experiences. This key tenet is implicit in much demographic research. Identity is frequently incorporated into studies of fertility, mortality and migration, and is recognised to influence survey responses (Poulin 2010). However, its use and meaning are inconsistent and limited.

Reflecting the discipline's concern with the influence of social characteristics on demographic behaviour, the term identity has most often been used to refer to a social identifier, such as an ethnic group (e.g. Agadjanian and Qian 1997; Hamilton *et al.* 2011; Perez and Hirschman 2009), religious affiliation (e.g. Weinreb *et al.* 2008) or sexual orientation (e.g. Poston and Baumle 2010; Strohm *et al.* 2009), rather than the meanings of those social categories for identity construction. Within this body of work there is considerable confusion regarding what constitutes 'identity'. For example, while Perez and Hirschman note that "ethnic identity" comes from group membership, aligning it with social identity theory (although this is not referenced) (Perez and Hirschman 2009, p. 3), Hammel *et al.* suggest that because ethnicity refers to group membership, it should not be considered an identity (Hammel *et al.* 2010, p. 1106).

The inclusion of the identity theories I used in this study could have increased the analytical understanding presented in this previous body of demographic work. For example, Perez (2009) and Poston (2010) considered 'identity' reporting in questionnaire surveys, noting a change in ethnic identification over time (Perez) or the 'misreporting' of asexuality among adults who on further investigation did feel sexual attraction (Poston). Both papers suggest behaviour (e.g. sexual abstinence) associated with respondents' ethnic or sexual identification. The inclusion of a developed identity theory, such as role identity, could have shed light on how and why people change their "ethnic identities" or present themselves as having an "asexual identity", based on the meanings of their behaviours and those identities. Further, such appreciation of identity theories could improve the writing of questionnaires in order to access the information researchers want to access (e.g. the prevalence of absence of sexual desire rather than absence of sexual activity).

Other scholars have used identity in ways more aligned to its use outside the discipline. However, this work rarely defines what kind of identity is being described. Some of this work uses identity inconsistently within the same piece of research. For example, with regard to contraceptive use, Lisa Richey's discussion of Tanzanian *family planning service providers' interpretations of contraceptive knowledge(s)* explicitly states that "issues of identity can help us to understand more thoroughly the interface between service provision and uptake" (Richley 2008, p. 492). However, throughout the paper the term 'identity' is used to refer to a social identity associated with a set of mutually-held meanings and behaviours, (for example, IUD users are "urbanized, morally-disciplined, and use contraceptives within the childbearing context (as opposed to before marriage or in adolescence)" p.484), a personality trait (for example, "the client's identity as "unconscientious" and "forgetful" as demonstrated by their remarks that she forgot her card" p.487), a role identity (e.g. "It is a gendered identity of the "good mother" and the "good wife" who takes proper care of her children and home which local women are expected to measure up against" p.492) and an individual's epistemology (e.g. "local identities are shaped by global knowledges and agendas: changes in international donor priorities must take place before it is understood at the clinic level". p.493). Although the paper offers very interesting and useful insights regarding the diffusion

of knowledge, the confused use of identity makes it difficult to draw out *what* "issues of identity" can add to our demographic understandings.

The most developed uses of identity in demography have been those concerned with gender identities. Research in the area of fertility and reproductive and sexual health has incorporated identities around gender, such as masculinities, femininities and motherhood, to produce more nuanced understandings of demographic behaviours than would otherwise have been possible. For example, in southern Malawi, Amy Kaler has produced an account of young men's risky sexual behaviour by exploring a configuration of masculinity that underpinned the belief and behaviour of being 'already infected' and therefore no longer at risk (Kaler 2003). Similarly, in her comparative ethnographic study of low fertility in Greece and the UK, Katerina Georgiadis explores the significance of motherhood, womanhood and gendered personhood identities for childbearing in each setting (Georgiadis 2007). However, demographers have very rarely explored other bases for identity, such as age, illness or place. Similarly, there has been little consideration of the importance of identity management for demographic behaviours and experiences.

Despite its varied use therefore, there has been little demographic engagement with the concept of identity. Calls for demographers to recognise that "Identity is complex, multiple and shifting, and cannot [be] adequately captured by simple categories such as "religion", "ethnicity", etc." (Coast *et al.* 2007, p. 509) have not been met with attempts to develop theoretical insights about identity. Without a shared understanding of what we mean when we talk about identity, demographic research incorporating identity (either as a social categorisation or as a more developed concept of the self) has been carried out in parallel. A coherent definition might encourage demographers to draw conceptual links between these studies and expand our understanding of the importance of identity for explaining demographic behaviours and events. Further, it would enable demographers and scholars from other disciplines to produce more inter-disciplinary research that includes identity, energising our understanding of the demographic world.

In this study, the incorporation of social and role identity theories and Identity Control Theory from outside of demography enabled me to develop a deeper analytical understanding of observations that had previously only been described in existing research (e.g. that work is associated with social status and people with HIV are considered the 'living dead'). In doing so, I produced a coherent framework that accounted for both, competing and contradictory narratives about a topic (such as old age), and cogency in the way people discussed the ostensibly different topics (such as ageing, sex and HIV infection). The framework produced can be seen as contributing to the development of a new "theoretical frontier" for demography (Riley and McCarthy 2003, p. 158). In line with the discipline's strengths, this is not a meta-theory of population, but a mid-range theory born from grounded analysis of high quality data.

8.4 Understandings of ageing and HIV in academic and policy arenas

This study (Chapters 3-6), academic writing from across the continent and disciplines (Chapter 1), and the national and international policy and programmatic arena (Chapter 7), all identify positive and negative understandings of old age. They each identify an image of old age consisting of 'elders' who occupy respected positions as morally- and socially-productive leaders of their families and communities. However, they also identify an image of old age consisting of frail, physically-unproductive old people who are excluded from the social world.

Academic and policy writing over the last 50 years has typically made sense of these contrasting images by ordering them chronologically. The first is posited as the "African tradition", the second as the unwelcome result of modernisation and demographic change. This temporal theory is both descriptive and predictive: already bad, the situation for older adults is expected to worsen as increasing social breakdown and rural poverty resulting from modernisation are accompanied by increasing numbers of old people in need of care. In time, the 'traditional' image of

old age (respected elders) will be replaced by the 'modern' image of old age (forgotten old people).

The beginnings of this modernisation theory for social change in Africa can be traced to academic and international policy developments between the mid-1960s and early 1980s. Following the development of modernisation as a refined theory in Western gerontology (Burgess 1960; Cowgill 1972), ethnographic and survey-based studies in Africa began to emerge in the mid-1960s, focused on wealthier, more 'developed' West Africa (e.g. Arth 1968; Azu 1974). This work, and the work that followed it, predicted the weakening of familial support for a growing population of old people as 'modernisation' changed the structures and functions of the 'traditional family'. Although early work noted that there were "still elements of the traditional system existing simultaneously with the adopted western mode of life" (Azu 1974, p. 116), the discourse that emerged was one of a more dramatic erosion of old adults' social roles, respected positions and the care they could expect from their children who, as part of the new social and economic world, were either unwilling or unable to assist them (e.g. Apt 1992).

In response to these concerns, in the early 1970s the United Nations Social Development Section commissioned pilot surveys in nine developing countries, including Uganda and Ghana (Apt 2005, p. 4). The subsequent World Assembly on Ageing in Vienna in 1982 marked the start of the development of an international policy context. The resulting International Plan of Action on Ageing (United Nations 1982) established the temporal account of the contrasting images centred on modernisation as the accepted analytical framework for research on African ageing.

Explicitly guided by this framework, academic research that followed sought to build an evidence base on older adults' needs to assist policy development. As noted in Chapter 1, much of this qualitative and quantitative work provided deductive hypothesis-led examinations of specific factors of ageing, such as health, familial support, social positions or living arrangements, and review papers examining and suggesting old-age welfare policies (e.g. Apt 1995; Dixon 1987; Habte-Gabr *et al.* 1987) as well as (Bamisaiye and DiDomenico 1983; Jack *et al.* 1984) quoted in (Peil

1987)). For example, Donald Adamchak and colleagues introduce their paper based on survey data collected in 1988 thus:

> *Using these perspectives as a framework, this paper attempts to describe and assess the current and future economic and support status of our sample of elderly Zimbabweans (Adamchak et al. 1991, p. 506).*

However, in Western gerontology, the structural-functionalist assumptions of modernisation theory that saw a linear and globally-uniform path between 'traditional' and 'modern' were shown to be inaccurate (e.g. Bengtson *et al.* 1975; Palmore and Manton 1974). Peculiarly, these critiques were well-established some years before the UN uncritically adopted the theoretical framework for addressing African ageing in 1982 (Aboderin 2004b). In 1987, Margaret Peil in a review of *Studies of Ageing in Africa* briefly criticised the emerging body of work on African ageing for its reliance on a theory that was unsubstantiated by the "idealized [*sic*] version of a golden past" presented in ethnographic work or not evidenced at all in the confident rhetoric of the national and international policy and programme makers (Peil 1987, pp. 459-460). There is very little evidence that her critique was taken on by either the academe or the policy-makers. There is no discernible shift in the discourse that followed, as Adamchak's 1991 paper confirms.

In 1999, introducing an issue of the *Southern African Journal of Gerontology*, editor Monica Ferreira noted the dominance of the macro structures of modernisation theory, AIDS and demographic and social change in shaping the study of African ageing. After questioning the existence of a "traditional" Africa in modernisation theories, she called for the use of alternative explanatory frameworks to investigate "situations and conditions of ageing" (Ferreira 1999, p. 2). Again in 2004, making no reference to Peil or Ferreira, Isabella Aboderin offered a 'first' critique of African modernisation theory. This was based on the model's conceptual and epistemological inability to explain declining material support for older adults in Africa (rather than its ability to account for the contrasting images of old age). Aboderin compares the model to its main alternative, the typically-linked 'material constraints model' that posits that economic shifts associated with modernisation have decreased families' ability to care for older adults, rather their traditional

cultural obligation to do so. Noting the lack of evidence for individuals' motives for providing familial support, now or in the past, she finds both models of modernisation theory wanting (Aboderin 2004b).

