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Bewitching sex workers, blaming wives: HIV/AIDS, stigma, and the gender politics of panic in western Kenya

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Abstract

Since access to HIV testing, counselling, and drug therapy has improved so dramatically, scholars have investigated ways this ‘scale-up’ has interacted with HIV/AIDS-related stigma in sub-Saharan Africa. Drawing on data collected during ethnographic research in a trading centre in western Kenya, this paper critically analyses two violent and localised case studies of panic over the ill health of particular community residents as a nuanced lens through which to explore the dynamic interplay of gender politics and processes of HIV/AIDS-related stigma in the aftershocks of the AIDS **crisis**. Gaining theoretical momentum from literatures focusing on stigma, gender, witchcraft, gossip, and accusation, we argue that the cases highlight collective anxieties, as well as local critiques of shifting gender roles and the strain of globalisation and legacies of uneven development on myriad forms of relationships. We further contend that these heightened moments of panic and accusation were deployments of power that ultimately sharpened local gender politics and conflicts on the ground in ways that complicated the social solidarity necessary to tackle social and health inequalities. The paper highlights one community’s challenge to eradicate the stigma associated with HIV/AIDS during a period of increased access to HIV services.

Keywords

HIV/AIDS; stigma; panic; gender; Kenya

Introduction

The past decade has witnessed dramatic improvements in understanding HIV/AIDS and an overwhelming international response to the epidemic, which has mobilised resources and an entire social movement unified in pursuit of justice and equity (Hirsch, Parker, & Aggleton, 2007). The AIDS **crisis** has spurred a drastic scale-up of HIV counselling, testing, and antiretroviral therapies (ART) across the globe and improved lives. How this scale-up has interacted with HIV/AIDS-related stigma and discrimination in sub-Saharan Africa has received much scholarly attention. Despite initial hopes that more equal access to ART

would eliminate stigma (Castro & Farmer, 2005), studies suggest that treatment alone is insufficient (Maughan-Brown, 2010; Wyrod, 2011). More work is needed to investigate *how* and *why* the stigma persists, while keeping in mind the broader—social, political, economic, scientific, and historic—contexts giving shape to such processes. Further, little ethnographic research examines stigmatizing practices from the perspectives and beliefs of those experiencing, interpreting, and resisting/contesting them in situ (Kleinman et al., 1995).

This study, by drawing on empirical evidence gathered during ethnographic research in a small trading centre in western Kenya, was designed to contribute to these gaps. By critically analysing local perceptions of two violent, localised, and exceptional case studies of incited panic over the ill health of particular community residents, we provide a nuanced depiction of the dynamic interplay of gender politics and HIV/AIDS-related stigma in the aftershocks of the AIDS **crisis**. The first case centres on public accusations of witchcraft made by a ‘sex worker’ towards the wife of her lover. Panic over the bewitching escalated into mob violence, and resulted in the social deaths or banishment of those involved. Case two documents local interpretations of and responses to circulating stories about a man who supposedly died of complications associated with AIDS and left a list of the married women he purposefully infected with HIV, leading to the physical and/or social deaths of some residents. We ask, Why did these two panics arise at the particular moments they did? In what ways are public health panics shaped by and shaping gender relations? What do such moments of panic reveal about the perceived and experienced effects and limitations of HIV/AIDS-related global health programs in this part of the world?

Methods and theory

The data presented in this paper were gathered by the lead author (EJP) as part of a larger ethnographic study of the social and structural dimensions of AIDS-related stigma during a period of increased HIV services (Pfeiffer, 2014). With research permissions from the Institutional Review Boards at Indiana University and Moi University, the fieldwork was conducted over a total of 9 months in 2011/2012. The overall study incorporated a wide range of methods, including daily participant observation in diverse settings (e.g., clinics, bars) and at various events throughout the community (e.g., burials, engagement parties) and semi-structured interviews. Data were further collected using life-history interviews, informal conversations with key consultants, and conversational journals (Watkins, Swidler, & Biruk, 2011). The first author (EJP) and research assistants conducted the interviews in English or Kiswahili, and most were audio recorded, transcribed, and translated into English. Detailed field notes were recorded during or soon after each interview, conversation, and participant observation session.

Four diverse and well-connected community members were hired and trained as research assistants for this project to help with several duties: 1) introduce and orient the investigator to residents and activities in the community, thereby building rapport and entry into the trading centre; 2) help revise, socially and linguistically, a set of open-ended interview protocols; 3) assist with the identification and recruitment of potential interlocutors across the social spectrum; and 4) interpret/translate during and debrief after interviews and participant observation sessions. Each day in the field, the lead author (EJP) rotated working

independently or alongside one of the four research assistants, each selected to reflect some of the social, linguistic, and ethnic variability found within the trading centre. This study made use of a snowball sampling technique (Bernard 2006), beginning with the lead researcher's own set of connections, then moving into the broad networks of the diverse research assistants, and extending outward from there. The decision to employ local residents from various backgrounds was an attempt to reduce the biases that are inherent within the ethnographic data collection process.