However, the review of the Malawian policy context in 2010 (Chapter 7) and academic literature to date (Chapter 1) presented in this thesis highlights the persistence of modernisation theory, or at least a macro-level theory of demographic and social change that has altered the situation of old adults. In both arenas, these theories underpin the appearance of the two contrasting images of old age. *The Draft National Policy for Older Persons in Malawi* notes:

> *Although the family remains the most important source of support for older persons in Malawi, family structures are changing and traditional patterns of care such as extended family values are no longer guaranteed. This is due to a number of factors including urbanisation; economic pressures; changing social values; and ravages caused by HIV and AIDS.*

Subsequently, two of the policy's nine objectives are to:

> *Promote intergenerational transfer of cultural knowledge and positive skills by older persons by 2015; [and] promote the role of communities and families in care and support of its older members by 2015.*
>
> (Government of Malawi 2008, Undated fifth draft [b] p. 13;p. 6)

In 2012 Nana Apt, one of the most widely-cited scholars working on African ageing, offered a review of Past Experiences and Strategic Directions for African ageing. She writes that:

> *The family… is rapidly changing as a result of structural forces operating worldwide. The change is even more prominent in the value base of African traditional society which revolved around respect for "the elder" and intergenerational sharing (Apt 1992). Elder respect is no longer taken for granted and aging [*sic*] in dignity amongst family members might sooner than expected become a story of Africa's past. In consideration of this it appears that the less old people are able to rely on traditional family care systems which are rapidly waning, the more they have to rely on their own income.*

(Apt 2012, p. 95)

There remains very little critical engagement with this discourse. A number of studies note that the situation of older adults is country-specific, but go on to investigate ageing using the a-contextual theoretical framework. The critiques offered by Peil, Ferreira and Aboderin appear to have had little impact. Rather, the understanding of social change as driving a shift in the roles and position of the elderly has been perpetuated by the cyclical referencing of early writing on the subject, rather than an evolving evidence base. For example, in the excerpt above, Apt references her own work from 20 years previously to evidence the shift. Data, such as the comparison of historical and contemporary data or the life histories of older adults, are rarely offered. The research carried out that has challenged the idea of "traditional" care for older Africans has not significantly altered the essentialising image of 'elders' negotiating modernising societies within their own writing, or across the disciplines (e.g. Makoni and Stroeken 2002). Even assuming that modernisation theory, or at least macro-level demographic and social change, can provide a satisfactory analytical account of the two images of older adults (or a decline in material support for older adults), the argument has not been significantly updated or developed over its 50 year theoretical reign to capture the perspectives of today's older adults or experiences outside this discourse.

In my study, the negative influences of macro-change (with the exception of the HIV epidemic) - either in terms of a change in values or an increasing neglect of older adults caused by poverty - rarely featured in respondent's narratives about material support they gave or received, or their understandings of old age based on wise elders or socially excluded frail old people (Chapter 3). Moreover, these two images of old age were part of a broader range of images and positions that included physically-capable older adults and unwise and foolish elders. These images and positions do not feature in the dominant discourse shared by the academe and the policy arena.

Rather than a societal-level temporal trajectory from traditional to modern, I have offered an alternative explanation of these contradictory discourses of old age based

on inductively-collected data. In my analytical account, the two images of old age exist simultaneously in 'society' (that is, in the discourses heard in the field site about old people 'in general' from older and younger adults), but also within the narratives of one individual. Based on the generation of data on issues that were most salient for respondents, and their grounded analysis, I have argued that the two images presented either a feared possible self or an alternative positive identity for older adults experiencing age or HIV-related bodily decline.

Regardless of any temporal shifts in the roles and status of older adults or the material support they receive, for respondents in rural Balaka, these two images were more strongly associated with a social and physical imperative to be productive. Their navigation between identifying with these images, and the others I identified, rested on respondents' corporeal ability for production, not on social shifts dictating the level of material support or respect they received from their children. Further, and in contrast to the dominant discourse in which an older adult is typically presented as one or other of these two static images of old age, respondents' navigation between identifying with the various images was in constant flux, evidenced by contrasting narratives recorded by repeat dependent interviews.

This grounded theory study was not designed to test, explore or even expand upon the dominant explanation of the two images of old age identified in academic and programmatic literature. The account forwarded in this thesis, and the general account of change over time in the social position of older adults (rather than the specific linear change forwarded by the ahistorical and apolitical deterministic modernisation theory), are not necessarily mutually exclusive. However, if they are happening, these temporal shifts are happening at a societal level. They did not reflect how old age was understood and experienced at the individual level in Balaka, and it is at this level that policies and programmes are targeted. Therefore, at least in Malawi, the findings of this study call for a more nuanced presentation of old age within the policy context.

8.5 Tentative policy implications

In contrast to much of the research on African ageing reviewed, this study did not aim to produce data to inform policy development. That is not to say that its findings do not have some relevance to policy makers. On one hand, many of my observations of older adults' lives and the data produced during interviews with older adults (not all of which are presented in this thesis) accord with the understandings of policy, NGO and academic stakeholders. As these stakeholders expected, respondents in this study were poor, did not have enough to eat all year, were, in general, experiencing declines in strength and their ability to be self-sufficient, and did not have access to adequate healthcare. Policies – but more importantly well-targeted programmes – to address these deficiencies, such as the piloted unconditional cash transfers and the more-successful farm inputs subsidies would be welcomed by respondents. These programmes would need to be accompanied by efforts to ensure that perceptions of older adults as "already dead" or unable to make use of the assistance do not lead to their exclusion.

On the other hand, the analytical account produced in this study did not accord with that documented by the academe and policy arena. It suggests that international and national policy makers must avoid reductive images of old age as a limited number of static positions. By limiting understandings of ageing experiences to the two images of wise elders or vulnerable old people by setting them within modernisation theory, the policy emerging in Malawi could not accurately provide for respondents.

The confusion regarding transmission of HIV at older ages documented in Chapter 7 highlights this. Although the *Draft National Policy for Older Persons* made reference to the sexual transmission of HIV in older ages, the concept had no traction with key informants. Neither image of wise elders nor vulnerable, unproductive old people could be reconciled with 'risky' sexual activity. In contrast, HIV-infection through caregiving, forwarded as the route of transmission in later life, could easily be accommodated by the dual images of wise and selfless elders, and over-burdened old people who, due to HIV/AIDS, are now called upon to give rather than receive familial support.

I have identified a more nuanced account of both, sexual activity in later life (Chapter 5), and the multiple aged identities of older adults with HIV (Chapter 6). Firstly, I identified sexual activity within and outside of long term relationships at advanced ages. Some respondents without (known) HIV were having sex that could put them at risk of HIV. Some respondents with HIV were having sex that could put their partners at risk of HIV. Further, the data produced in the study indicate the importance of the exchange of sexual fluid for healthy, pleasurable sex for both women and men at older age. Although sexually-active respondents attending HIV support groups reported using condoms, the significance of "blood" for pleasurable and healthy sex may be a barrier to condom use for older adults who have not been exposed to the positive living message. Previously, low condom use in later life has only been expected to reflect low knowledge of HIV prevention measures (HelpAge International 2004; Negin and Cumming 2010; Negin *et al.* 2011), including difficulty interpreting materials promoting condoms (Ingstad *et al.* 1997; Muturi and Mwangi 2011), or involve women's difficulty negotiating condom use when their contraceptive value is redundant (Williams and Tumwekwase 2001).

Moreover, respondents with HIV referred to a range of meanings of the adult identity both before and after diagnosis that does not accord with the two images of old age in the dominant discourse. While some did indeed identify with the image of morally productive elders, and forward non-sexual transmission of HIV, others adopted this understanding of the adult identity only after diagnosis of HIV that they believed was sexually-transmitted. Still others identified themselves as physically productive and sexually active older adults both before and after diagnosis. Further, these identities – and their associated behaviours – were not static. Older adults in this study were sexually-restrained caring elders *and* physically productive sexually accomplished adults.

Janet Seeley has argued that meeting the emotional needs of older adults in Africa may be as important as meeting their physical needs (Seeley *et al.* 2009, p. 131). This thesis suggests that policies could usefully focus on supporting older adults' own efforts to maintain positive identities by ensuring the social validity of the elder role as Seeley suggests, but also social recognition of older adults' physical and

sexual productivity. At the same time, older adults' interview performances indicate that older adults may be reluctant to request care and support when they need it. As noted in the UK (based on different contextually-specific understandings of old age) (Breheny and Stephens 2009), accounts of old age in policy and programme discourses should avoid positioning self-reliance and the receipt of reciprocal familial care as markers of successful ageing. Instead efforts should be made to assist older adults in ways that do not challenge or undermine their adult identities.

8.6 Limitations of the study

Some of the limitations of the data produced in this study were discussed in Chapter 2 (Section 2.5.11). These focused on the sampling strategy used that privileged the inclusion of respondents who are likely to differ from other older adults in rural Balaka on characteristics of interest (receipt of familial and HIV support and expectations of research), use of a chronological age that had little salience for the respondents themselves, and the absence of younger adults' perspectives, both on older age and on their own experiences of HIV. In addition, the study is limited in both its scope and its geographical focus.

Firstly, this thesis illustrates that ageing and old age are socially embedded, in keeping with anthropological research that has considered ageing and old age within much broader descriptions of social life and organisation. In contrast to gerontological research in Africa that has been criticised for its treatment of ageing as "an autonomous, independent, scholarly object" (Makoni 2008, p. 203), the content of interviews and collection of observational data ensured that the data constructed did not present older adults as living in isolation. From the livelihood system to the feared receipt of personal care, experiences identified here were dependent on older adults' social interactions. Indeed, interviews with some respondents' family members constructed rich data that helped me to produce the analytical account presented. This is highlighted by interviews with Daniel and his mother, Lizzie. Their descriptions of each other and themselves emphasised the importance of others' perceptions in the construction of role identity, the salience of

interviews as a site of identity performance, the importance of identity maintenance in shaping experiences of ageing and HIV infection, as well as the nature of familial relationships and familial support in old age. However, interviews with family members were limited in number. This reflected the theoretical sampling strategy: based on the questions emerging from my analysis of the constructed data, it was more salient to discuss these questions with older adults than introduce further samples of family members within the time available for fieldwork. Nevertheless, greater efforts to include other family members, including much younger family members, may have produced similarly interesting data that would have enriched the account of ageing documented in this thesis.

Secondly, the utility of longitudinal qualitative research to understand ageing experiences has been identified in Uganda (Wright *et al.* 2012). Although not specifically aiming to capture change over time, the visits to a sub-sample of respondents in 2010 in this study also indicated the significance of longitudinal approaches. For example, two respondents of the six I planned to visit in 2010, Winford and Arnold, had died. Interestingly, these two respondents gave some of the strongest performances of identity management in 2009, emphasising their physical, sexual and moral productivity. The opportunity to continue visiting them up to their deaths may have produced considerable shifts in their performances that would have given more nuanced understandings of old age. Similarly, one respondent, Zione, visited in 2010 reported being inspired to get an HIV test following our conversations in 2009[61]. Having tested positive and started ART, she was in much better health, reported feeling (and indeed appeared) considerably younger and was experiencing old age quite differently. Extending this study to access more longitudinal data would allow richer understanding of Zione's and others' changing experiences of ageing and HIV.

[61] This example, along with a number of others, highlights the influence of researchers on the data constructed. As the case of Lyness, who reported giving up his extramarital *chibwenzi* [lovers] following the advice of the MLSFH survey team, and the generally high levels of knowledge about HIV and HIV prevention following a decade of answering questionnaires on the topic, these examples should encourage qualitative and quantitative field researchers to acknowledge the influence of conducting research on the data they construct.

Finally, research on African ageing has typically focused on older women or has examined ageing through the lens of gender (King 2008; Udvardy and Cattell 1992). This reflects both a focus on the status, autonomy, and empowerment of women in international development and the feminisation of population ageing in Africa. Further, academic and grey literature has consistently pointed to the central role of gender for increasing vulnerability in old age in Africa (e.g. Government of Malawi 2008). However, gendered differences in ageing were not salient in the data constructed in this study. This is in accordance with previous research among younger women in Malawi. Comparing gendered experiences in the patrilineal northern and matrilineal southern regions, Schatz has found that women in Malawi are not vulnerable or powerless (Schatz 2002, 2005). This study deliberately focused on experiences of older adults in one district in order to produce a more in-depth understanding. However, it is possible that in contrast to the experiences of younger women, the experiences of older women were shaped by their status within this matrilineal and matrilocal setting. In contrast to Schatz' work, more recent research on land tenure security in Malawi has identified changes in all-aged women's rights to access and use of land, in both patrilineal and matrilineal areas (Kaarhus 2010). Considering ageing experiences in the patrilineal north of Malawi may therefore have yielded data in which gender was more salient.

8.7 Future research

This thesis provides an emic understanding of ageing, sex and HIV that is traced to specific, locally-contextual meanings and experiences that should warn against the pursuit of universal answers. While the sampling strategy used produced a sample of older men and women who were, to an extent (with the exception of HIV, which was over-sampled) typical of older adults in the region, the study did not aim to generate understandings of ageing experiences that would be applicable to adults throughout Malawi, let alone other African settings. In the very least, the centrality of the livelihood system based on agricultural self-sufficiency in the analytical account produced makes its relevance to older adults living in areas with different livelihood systems, such as those in Malawian cities, less clear. For example, Sagner described

the ageing body as having "restricted relevance" for the self-identity of older Xhosa speakers in South Africa (Sagner 2002, p. 59), a middle-income country (World Bank 2012). In his study, while complete failure of the old body threatened older adults' status of 'being', personhood was more associated with being a relational member of a community than on being bodily self-reliant. Sagner describes the few older adults to discuss the salience of the body in their experiences of ageing as subscribing "to Western inspired discourses that see bodily attributes as representative of (older) selves and bodily ageing as stigmatising which should therefore be covered up" [*sic*] (Sagner 2002, p. 59). In the analytical account I have presented in this thesis, the emphasis on the body was grounded in respondents' narratives.

Although Sagner's presentation reflects a broader concern to assert social rather than physiological basis for understanding old age and health more broadly among gerontologists and anthropologists writing at that time (e.g. Morris 2011; Pool 1994; Twigg 2004), the absence of the body in the data he constructs may also reflect lesser salience of the body for livelihood systems in urban Cape Town. These contrasting, 'unembodied' accounts of ageing in Africa suggest the need for further, more grounded investigations of ageing experiences in different settings. An interesting area for further study would therefore be to consider how well an analytical framework based on the construction and maintenance of positive identities, regardless of the basis for those identities, can account for experiences of growing old in these other settings.

This thesis suggests new ways of thinking about the meaning of ageing, sexuality in later life and HIV after 49. This has given rise to some initial reflection on the nature and implicit understandings of research on African ageing. While Peil, Fereira, Aboderin and Makoni have argued for a move away from modernisation theory (discussed above) or the lament discourses that view African ageing as problematic (discussed in Chapter 1), there is clear need for some extended critical thinking about African gerontology. We need to discuss how to move beyond the dominance of these concepts in the hypotheses of ageing research. This thesis offers the inductive generation of data on ageing experiences using grounded theory as one way to do

this. Inductive work that privileges the voices and concerns of the population of interest, and gives space for 'new' and unexplored understandings to be developed, is likely to help us advance the academic debates and understandings about African ageing.

Further research might fruitfully consider the use of chronological ageing in policies and programming. Following international standards, all government and civil society stakeholders in Lilongwe considered old age to start at 60 years. The age was documented in the National Policy, the research produced, UN stakeholder documents, NGO documents and even the strapline of the Bingu Silvergrey Foundation ("Life begins at 60!"). The use of chronological age makes the administration of policies and programmes easier, the identification of need based on population statistics possible, and the international comparison of data more feasible.

However in this study, focused on meanings and experiences of *becoming*, rather than *being* old (a label that respondents did or did not identify with independent of their chronological age), chronological age was of less relevance than the body. While there were significant differences between younger and older old adults' bodies, their understandings of growing old and their ways of negotiating old age identities were very similar. Further, there were significant differences between the bodies and experiences of adults categorised by the researchers as being the same age. While these adults' understandings of growing old were similar, their strategies for negotiating old age identities differed. For example, Winford and Yotamu were both aged between 80 and 90. However, while Yotamu, interviewed alongside his wife Ruth, was frail and spent much of his time in their compound, farming only the closest garden, Winford was a pastor, a farmer and having just divorced his wife, was ready to start looking for a new one with whom to share farm, house and bed work. The majority of respondents did not know their chronological age. Even if they did, the relevance of policies and programmes based on their chronological age-set is questionable.

Reflecting the bi-directional relationship between discourse and experience, research among older adults in South Africa and Botswana has discussed their redefinition of

old age based on the chronological status needed to attain the national pensions (Bohman *et al.* 2011; Livingston 2002). In Botswana, Julia Livingston has discussed how the imposition of this chronological age, typically allotted to individuals by local chiefs based on some experiential criteria and often contested, has "splintered" concepts of old age. In her research, based on two years of ethnographic data collection, she explores how 'pensionable age' has caused frustration and physical insecurity among older adults who are locally-defined to be old but have not yet been certified as such (Livingston 2002). Given that the Malawian policy environment in 2010 was still emerging and did not yet correspond to any programmes, there is opportunity to discuss alternatives. The paradox presented by research ostensibly privileging emic perspectives on older age and yet constructing this knowledge based on data from interviews with adults aged 50 years and older has been noted in this thesis. Further research and thought could suggest a way out of this impasse for academic development and policy making.

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Appendices

Appendix A| Grounded Theory in demography journals

To assess the extent of demographers' use of grounded theory, I mapped its use within the ten most consulted journals by demographers, as identified by (Van Dalen and Henkens 2012). While there is overlap between these journals and the most frequently cited journals for demography (based on ISI Web of Knowledge Journal Citation Reports for demography on 6 August 2012), this approach is limited in assuming that the most frequently consulted journals are the most frequently used outlets for demographic publications.

The review was carried out on 6 August 2012 using the search term "grounded theory" (anywhere in the article). All volumes available electronically were reviewed. All articles retrieved were reviewed. Articles that did not report research that made use of grounded theory were discarded (e.g. use of the phrase "grounded theory" without referring to the methodology or an introduction to a journal special issue). The articles reporting research using grounded theory are detailed in the table. Only twelve articles were identified. The majority of these used grounded theory – and in particular the use of coding - to guide data analysis but did not use the method for the collection of data.

Journal title	**Reviewed volumes**	**Relevant articles**	**How grounded theory is used**
1. Population and Development Review	1999 – Present	0	N/A
2. Demography	1997 – Present	0	N/A
3. Population Studies	1985 - Present	0	N/A
4. Population	1989 - Present	0	N/A

5. Demographic Research	1999 - Present	4	Mynarska, M., & Bernardi, L. (2007). Meanings and attitudes attached to cohabitation in Poland: Qualitative analyses of the slow diffusion of cohabitation among the young generation. Demographic Research, 16(17), 519-554. **Grounded theory approach used for analysing collected qualitative data** Schröder, C. (2008). The influence of parents on cohabitation in Italy - Insights from two regional contexts. Demographic Research, 19(48), 1693-1726. **Grounded theory approach used for analysing collected qualitative data** Bignami-Van Assche, S., Van Assche, A., Anglewicz, P., Fleming, P., & van de Ruit, C. (2011). HIV/AIDS and time allocation in rural Malawi. Demographic Research, 24(27), 671-708. **Grounded theory approach used for collection of some data and analysis of collected qualitative data** Grant, M. J. (2008). Children's school participation and HIV/AIDS in rural Malawi: The role of parental knowledge and perceptions. Demographic Research, 19(46), 1603-1634 **Grounded theory approach used for collection and analysis of collected qualitative data**
6. Genus	1934 - Present	0	N/A
7. International Perspectives on Sexual and Reproductive Health (International Family Planning Perspectives)	1995 - Present	0	N/A
8. Population Bulletin	1988 - Present	0	N/A
9. European Journal of Population	1997 - Present	3	Bernardi, L., Klärner, A., & von der Lippe, H. (2008). Job Insecurity and the Timing of Parenthood: A Comparison between Eastern and

			Western Germany. European Journal of Population/Revue européenne de Démographie, 24(3), 287-313. **Grounded theory approach used for analysing collected qualitative data** Hampshire, K., Blell, M., & Simpson, B. (2012). Navigating New Socio-Demographic Landscapes: Using Anthropological Demography to Understand the 'Persistence' of High and Early Fertility Among British Pakistanis. European Journal of Population/Revue européenne de Démographie, 28(1), 39-63. **Grounded theory approach used for analysing collected qualitative data** Mynarska, M. (2010). Deadline for Parenthood: fertility postponement and age norms in Poland. European Journal of Population 26(3), 351-373 **Grounded theory approach used for analysing collected qualitative data**
10. Studies in Family Planning	1999 - Present	5	Kulczycki, A. (2004). The Sociocultural Context of Condom Use Within Marriage in Rural Lebanon. *Studies in Family Planning, 35*(4), 246-260. **Grounded theory approach used for analysing collected qualitative data** Varga, C. A. (2003). How Gender Roles Influence Sexual and Reproductive Health Among South African Adolescents. *Studies in Family Planning, 34*(3), 160-172. **Grounded theory approach used for collection and analysis of collected qualitative data** van Dijk, M. G., Arellano Mendoza, L. J., Arangure Peraza, A. G., Toriz Prado, A. A., Krumholz, A., & Yam, E. A. (2011). Women's Experiences with Legal Abortion in Mexico City: A Qualitative Study.

			Studies in Family Planning, 42(3), 167-174. **Grounded theory approach used for analysing collected qualitative data** Maharaj, P., & Cleland, J. (2004). Condom Use Within Marital and Cohabiting Partnerships in KwaZulu-Natal, South Africa. *Studies in Family Planning, 35*(2), 116-124. **Grounded theory approach used for analysing collected qualitative data** Varga, C. A. (2002). Pregnancy Termination among South African Adolescents. *Studies in Family Planning, 33*(4), 283-298. **Grounded theory approach used for analysing collected qualitative data**

Appendix B| Example repeat dependent interview guides

Dependent interviewing: Second Interview Guide for Polly Lwanda

Thank you for allowing me to come back to continue our conversation. I really enjoyed our last conversation, you said so many really interesting things.

How are you?

How has your week been since I last saw you?

SECTION A) Experience of ageing

Are you feeling better now? Last time you told me that you had been ill with shoulder aches and coldness?

Did they tell you what you were suffering from when you went to the hospital?

Which hospital did you go to? How did you get there? Is it easy to get to the hospital?

How is your husband now?

You said that you work at the clinic once a month. Have I got that right?

You weigh babies? What for?

Is this a voluntary job?

You said that you also encourage people in your village to have good health. How do you do this?

In what capacity do you do this? (What type of person are you being when you do this? A chief or an elder for example?)

How often do you do this?

Can you talk me through the last time you encouraged people in the village?

How do people respond to you?

Why do you do this?

You said you also advise young women you meet around the village, not necessarily about health issues. How do they react to your advising them?

Do they ask for your advice?

[If yes:] Why do you think they ask you in particular? How do they know you will be able to help them?

[if no:] So you just give them advice? How do you know what issue to advise them about?

Can you tell me about the last time you advised someone you met by the borehole or around the village? (*Probe*: What did you say? What did they say? etc.)

____

It sounds like you have had a very interesting life, I really enjoyed hearing about it last week. Can I ask you some more questions about it?

Did you get married the first time when you were very young? How old were you?

And you said that was in 1954? Is that right?

How old were you in 1992 when you left your late husband?

How old were you when he died? I'm sorry, I didn't understand how long ago that happened.

How did he die?/ What did he die of?

How old was he when he died?

How do you feel that he was here alone?

[If husband was older:] Do you think he had a good old age?

Were you surprised that he provided for you and your children in his will? How did you feel about it?

So now you are how old?

And you got remarried this year? Congratulations.

Have your late husband's family accepted your new husband as they said they would?

You talked a bit about the things a husband can be good for last week. Why did *you* chose to get remarried?

You said some of your children said you should not get remarried. Why did they think that?

What did they say to you?

How did you feel about that?

Now that you are married, do they still think you should not be married? Why/ why not?

We talked about your friends and how important they are to you. You said that you talk about important things and you told me all about how you encourage each other in your religions. Do you ever talk about non-important things – like food or farming or things you have heard about people you all know for example?

[If no:] Why not?

[If yes:] What do you talk about?

SECTION B) Strength, working and support

You said that your strength has changed as you have got older. Could you tell me more about that?

How do you feel about losing strength?

You said it affects you by stopping you working properly.

How important is being able to work? Why?

Is being able to work important to you? Why?

How does not being able to work make you feel?

Do you want to be able to work as you used to? Why?

Do your friends also find they cannot work so much? Why do you think they find this?

Did you expect to be able to work at this age when you were younger? What did you expect?

Someone told me that the medicine for problems is hard work, is that true?

Why do you encourage your children to work hard in their gardens?

Do you think the process of doing the work, even without the reward, can be good for them?

It sounds like hard work doesn't always have a reward though? You told me about the crops that haven't grown because of the poor harvest.

How do you see your future in terms of work? What will happen at then?

You said that your children are very good at supporting you. Do you think in the future you will work less and rely more on support?

When I asked if you felt you were an old person you said you were an “nkhalamba asking for support”. Is asking for support part of what it means to be old?

You said that your friends are important to you because if you fall sick they are the ones that bring you water, firewood and food. How come your children don't do those things?

You said the difference between the support that comes from friends and the support that comes from children is that friends tell people they assisted you. Would your friends do that? Have they ever done that?

Why is it bad if they tell people?

You said that you are caring for your granddaughter because you didn't have a child in your house and you wanted to care for a child the way you cared for your own child. Why did you want this?

How does it make you feel when you are looking after a child?

Does having a child in your house make you feel younger?

You said that you cared for a boy who passed away. What was the relationship between you and this boy?

What disease do you think he was suffering from, the one you were scared to catch?

Was caring for him very difficult?

Did anyone help you in caring for him?

Where did you learn that you could catch his disease from touching his dirty clothes and chitenje?

How did caring for him make you feel?

Did caring for him involve many expenses?

Do you think that caring for him had any impact on your health? How?

Did you anyone help you care for him? How did that make you feel?

What was the most difficult thing about caring for him?

What would have made caring for him easier?

SECTION C) Edzi

You mentioned edzi a few times last week.

You said that you advise young people about edzi. Where did you get the information to tell them?

From here, use the main interview guide from section 4 onwards

Dependent interviewing: Third Interview Guide for Polly Lwanda

Thank you for allowing me to come and continue our conversation. Emily and I are enjoying our chats so much. You have so many interesting things to say and are being so kind allowing us to come here.

How have you been since last week?

SECTION A) Love and marriage

Have you been enjoying wearing your new suit?

Why do you think your husband bought you it? Was it a surprise for you or did you ask for it?

Did he also buy your co-wife a suit?

How did that make you feel?

You told me that you chose to get remarried because you wanted someone to know if you were sick in the night and someone to help you work. Why did you choose to get married to *this* man? *(Probe:* Was it just because he asked? Was it because as the chief you knew he would be able to have money to provide for you? Were you in love with him? Etc.)

How did you decide to get married with him? Did he just propose to you or did you suggest marriage to him or what? What happened?

Did you already love him before he proposed?

How did you feel on your wedding day?

Do you know how your co-wife felt about it?

You said that some of your children didn't want you to get married because you were struggling with your previous husband. Do you mean they thought that this man might turn out like the other one and start drinking?

You said that before you got married your daughter was taking care of you but that after you got married you have started to take care of yourself again. What caused the change? (*Probe*: Why was your daughter taking care of you before? Why isn't she taking care of you now? Are you more able to work now than you were before? Why?)

When we talked about your son's illness you said his wife divorced him at that time and said she will come back to him when he is well again. Why would she do this?

What did you think about this? (*Probe*: Should she have cared for her husband?)

You said that you are taking caring of your granddaughter and would do that even if her mother was not moving and could take care of her herself. Why do you like having your granddaughter with you?

I'm sorry to go back to it, but I just want to make sure I understand you properly. When I asked you why it is bad that people tell other people if they have helped someone, you said that it is like you end up with the sin of planting a crop somewhere else and coming yourself to cut it again. Can you explain this to me again?

SECTION B) Work

You said that that week you had been to pick up your husband's wages at [name] village? What does he work as there? I didn't quite understand why they were paying him...

You said that at [name] the sub-T.A was telling your husband and to encourage his village to work hard. Why do you think that was?

I didn't understand what you were saying about encouraging people in your village to have good health. Are you the health advisor? Or do you mean you help because people in the village come here to your home to listen to the health advisors?

[If she is a health advisor:] How did you get this job? Is it connected to being the Chief's wife?

Are you paid for that job or only when you go for training like the cholera training at [place name]?

When you told me about your job weighing babies you said that if there are more trainings you would want them to choose a girl because you are getting old. Why would you want them to choose a girl? Why don't you want training because you are getting old?

Is that also why you want to stop doing the job? I didn't understand – I thought you didn't want to carry on the job because you are *not* picked for training?

When do you think you will retire from this job? Why will you do that?

When did you go to Zam-Zam Madrassah in Zomba to learn Islamic study? Was that last year?

And did you say you were living in Zomba at the time?

Did you have to pay?

You said that the reason you started going to the mosque was because the Christian churches were too far away, is that right?

Was your late husband a Muslim?

Is your current husband a Muslim?

You said that at the school you were aiming high. It sounds like you have always aimed high, is that right?

Are you still aiming high?

SECTION C) Old age

When we talked about work last week you said that you work hard because you are in the last days. What did you mean last days? *(Probe:* Last days of the world? Or your last days because you are getting older?)

SECTION D) Edzi

We mentioned edzi a few times last week.

How do you think your son got edzi?

How is it spread generally?

Is it possible to get edzi through witchcraft?

Do you know anyone who has been accused of witchcraft or bewitched in relation to edzi?

You said that if your son had been tested maybe he would have got medications. Can edzi be cured?

Do you think condoms are effective in stopping edzi spread?

Do you know how they work?

Have you ever used a condom?

Would you ever use a condom? Why/Why not?

How would you feel about going to buy condoms? Do you think people would know? What would they say about you?

Is edzi a new disease?

[If no:]

How long has edzi been around?

Did people call it something else in the past?

Is edzi still sometimes referred to by that other name?

What causes [other name]?

How did people respond to [other name] in the past?

Do you think edzi and [other name] is the same disease?

Have you noticed [other name] has increased over the last 30 years?

[If yes:]

Why do you think edzi came to Malawi? (*Probe*: Do people behave differently now from when you were my age?)

[If she talks about azungu coming to Malawi to name 'edzi':]

What happened? Can you recreate the story for me? (*Probe*: Why do you think the researchers came? What did you think of the researchers coming? Before the researchers came for edzi did they come for other things? In the same numbers? What did you think when the researchers first came? How did people respond to people who had what we now call edzi? What did people think of the patients? What did people say of the patients? How did people think they got the disease? What did families do to care for the patients?)

What did people think when edzi first came to Malawi?

Has that changed over time?

How is edzi different from other diseases? (*Probe*: If she says "edzi has no cure" ask them to explain further what they mean. Have there been no diseases previously that have no cure?)

___

[Ask Polly if we can visit her again if you don't finish these sections or you think there are new issues to follow-up.]

Dependent interviewing: Fourth Interview Guide for Polly Lwanda

Thank you so much for allowing me to visit you again to continue our conversation. We are so happy to be able to hear more of your stories and wisdom, you tell us such interesting things.

How are you?

How was your week?

(*Probe* further on her responses)

SECTION A) Life story

You told me about your life last week and your time in Zomba. Let's start there, I just want to check I have got everything right because I think your story is so interesting and I don't want to miss anything. So you left your drunk husband here in Nyanga and went to Zomba alone?

Did your children go to Zomba with you? Why/ why not?

When you were in Zomba people said there was someone from Zimbabwe that you should met and when you met with him you realised that he was the son of your brother?

So you lived with this nephew for some time. How long?

Did you care for him as a parent?

How old were you at that time?

Are you still in touch with him?

You said that before you met that nephew you met another person from Zimbabwe – a lady. Was she an older lady?

You said that she wanted you to stay with her and care for her because she had no husband and her four children had died, is that right?

Did she have *any* other family or was she living alone?

What witchcraft was she doing on you to make you stay?

When in Zomba you went to the hospital with your sister because you had lost a lot of weight due to stress. When was this?

Why were you so stressed?

SECTION B) Love and marriage

Why didn't your children want you to marry a chief? I didn't really understand what you said last week. Or is it that they didn't want you to marry at all?

You said that you told your children that you love your husband. Did you love him after he proposed or after the wedding?

How did you know you were in love with him?

Why did you fall in love with him?

We talked about your co-wife living by the Roman Catholic Church and Gift Whiteson's place? Not the house near the borehole with the kraal in the front?

I didn't realise your co-wife lived so far away. How often does your husband go there?

How long does he stay?

How do you feel when he's gone?

SECTION C) Support

Last week you told me that you have raised children who aren't yours but that you don't see these children now they are married. Were they your grandchildren or...?

How does it feel that you don't see them now?

Did you expect to see them in the same way that you expect to be remembered by the granddaughter you are caring for now?

How did you come to be looking after this granddaughter? Did your daughter ask you to take her while she moves about or did you ask if you could have her or...?

SECTION D) Ageing and work

You said that you no longer want to be a health advisor because of ageing. What is it about age that makes you want to stop? (*Probe*: You feel too tired? It's not a suitable job for an old person? You are bored of it?)

You said that one of the reasons you want to stop is because you are busy. What are you busy with? (*Probe*: Is it that you are starting new things now or that you are finding it harder to fit in all your jobs as your strength declines?)

You said that women from the village asked you why you aren't at work. Why don't you want to tell them you have retired? Why pretend you don't know the date?

Will you continue to advise people about good health even though you have stopped doing the under 5 clinic?

Have you got lots of new roles now you are married?

SECTION E) Understandings of old age

When we were talking last time you said a few times that when one has grey hair you want for death to strike you. You said "I am already dead". Do you really feel like this?

What makes you feel like this?/ Why don't you feel like that?

You said that it wouldn't matter if you got kachilombo because you are waiting for death now. Do you feel like your life is winding down? Despite your new marriage? And new clothes?!

When speaking about yourself you call yourself aged quite a lot. How old are you again?

Do you know people who are older than you?

[If yes:] What are their lives like?

Are they "already dead"? Why/ why not?

[If no:] Does that make you feel older?

SECTION F) Edzi

You told me about the way you can spread kachilombo – through sex, needles, witchcraft. Is that right?

Did I also understand you right that people who everyone knows must have been infected with kachilombo from their husbands are more respected?

You said that old people with kachilombo are those who don't control their hearts. Could you tell me more?

What is the link between controlling one's heart and kachilombo?

Do most old people have the desires but that they manage to control them?

Is controlling one's heart part of being a good elder?

What do people think of older people who don't control their hearts? Are they respected?

Do you know any older people who don't control their hearts?

You said that if older people get kachilombo they fail to get to hospital as young people do. Why is that?

You also said that getting edzi now would be different from getting it at age 40 because old people get sick frequently. How would them getting sick anyway affect their experiences of kachilombo?

You said that when the Lets Chat tested you last year you were worried because you didn't know what they would tell you. Did you think, at that moment, that you could be infected?

[If yes:] Why did you think that? How would you have got infected?

[If no:] Why were you worried then?

We also talked about what would have happened if Lets Chat had told you that you have the virus last year. Do you think your husband would have still proposed to you? Why/ Why not?

Would he have married you if he found out after he proposed? Why/ Why not?

If he had come to propose to you just after you got the results, do you think you would have told him? Why/ Why not?

You also said that your husband might have divorced you if it was after the wedding. Why do couples break up if one is infected?

You said that if you died or were infected with kachilombo your children wouldn't tell anyone because people would talk. What would people say? (*Probe*: Could you tell me some of the things?)

Why would they say that?

Why is them saying that bad/ why would that upset you or your children?

What challenges do you think you would face if you were infected now?

Has edzi had any (other) impact on your life?

[If yes:] In what ways?

If you were infected at the moment, how would you be thinking about your future?

SECTION G) Outlook on life

We talked a lot over the course of these conversations about things being God's plan. What does this mean for how you live your life? (*Probe*: How does knowing that this is just God's plan for you make you think about life and decisions you have to make? Put another way, if life was just chance and God wasn't controlling anything, He is just waiting for you in Heaven, how would you think about life and decisions?)

How does knowing that everything is in God's plan make you feel when you face a problem? (*Probe*: Does it make you happier? Does it make that problem seem smaller?)

How do you know what things or problems to accept as God's plan and which to find solutions for?

Have you always felt like your life is God's plan or is it since you started going to the Church and then Mosque after you were drinking or...?

Thank you so very much for allowing me to come to have these conversations with you, Emily and I have really enjoyed getting to know you. We can't thank you enough for all the help you have given us for the research.

(*Probe*: Anything else we could/ should know about your life or things about older people or kachilombo? Any questions?)

Dependent Interviewing: Second Interview Guide for Winford Black

Thank you so much for allowing me to come to talk to you again. I really enjoyed our conversation last week. We are learning so many really interesting things from you.

How have you been since I last saw you?

SECTION A) Understandings of old age

Last week you said that your grandchildren joke that you are not old. Do you consider yourself as an old man?

Why/ Why not?

What are the qualities of an old person?

You have got old friends in the village whose life now you admire. Why do you admire them? Are there any old friends whose life you don't admire?

When I was talking to my friend last week he told me that some people don't want to be called agogo and refuse to grow. Have you ever heard of this?

[If yes:] Why do you think people do this?

Is there anything you can do to prevent the signs of ageing? (*Probe*: Herbs, sex, not having children)

Would you want to?

You said that your body is ageing. What is happening to it? Did you mean the pains in your knees and head or are there other changes?

How do these changes in your body affect your life? Anything other than farming as we discussed?

How do you feel about the changes you are seeing in your body? (*Probe*: Sad? Indifferent? Happy?)

You said that being 50 was the best time in your life. How do you feel about growing older?

SECTION B) Marriage

Last week we talked briefly about your second wife. You said she wanted to give you diseases? What did you mean by this?

(*See if you can find out more about what the bad things she said were. He said he couldn't say last week*)

What did she say when you told her to leave?

What did the people who had introduced you to her say? Were they surprised?

You said that you wanted to see how much you harvest before marrying again. What difference will it make? (*Probe*: What's the significance of having money for marriage?)

You said that you found your second wife was just after your money. Why do you want money for a third wife?

Why do you want another wife? (*Probe*: For companionship? For sex? For help with chores?)

If you find you can take a new wife, what will you look for in her? (*Probe*: What qualities should she have? What age should she be?)

How will you find her?

What do your children and grandchildren think of you getting remarried?

SECTION C) Support

You told me that you only get support from two of your children, although they all come to visit you. Why do you think only two of your children help you and not all of them?

Why is it these two children? (*Probe*: Did you have a better relationship with them when they were growing up? Are they more able to help you?)

You said that you can't just ask for more assistance. I have heard this from other people but no one has ever explained to me why not. Why can't you just ask?

You said you are taking care of your children. I didn't really ask how? What kinds of things do you do to support them?

How do you feel about this? (*Probe*: Happy you are still able to help? Disappointed that they are not the ones supporting you?)

Talking about caring for the sick, you told me that how you care for the sick depends on how you were born. What did you mean by this?

SECTION D) Understandings of AIDS

Last week we talked about AIDS and you told me that you had a HIV test from the Lets Chat people. You said that you were ready to learn, but what were you expecting?

How did you feel before you got the result?

How did you feel after you got the result?

When you were telling me about the people who showed you condoms you said that you told them it "doesn't concern you". Why not?

Would you ever consider using them? Why/Why not?

You said that old people and young people can get AIDS and that having AIDS later in life is no better or worse than having it in younger life. Although one is not better or worse, can you think of any differences?

Say you did get AIDS now, even though that is unlikely, would your family and friends react in the same way that they would have done if you had been 50? Or 40?

Do you know of any older people who people say got AIDS?

[If yes:] What do you think of these people?

You said you plan to encourage your new wife to take an HIV test and that if she is positive you would not marry her. What about if you found out she had the virus after you were married? Would you leave her? Why/ Why not?

You said that it would be a burden. What is the burden?

You said that you hear about AIDS from people in the village. What kinds of things do they say to you? (*Probe*: Or are they talking to each other and you overhear?)

Do people talk about AIDS a lot?

Do people come here to visit you or do you hear them when you go into the village?

You said that AIDS is stopping Malawi develop. How?

What would be happening in Malawi if AIDS didn't exist?

SECTION E) Experiences of ageing

You said that only relatives come here for advice. Why can't you advise others?

You mentioned that some people don't respect you. Who? Why not?

Thank you so much for allowing me to have this conversation with you. I am learning so much! Would it be possible to come to see you again so that we can hear more stories? Could I come again?

Dependent Interviewing: Third Interview Guide for Winford Black

Thank you so much for allowing me to come to talk to you again. I am really enjoying our conversations. The way you have been so open to us is really helping the research.

So how have you been since I last saw you?

SECTION A) Finding a new wife

Have you decided whether you will take another wife yet?

[If yes:] Will you build her a home or just extend this one?

When we talked about your finding another wife you said you get on your bike and ask her for marriage. So do you have someone in mind? Or did you mean you would cycle around the village looking?!

I want to find out more about your thoughts on what would happen if your new wife had HIV. You said that you would leave her if this happened – for your own survival or so you wouldn't have to care for her? I didn't quite understand what you meant before.

You said that a person *could* stay in the marriage but that they would not be happy. Why wouldn't they be happy?

You said that condoms were very bad things. Why are they bad?

Why do you think that? (What are you basing that on?)

SECTION B) Advice

Why do the young people who aren't your children shout at you if you try to advise them?

You said they accuse you of being mad? (mad as in insane or mad as in angry?)

On the subject of not being respected, you said that people from other villages don't respect you because they don't think you are a Muslim. So the lack of respect has nothing to do with age?

SECTION C) Having AIDS in later life

You said that old people who have AIDS won't be taken seriously when they advise children. Could you tell me more about that? Why won't they be taken seriously? Will they not be taken seriously when they advise about AIDS or when they advise about other things too?

How would you feel if your children didn't take you seriously when you tried to advise them? Why?

Do you think it would be hard to tell your children you had AIDS if you were an HIV positive at your age? Why/ Why not?

How do you think the rest of the community would react if you had HIV at your age?

How would that make you feel?

What kinds of old people get AIDS?

I think you said you hadn't, but just to check, have you ever heard of an old person getting AIDS?

You said that people don't expect old people to have AIDS because they are expected to get sick anyway. Would that make having AIDS easier for old people because no one would know, or harder because they might not get the support a younger person would?

Do you think people who get AIDS at old age face any challenges? What?

What do you think your life would have been like if Lets Chat had told you that you were positive that day?

What would your first thoughts have been?

You said you would have believed you had got the virus from your second wife?

How do you think your family would have reacted?

How would you have reacted?

How would you have been thinking about the future, compared to how you think about the future knowing that you do not have the virus?

SECTION D) AIDS in general

We have talked about the people who you have overheard talking about AIDS at the borehole. Is it only women who talk about getting AIDS from men, or do men also talk?

I was interested that you said you hear the women talk about "women's issues". Don't they mind that you can hear? Why/ why not?

When you meet these women are you at the borehole collecting water yourself?

Do the women ever talk about people who are said to have AIDS?

You said that we are the only people who talk to you about AIDS at your home. Don't your children or grandchildren ever discuss AIDS? If so, what do they say?

When we were talking about whether AIDS is a problem for Malawi you said that people with AIDS die along with their work but that other people are still working. So how has AIDS stopped Malawi developing as you said?

____

As you know, we are trying to understand what life is like for people your age and how you feel about life and how you feel about AIDS. I am sure that we haven't managed to understand what life is really like for you or how you feel in these three conversations – we just don't know what questions to ask you! What else could you tell us that would help us to understand you and your experiences better?

____

Thank you so much for allowing me to come to have these conversations with you. I have enjoyed talking to you so much and I know that Emily has enjoyed reading the notes I make on our conversations. This is will probably be the last time I come to visit you. Do you have any questions about the research?

Thank you again, so much for sparing us so much time and being so open with us, it is very much appreciated.

Appendix C| Key to interview transcriptions as reproduced in this thesis

Word-	A word that is cut off (not finished) e.g. my grandchi-
Word//	A speech is interrupted e.g. my grandchild was//
//Word	The speech that was interrupting the one before it e.g. //what did you say to your grandchild?
{Word} {Word}	Words spoken at the same time e.g. I: {Do you think-} R: {I left to} go to Balaka that time
<u>Word</u> or Wor<u>d</u>	A word or part of a word that is said with emphasis e.g. Go <u>away</u>!
WORD	Spoken loudly
[Description]	Descriptions of the respondent's narrative e.g. [Laughs]
[RA: comment]	The research assistant's translation of what is being said. This includes literal and non-literal translations of words and descriptions of any Malawian practices. e.g. [Research assistant: this is an energy-giving vitamin for the body]
[2]	Pause of two seconds
[3]	Pause of three seconds etc.
[…]	Denotes excerpts are from different places in the (single) interview narrative

Appendix D| Example focus group interview guide

Focus group discussion with HIV positive adults aged over 59

Kondwera Support Group, [Place identifier]

2 June 2009

Thank you for allowing us to attend your group and have this discussion with you. We think there is a lot we can learn from your experiences and what you say is very important to us. Because it's so important to us, we hope it is OK with you if we record our conversation?

[Explain again about the study and ask if they have questions]

Emily is conducting some research for a PhD at the London School of Economics in the UK. We are researching people's experiences of getting older with HIV. We want to know about your experiences of ageing and how you experience having HIV. We are interested in anything you have to tell us! We hope to use what you tell us to write a book and some articles for publication. There wouldn't be any way to identify you in these writings. Does anyone have any questions about that?

Maybe we could start with some introductions – though I am sure you all know each other! Maybe you could say your name, age and a little about yourself?

[The following can be addressed in any order. Try to follow up on what respondents say rather than sticking to this list. If one person talks a lot, try to bring other people into the discussion by asking them if they feel the same.]

1. Support groups

- Can you tell me about your support group here – what do you do here?
- How did you all find out about it?
- How long have you all been members?
- What did your first visit feel like? (Probe: Were you nervous? Excited? Why?)
- Were you surprised to find people here your own age? Why/ why not?

2. Understandings of old age

- What (who) is an old person? What are the qualities of an old person?
- Do you consider yourselves to be old people yet?
- Who are your age mates that you admire?

3. Realities

- What are the things that are most concerning to you about HIV or about your age? [Follow this up]
- Are any of you caring for children? How does that affect you?
- When people your age get sick, who takes care of them? (Probe: Parents or children? Husbands/wives? If you get sick, who do you think will be the one to take care of you?)
- Why these people and not others?
- Is this different from the people who take care of say, 40 year olds?
- Have you made plans for the future? Do you think it's more important to have plans in place the older you get? Or maybe less important?

4. Disclosure and support

- When you found about your HIV infection, who did you tell?
- Have you told your parents? Why/ Why not? (Probe: If they say that it would upset their parents ask why; ask why not upsetting them is reason enough to not tell them, ask them what their parents would do if they found out, ask them if they would have told their parents if they were younger)
- Who are the people that support you and help you to manage your infection? (Probe: do you think it would have been the same people supporting you if you had found you were infected 10 or 15 years ago?)
- How do you think people outside the support group perceive people living with HIV? (Probe: In your families, villages, churches/temples/mosques)
- Do you think other people think differently about older and younger people with HIV? (Probe: Maybe they expect younger people to be HIV positive and not older people?)
- Have you noticed any changes in the way people think about (old) people living with AIDS?

5. Differences between old and young

- Do you think it's different having HIV as an older people than as a younger person? (Probe: is anything at all different? Maybe its different in terms of the people you are supporting, people who are supporting you, the people who will care for you if you become ill, sexual or romantic relationships, maybe its different because of finishing having children?)

6. HIV Risks between old and young

- Do you think risks of HIV infection are different for different age groups? How are they different? Should they be different?

- Do you think people your age and older are given enough HIV information? Are people your age targeted by prevention campaigns?

7. Challenges

- What challenges do you face as older people?
- What challenges do you face as people living with HIV?
- Do you think any of those challenges overlap? Are the same? Make something easier or harder?

8. Worries

- What do you all worry about most? Why?
- What things do you worry about less and why?
- How do you cope with these problems? What kinds of coping strategies do you (or “do people your age”) employ?

Should it come up: Condom use

- How easy is it to use condoms with your partners?
- Where do you get condoms? How do you feel when you get condoms? Is it embarrassing?

Appendix E| Respondent information sheets (English, Chiyao, Chichewa)

Malawi Longitudinal Study of Families and Health ('Lets Chat')
&
London School of Economics and Political Science

Information Sheet

Investigator's name: Emily Freeman

Investigator's address: The London School of Economics and Political Science, Department of Social Policy, Houghton Street, London, WC2A 2AE, England.

Investigator's telephone number: 0999454871

Investigator's email address: e.freeman@lse.ac.uk

Experiences of Ageing and HIV/AIDS in rural Malawi

You are invited to take part in a collaborative research project between the London School of Economics and the Malawi Longitudinal Study of Families and Health, which is conducted by Chancellor College and the University of Pennsylvania. The study is being led by Emily Freeman as part of her PhD research at the London School of Economics.

The study is about older adults' experiences of ageing and of life today, including your experiences of HIV/AIDS. We would like to talk to you about these issues. Taking part in the study is completely voluntary. We will read you some more information about the study to help you decide whether you

would like to participate. You may keep a copy of this information if you wish. We are happy to answer any further questions you have about the study.

What is the aim of the study?

The purpose of the study is to better understand older adult's experiences of life in rural Malawi. We would like to learn more about attitudes and behaviours in relation to family, relationships, sex, illness, HIV/AIDS and death, as well as anything else that you feel affects your life.

Who is eligible to take part in the study?

Anybody over the age of 49 is eligible to take part in the study. You are being invited to take part in the study because you or your children have previously agreed to participate in the Malawi Longitudinal Study of Families and Health ('Lets Chat'). Approximately 40 elders will be taking part in the study in Balaka District.

What will it mean to take part in this study?

If you decide to take part in the study we will arrange a convenient time to come to talk to you. We may also ask if we can come to talk to you again if we find there is more we would like to discuss with you. Agreeing to the first chat doesn't mean you have to take part in further interviews.

What will happen during this interview?

The interviewer will chat with you about your experiences of life and getting older, problems and HIV/AIDS. We would like you to talk freely about any issues that are important to you and that you think would be interesting for our study: We think there is a lot we can learn from you! You do not have to answer any questions you do not feel comfortable with, and you may stop the interview at any time.

With your permission, we would like to record what you say in the interview. This is so that we can remember your thoughts accurately, and do not miss any important information.

The interview will take place in or around your home in an area in which our conversation cannot be overheard to ensure your confidentiality. You choose where you would like the interview to take place. The interview will

last as long as you choose, and you can end the conversation at any time. However the interview is likely to last at least 30 minutes.

Who will see the information you tell us?

Everything you tell us will be completely confidential. Only staff employed by the research project will have access to the recording of your interview. Later, when we discuss the study results with people who do not work on this specific study of ageing, we will remove any information that could be used to identify you, such as your name, village name, or the names of anyone you mention during the interview. Your name will be changed to an ID number so that we can link what you say in the interview to other information you have previously given to the Malawi Longitudinal Study of Families and Health.

What will we do with the information we collect?

The findings of the study will be published in scientific journals and a PhD thesis (book). Every effort will be made to ensure that you will not be identifiable in any of these publications (unless you tell us that you would like to be). For example, if any quotations from your interview are included, we will change your name, the names of people or places you talk about or anything else that could be used to identify you. If you would prefer that the things you say in the interviews are not included in these papers, even though they will be used anonymously, please say so - you would still be welcome to take part in the study.

Because we value the information you will give us in the interview, we will store it in a safe place. The recordings and transcripts (written notes of what was said) of your interviews will be kept by the University of Essex in the UK in their 'Qualidata' data bank. Anything you say in your interviews that could readily identify you will be removed before this information is stored in these data banks. Other researchers can ask to see your anonymised interviews once they have been put into the data banks, and they may use them in their own work. There are strict rules about who is allowed to do this and how they are allowed to use your interviews. If you would prefer your interviews were not put into the data bank, please say so – you would still be welcome to take part in the study.

How will you benefit from the study?

We hope you may find chatting with the interviewer enjoyable. However we envisage no direct benefit to you.

Will I be paid for participating in the study?

You will not be paid for participating in the study, but you will receive a small gift to thank you for taking part in the interview.

What are the risks involved?

No harm will come to you as a result of taking part in the study. However, it is possible that you may find talking about some sensitive issues uncomfortable. Again, you do not have to talk about anything you do not want to.

What if I decide I don't want to take part in the study?

You are welcome to decline to take part in the study. There will be no consequences of this. You do not need to provide a reason for not participating. It will not affect any care, rights or access to services you receive now or in the future. You will still be welcome to take part in any further studies by the Malawi Longitudinal Study of Families and Health.

If you decide to take part in the interview and later change your mind, you can withdraw from the study at any time without giving reasons by contacting us in any of the above ways. The information you have given us will be removed from our records. Again there will be no consequences of this and it will not affect any care, rights or access to services you receive now or in the future.

If you would like some more time to consider whether you would like to take part in the study, or discuss the study with your friends and family that is fine. We will give you a copy of this information to keep and we can arrange a time to come back to find out your decision.

Who approved this study?

The Research Ethics Committees at Chancellor College, the University of Pennsylvania and the London School of Economics have approved this

study. This means that they believe the study to be of academic value and that no harm will come to those who participate in the study.

How can I find out the results of this study?

Once all the interviews have been conducted, we will write a short report on the study written especially for study participants. Please let us know if you would like a copy of this information. We will ask for your address so that we can send this to you.

Who can I contact if I want to know more?

We will be happy to answer any questions you have now or in the future. You can contact us in any of the ways details at the top of this sheet.

If you decide to take part in the study we will ask you to sign a consent form. This is to confirm that you understand what we have explained to you about the study and are willing to take part. We can give you a copy of this form if you would like to keep it, but you will never need to show it to us in the future. The form is just so that we can show that we told you about the study and you were happy to talk to us.

Consent Form

Study title: Experiences of Ageing and HIV/AIDS in rural Malawi

I have been asked to participate in a study about experiences of ageing and HIV/AIDS. Information about this study has been explained to me and I have understood it.

The interviewer has answered any immediate questions I have about this study. I can contact Emily Freeman if I have further questions or if I wish to make a complaint.

I understand that the interview will be recorded unless I specifically ask for it not to be.

I understand that I may withdraw from this study at any time without giving a reason.

Signature or thumbprint of the Participant:……..

Name of participant:……..
(Interviewer: Do not write name on copy of consent form given to the respondent)

Date: ……

Signature of the Interviewer:……

Name of the Interviewer:……

Malawi Longitudinal Study of Family and Health ('Lets Chats')

&

London School of Economics

Chikalata Chakuulusya Utenga

Lina la wakuungunyaungunya: Emily Freeman

Adilesi ja wakuungunya: The London School of Economics and Political Science, Department of Social Policy, Houghton Street, London, WC2A 2AE, England.

Telefoni ja wakuungunya: 0999 454 871

Adilese jine ja wakuungunya: E.Freeman@lse.ac.uk

Yine yakusimana nayo pa ukalamba kupwatika ya kachilombo ka HIV ni ulwele wa 'edzi' m'madera ga m'misi M'Malawi

Ali wakuwendedwa kujigala nawo mbali mu kuwungunya kwakutendesya mwakamulana pachilikati pa London School of Economics ni wa Malawi Longitudinal Study of Families and Health yayili yakutendedwa ni wa Chancellor College ni wa University ja Pennsylvania. Kaungunyaju wakutendesya ni a Emilly Freeman ali jwakakamulichisya mu chigawo cha majiganyo gawo ga PhD pa sukulu ja London School of Economics.

Kuungunyaku kukusana ni achakulungwa mwakulingana ni yakusimana nayo pa ukulu wawo kupwatika ya kachilombo ka HIV ni ulwele wa 'edzi' m'madela ga m'misi m'chilambo cha Malawi. Tuwe wakusangalala kunguluka nawo

ngani seleso. Kujigala nawo mbali pa kuungunyaku kwangakakamisya. Chitwawalinjile utenga kuti atusalile kuti naga chachigale nawo mbali lapena iyayi. Komboleka kusunga chikalatachi naga akusosa. Tuchiwa soni wakusangalala kwanga mausyo gawo gakusana ni kuungunyaku.

Chakulinga cha kuungunyaku ni chapi?

Chakulinga cha kuungunyaku ni chakuti tupate yakusimana nayo achakulungwakulungwa m'madela ga m;misi m'malawi muno.

Wani wali wakusosegwa kujigala nawo mbali mu kuungunyaku?

Waliwose wakwete yaka yakupitilila 49 mpakana ajigale nawo mbali mukungunyaku. Tukwawenda kujigala nawo mbali ligongo lakuti munyumamu wawojo wajigele nawo mbali mu kuungunyaungunya kwawatesile wa Malawi Longitudinal Study of Families and Health ('Lets Chat'). Wandu achakulungwa wakwana 40 akujigala nawo mbali mukuungunyaku m'maboma ga Balaka.

Yigopolela kuti chichi kujigala nawo mbali mukuungunyaku?

Naga ali asosile kujigala nawo mbali mu kuungunyaku tuchilangana ndawi jakuti tukunguluche nawo. Tuchiwenda soni kunguluka kwine naga pali papatikene kuti pana yine yakuti twausye kuti atusalile. Kunda kujigala nawo mbali pa kuungunyaku nikunguluka nawo ngayikutandausya kuti jachijigala nawo mbali pa kuungunya kwine kwa msogolo muno.

Yakutendegwa pa kungulukaku?

Wakwakungulusya chachawusya yakusimana nayo pa ukulu wawo nambo soni ya kachilombo ka HIV ni chilwele cha 'edzi'. Tuchisaka kunguluka nawo mwagopoka pa yaliyose yayili yakusosegwa kwa wawojo, ni yine yakuyiwona kuti yili yakusosegwa pa kuungunyaku. Tukulupilila kuti pana yejinji yatuchilijiganya kumila kwa wawojo. Ali wagopoka ngajanga mawusyo gakugawona kuti ngawa wagopoka kwanga.

Ali akundile tuchijambula yatuchikungulukaga ni chakulinga chakuti tukakumbuchile ngani syawosyo nikuti soni tukaja kuleka chine chilichose. Kungulukaku tuchikunguluchila pa m'nango pawo pa malo gakupita mbepo. Ali wagopoka kusagula malogo nambo soni ulewu wa ndawi ja kukunguluka kwetu nambo soni ali wagopoka kwimika kunguluka kwetu ndawi jilijose. Kunguluka tukuchiwa kwa maminisi gakwana makumi gatatu.

Ana yatuchiyipata tuchitenda nayo chichi?

Yakupatikana pa kuungunyaku tiyichilembedwa m'mabuku ga kuungunya ga PHD. Tuchitenda yakomboleka kuti wawojo ngasamanyikwa m'mabuku gelega. Mena gawandu kapena ga misi tuchigatosya nikuwika m'malo mwakwe ma nambala ni chakulinga chakuti akamanyikwa.Komboleka kusagula kuti malowe gawo galembedwe m'mabukugo nambo atamusi ili m'yoyo ngawa kuti wawojo tachimanyikwa nambo soni ali wagopoka kujigala nawo mbali.

Tuchichimbichisya yakuwecheta yawo nikuyisunga pa malo gambone gakusunjika chenene kusukulu ja penani ja Essex ku ulaya m'malo gakusunjila yindu ya kuungunya gakusagatenda kuti "Qualidata" banki. Yosope yatawechete yakuti mkuwa mkwamanyisya tuchiyitosya. Naga wane wakungunya ali asosile kamulikasya masengo pachiwa pana malamusi gangalama kwa wandu welewo. Naga ali asosile kuti yakuwechetayi yikaja kusunjidwa m'malo gakusunjilago asale nambo ali wagopoka nikupocheledwa kujigala nawo mbali.

Ana tachiapata chichi mukuungunyaku?

Tukumanyilila kuti tachiwa wakusangalala kunguluka nim'we nambo pangali chachipata mu ndawi jeleji.

Ana chinjipochela kalikose pakujigala nawo mbali mukuungunyaku?

Ngasapochela chine chilichose nambo pana mtuka watachipochela.

Ana pana yakogoya ya mpaka asimane nayo?

Pangali chakogoya chine chilchose pakujigala nawo mbali nambo mpaka yikomboleche kuti awe wakutawika pakuwecheta ni soni timbwilisye kuti akawecheta yichindu yangakusaka kuwecheta.

Ana naga ndili sagwile ngajigala nawo mbali?

Ali wakundidwa ngajigala nawo mbali mukungunyaku pangali yakusausya yine iliyose soni ngapakusosegwa kulepeleka ligongo lakwe soni ngayikuwandikana ndi ukoto ni umi wawo pasogolo pano nambo soni tachiwendedwape kusogolo kuno kujigala nawo mbali mu kuungunya kwa wa Malawi Lonitudinal Study of Fmilies and Health. Naga ali asagwile kuchigala nawo mbali mukuungunyaku kaneko soni nikusinda nganisyo nikuleka komboleka kutumanyisya mulitala line lililose tuchitosya yosope yatusalile.

Nambo soni naga ali asosile kutama ni mpata welewu kuti aganisye kaje yakujigala nawo mbali kapena kuwechetana ni achimijawo ni mawasa gawo mpaka atende m'yoyo nambo soni tuchileka chikalata cha mtengawu kuti asunje nambo soni tuchiyika soni kwisa kupikana nganisyo syawo.

Ana wani wajitichisye kuungunyaku?

Wa gulu ja kuungunya wakutochela ku sukulu ja penani ja Chancellor College, Pennsylvania, ni wa London School of Economics niwajitichisye kuungunyaku. Ayi yikutusalila kuti kaungunyaju chawe jwakulongolela m'nope nikuti soni tipawe pangali yakusausya pakujigala nawo mbali.

Ana tachipata uli yakuyichisya ya kuungunyaku?

Yakunguluka yetu patuchimalapo tuchiyilemba yine yindu ya kuungunyaungunyaku kwamanyisya wosope wene wakujigala nawo mbali. Chonde atusalile naga mpaka awe wakusosa kuti chitwatumichisye mwangasausya. Chonde atupe adilesi jawo kuti chitwatumichisye mwangasausya.

Ana mpaka mbechete ni wani naga ndili sosile kumanyilila?

Mpaka tuwe wakunonyela kwanga mausyo gawo mpaka msogolo muno mpaka tukomboleche kutagulilana nawo pa adilesi jajili penanipo. Naga ali asagwile kujigala nawo mbali tukwawenda kuti atusayinile chikalata chakwawenda kuti tumanyilile kuti apikanichisye yatuwechete nawo yakusana ni kuungunyaku nambo soni chitwalechele chakalata chine chakuti asunje chakulandana ni mtengawu.

CHIKALATA CHAKWAWENDA KUJIGALA NAWO MBALI

Ambindile kujigala nawo mbali mukuungunya ni yakusana ni ukulu nambo soni kachilombo ka HIV ni ulwele wa ‘edzi’. Alongosolele chenene ya kuungunyaku nambo soni mbikaninichisye.

Wakumbusya soni ajanjile mawusyo gangu gakusana ndi kuwungunyaku. Nambo soni kuti mpaka mbechete ni Emily Freeman naga ndili ngwete mawusyo kapena madandaulo.

Mbikanichisye kuti kunguluka kwetu chakujambule nambo naga ndili sachile kuti akajambula nganawa ajambule.

Mbikene soni kuti komboleka kuleka kutenda nawo yakuungunyaku ndawi jine jilijose jasosile pangapeleka ligongo.

Siginecha / Chidindo cha wakujigala mbali:……

Lina la wakujigala nawo mbali:……

Lisiku:……

Siginecha ja wakuusya:……..

Malawi Longitudinal Study of Families and Health ('Lets Chat')

&

London School of Economics and Political Science

Kalata Yofalitsa Uthenga

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Zomwe anthu amakumana nazo akamakula kuphatikizapo za kachilombo ka HIV ndi Edzi mmadera a kumidzi Mmalawi.

Muli kupemphedwa kutenga nawo mbali mu kafukufufu wa mngwirizano pakati London School of Economics ndi Malawi Longitudinal Study of Families and Health, amene akuchitidwa ndi Chancellor Collage ndi Sukulu ya ukachenjede ya ku Pennsylvania. Kafukufukuyu akusogoleredwa ndi Emily Freeman ngati mbali imodzi ya maphunziro ake a PhD pa sukulu ya London School of Economics.

Kafukufukuyu ndi okhudzana ndi zomwe anthu amakumana nazo pokula, ndi za moyo wa lero kuphatikizapo zomwe mumakumana nazo za HIV/AIDS. Tikufuna kucheza nanu pankhani zimenezi. Kutenga nawo mbali pa kafukufukuyu ndi kosakakamiza. Tikuwerengerani uthengawu kuti musankhe

kutenga nawo mbali kapena ayi. Muthanso kusunga kalata ya uthengawu ngati mungakonde. Tidzakhala okondwa kuyankha mafunso ena onse amene mungakhale nawo okhudza kafukufuku ameneyu.

Cholinga cha kafukufukuyu ndi chiyani?

Cholinga cha kafukufukuyu ndi choti timvetsetse bwino zomwe anthu akulu amakumana mmadera aku midzi ya Malawi.Tikufuna tiphunzire zambiri zokhudza malingaliro a anthu ndi zikhalidwe zokhudzana ndi mabanja, maubale, kugonana, matenda, HIV/AIDS, ndi imfa, komanso chilichonse chomwe mukuwona kuti chimakhudzana moyo wanu.

Amene ali oyenera mukafukufufukuyu ndi ndani?

Aliyense amene ali wopitirira zaka 49 atha kutenga nawo mbali. Muli opemphedwa kutenga nawo mbali chifukwa inu kapena ana anu mbuyomo munalora kutenga nawo mbali mu Malawi Longitudinal Study of Families and Health (‘Lets chat’). Pafupifupi akuluakulu 40 akhala akutenga mbali mu kafukufuku ameneyu m’maboma a Balaka.

Zikutanthauzanji kutenga nawo mbali mukafukufukuyu?

Ngati mungasankhe kutenga nawo mbali mukafukufukuyu tidzakonza nthawi yabwino yoti tidzachedze nanu. Titha kudzafunsanso ngati tingadzacheze nanunso ngti kupezeke kuti pali zinanso zoti tikambirane nanu. Kuvomera kutenga nawo mbali pa kucheza koyamba sikutanthauza kuti mudzatenganso mbali pa kafukufuku wamtsogolo muno.

Zochitika m’kuchezaku?

Wakafukufuku adzacheza nanu zokhudza zomwe mwakumana nazo m’moyo, and za ukulu wanu, mavuto ndi HIV/AIDS. Tikufuna kuti muyankhule mwa momasuka pa zilizonse zofunikira kwa inu, ndi zomwe mukuganiza zili zofunikira pa kafukufuku wathu: tikuganiza pali zambiri zomwe tingaphunzire kwa kuchokera inu. Simukuyenera kuyakha mafunso omwe simukumasuka nawo, ndiponso mutha kusiyitsa kuchezako nthawi ili yonse..

Monga mwa chilorezo chanu tijambula zomwe tikhale tikukambirana ndi cholinga choti tikakumbukira bwino maganizo anu ndikutinso tisaphonye chinachilichonse. kucheza kwathu kuchitikira pa khomo panu pamalo oduka mphepo kuti zikhale zachinsinsi; mutha kusankha malo ena aliwonse

komanso kuchezaku kutalika ndi mmene inu mukufunira ndipo mukhoza kuimitsa nthawi ina iliyonse ndipo ticheza mphindi zosachepera makumi atatu.

Ndani yemwe akawone uthengawu?

Zones zomwe mutatiwuze zizakhala zachinsinsi. Anthu okhawo ogwira ntchito mukafukufukuyu adzatha kuwona zolembedwa ndi zojambulidwazo pomaliza pa zokambirana ndi zotsatira za kafukufukuyu anthu ena azatha kuwona nawo koma tizakhala titachotsamo zinthu zofunikira zoti munthu atha kukudziwa monga dzina, mudzi, ndiponso maina omwe mutchule nkucheza kwathu. Dzina lanu lizasinthidwa kukhala nambala yokha ndi cholinga choti zigwilizane ndi zomwe munayankhula mukafukufuku wa Malawi Longitudinal Study of Families and Health.

Kodi zomwe tipeze tizapanga nazo chiyani?

Zotsatira za kafukufukuyu zidzalembedwa mu ma buku a zofufuzafufuza ndi PhD. Tidzayetsetsa mothekera kuti inu musadziwike mmabuku amenewa (pokhapokha mutiuze kuti mukufuna kuyikidwamo). mwachitsanzo tikaphatikiza zoyankhula zanu tidzasintha dzina lanu ndi maina a anthu omwe mutchule ndiponso mukhoza kusankha kuti mawu anu asalembedwe mbukumu , ngakhalebe zilichoncho zidzakhala zosazindikilidwa komanso ndinu olandilidwa kutenganawo mbali.

Tidzalemekeza zokamba zanu ndikudzisunga mmalo otetezedwa bwino ku sukulu ya ukachenjede ya Essex ku UK mu ‘Qualidata’ data bank. Zonse zomwe mukambe zomwe mungazindikilidwe nazo zidzachotsedwa. Ena a kafukufuku adzafuna kuti awone zozindikiri zanu kuti agwiritse ntchito, pali malamulo ake okhwima kwa ololedwa ndi mmene angagwiritsire ntchito zoyankhula zanu. Ngati mungakonde kuti zokambilanazi zisakasungidwe mmalo osungiramo chonde nenani-koma mudzakhala olandilidwa kutenga nawo mbali mukafukufukuyu.

Kodi mudzapindulanji mukafukufukuyu?

Tili ndi chikhulupiliro kuti mudzakhala okondwa pakucheza nafe. Simudzapindula mwachindunji.

Kodi ndidzalipidwa pa kutenga nawo mbali m'kafukufukuyu?
Simudzalipidwa chinachichonse pakutenga nawo mbali koma mudzalandira mphatso yaying'ono ya zikomo chifukwa chotenga mbali.

Kodi pali zoopsya zomwe ndingakumane nazo?
Palibe choopsya china chilichonse pakutenga nawo mbali. Koma zikhoza kutheka kuti mukhoza kukhala omangika kuyankhula za manyazi ndibwerezanso kuti musayankhule zinthu zomwe simukufuna kuyankhula.

Kodi nanga nditasankha kusatenga nawo mbali?
Muli ololedwa kukana kutenga nawo mbali mukafukufukuyu. Palibe chovuta chinachilichonse ndipo sipasowekanso kupereka chifukwa chake, ndio sidzidza khuzanso chisamaliro chanu kaya ufulu wanu mtsogolo muno ndipo mudzkhala muli opemphedwa kutenga nawo mbali mu kafukufuku wa Malawi Longitudinal Study of Families and Health.

Mukasankha kutenga nawo mbali mukafukufukuyu kenako nkusintha maganizo anu mukhoza kusiya ndipo mukhoza kutidziwitsa munjira inailiyonse. Zomwe mutatiuze muzojambula zathu tidzadzichotsamo.

Komanso ngati mungafune kukhala ndi mpata wautali kuti muganize kaye bwino musanatenge nawo mbali, kapenanso kukambilana ndi anzanu ndi banja lanu mungatero. Ndipo tikusiilani chikalata chofalitsa za uthengawu kuti musunge ndipo tidzabweranso kuti tidzamve maganizo anu.

Kodi anavomereza kafukufukuyu ndani?
A gulu la zofufuzafufuza aku sukulu ya ukachenjede ya Chancellor Collage, Pennsylvania, ndi a London School of Economics ndi omwe anavomereza kafukufukuyu.izi zikusonyeza kuti ali ndi chikhulupiliro kuti kafukufukuyu akhala opambana ndiponso sipakhala choopsya china chilichonse pakutenga nawo mbali.

Kodi ndidzapedza nawo bwanji zotsatira za kafukufukuyu?
Zocheza zathu zikatha tidzalemba zinthu zina za kafukufukuyu kwadziwitsa onse otenga nawo mbali. Chonde tidziwitseni ngati mungakonde kuti tikutumidzireni ndipo tikupemphani kuti mutipatse adilesi yanu yoti tikhoza kutumiza mosavuta.

Kodi ndingayankhule ndi ndani ngati ndingakhale zofuna kudziwa?
Tidzakhala okondwa kuyankha mafunso anu panopo komanso mtsogolo muno. Mukhoza kulumikizana nafe pa adilesi yomwe ili pamwambapo.

Mukasankha kutenga nawo mbali tikupemphani kuti musayine chikalata cha pempho lathuli. Izi zithandiza kuti tidziwe kuti mwamva zomwe talankhula nanu zokhuza kafukufukuyu ndipo muli wofuna kufuna kutenga mbali. Titha kukupatsani chikalata cha pemphochi ngati mungachisunge, koma simudzafunika kutiwonetsa chikalatachi patsogolo. Chikalatachi ndi chongsonyeza kuti takuwuzani za kafukufukuyu ndipomunali wosangalala kuyankhulitsana nafe.

Kalata Ya Pempho Lotenga nawo mbali

Mutu wa Kafukufuku : Zokumana nazo pa ukulu ndi Kachilombo ka HIV ndi matenda a Edzi mmidzi ya Mmalawi

Ndapemphedwa kutenga nawo mbali mu kafukufuku wa zokumana nazo pa ukulu ndi kachilombo ka HIV ndi matenda a Edzi. Ndafotokozeredwa za uthenga wa kafukufukuyu ndipo ndamvetsa.

Ondifunsanso ayankha mafunso anga okhuzana ndi kafukufukuyu. Ndipo ndikhoza kuyankhulana ndi Emily Freeman ngati ndingakhale ndi mafunso kapena chidandaulo.

Ndikumvetsa kuti kuchezaku kujamburidwa pokhapokha ndipemphe kuti asajambule

Ndamvanso kuti ndikhonza kutuluka mu kafukufukuyu nthawi ina iliyonse popanda kupereka chifukwa chenicheni.

Siginechala/chidindo cha otenganawo mbali:……

Dzina la otenganawo mbali:……...

Nambala ya oyankha ya MDICP (ngati ilipo):……

Date:……..

Siginechala ya ofunsa:……

Appendix F| Key informants' organisations

Organisation	Nature
The Food and Agriculture Organization of the United Nations (FAO) United Nations Population Fund (UNDP)	International agency
Ministry for Disabled Persons and the Elderly Ministry for Gender, Children and Community Development Ministry for Development Planning and Cooperation Ministry of Health	Government ministry
Demography Department, National Statistics Office (NSO)	Government department
National AIDS Commission (NAC)	Government-established public trust
The Bingu Silvergrey Foundation (BFG)	President's personal charitable foundation
Public Service Pensioners Association (PUSEPA) Hope for the Elderly (HOPE) Aged Support Society of Malawi (ASSOm) Aged Welfare and Development Association (AWEDA) Elderly People's Association (EPA) Global Hope Mobilisation Kalibu Ministry Elderly Project	Malawian nongovernmental charitable organisation
Anonymous key informant	International charitable organisation, not currently working in Malawi
College of Medicine, University of Malawi Department of Demography, Chancellor College	Academic institution