As the fieldwork progressed, data were regularly analysed by the team using an iterative thematic coding approach commonly used in ethnographic analysis (Ryan & Bernard, 2003) and to guide subsequent areas of investigation. Gender politics and anxieties/tensions over shifting gender roles and relationships emerged as persistent themes and were explored in greater depth. After the incidents highlighted occurred, the investigator inserted lines of inquiry during casual conversations with key informants to probe local understandings of them. Often the topics emerged unsolicited during semi-structured interviews and other methodological strategies. After data were collected, interview transcripts relevant to the cases in this paper were reviewed, analysed, and triangulated with pertinent conversational journal entries and field notes by both authors (EJP and HMKM), resolving differences by discussion.

The rationale for the selection of the two case studies is threefold. First, area residents continued to process the details of them with one another and the researchers throughout the study period, thus suggesting they were locally meaningful. Second, both document overt episodes of stigma, accusation, and blame as they unfolded. HIV/AIDS and the issues surrounding social stigma are sensitive topics, making it difficult for investigators to retrieve accurate information through formal questionnaires/surveys where individuals tend to respond with socially appropriate responses (Winkelman, 2009). Investigating such processes as they erupt exposes how and why they become operationalised, as well as the local effects and explanations of them. Finally, both cases reflect exceptional moments in the trading centre. Scrutinising exceptions illuminates the everyday, otherwise tacit, cultural logics, norms, expectations, and rules giving shape to gender, marital, and sexual relations and HIV/AIDS.

Stigma theory

Stigma has long been noted as a driver of the HIV/AIDS epidemic (Piot, 2000). This disease has prompted social scientists to (re)conceptualise stigma as a complex social process dependent upon social, economic, and political powers (Link & Phelan, 2001), and as part of an ongoing struggle over the maintenance and legitimisation of myriad forms of inequalities, including those associated with gender, sexuality, class, and race/ethnicity (Parker & Aggleton, 2003). Studies suggest that because HIV/AIDS is linked to inequalities, discourses about the disease evoke a strong sense of morality (Dilger, 2008). As such, this study gains further theoretical momentum from Yang et al. (2007, p. 1525), who contend that stigma is essentially a moral issue that reveals 'what is most at stake' or threatened among both the stigmatisers and the stigmatised sharing a 'local social world'. We argue that heightened moments of panic and accusations point to collective cultural anxieties, and thus

are deployments of power during struggles over what is most at stake in one community at one point in time.

Gender in sub-Saharan Africa

Gender relations and sexual practices are not determined simply by biology/physiology (Falola & House-Soremekun, 2011), but are shaped by historical trajectories and interweaving cultural, social, economic, political, and other structural factors (Parker, 2001, p. 168). Over the past several decades, scholarship has focused critical attention on shifting manifestations of gender and sexuality in African societies (Arnfred, 2005; Falola & House-Soremekun, 2011). Numerous scholars have convincingly argued that the social constructions of gender, marital, and sexual norms and relations have been transformed over time by processes of transnationalism and globalisation, in ways that have aggravated gender inequalities across the continent (J. Cole & Thomas, 2009; Grosz-Ngaté & Kokole, 1997; Hodgson, 2001; Robertson, 1996).

Changes in gender relations have had profound impacts on the spread of HIV/AIDS (see Hunter, 2002, 2007; Parikh 2009), and indeed, gender inequality continues to be one of the most significant factors contributing to the inability of women to protect themselves from HIV, causing them to be disproportionately infected (Whelehan 2009). Studies from Kenya suggest that society is less tolerant of women living with HIV, thus they experience stigma and discrimination more often when compared to men (Amuyunzu-Nyamongo et al., 2007). At the same time, the AIDS epidemic (and the technologies of response to it) continues to reconfigure such relationships in Africa and beyond (Hirsch et al., 2009) This paper explores shifting gender, marital, and sexual relationships during a period of increased availability of HIV/AIDS-related services. We argue that public health panics reveal perceived local impacts of increasing social and economic inequalities and changes on gender and other relations. We further contend that these moments of panic expose fierce negotiations over the meanings of those changes and offer insights for global health interventions.

Witchcraft, gossip, and accusation

To further contextualise the cases presented, the analytical insights of scholars who have written about witchcraft, gossip, and accusation in sub-Saharan Africa are useful. Scholars contend that manifestations of witchcraft serve as idioms used to make sense of social and economic crises and changes (Comaroff & Comaroff 1993). Witchcraft accusations are fuelled by structural and social arrangements and inequalities that are played out between individuals. Ashforth (2005) suggests a gendered dimension to witchcraft, noting that women more often employ such forces during conflicts, especially as jealousy/envy arises between lovers, spouses, and co-wives.

Similar to stigma, witchcraft has been theorised as a form of power (Geschiere 1997) and used to explain misfortunes, including those associated with illness and death (Evans-Pritchard, 1993). Communities experiencing high rates of HIV infections and AIDS-related deaths across sub-Saharan Africa often witness an upsurge of beliefs and suspicions of witchcraft (Rödlach, 2006; Thomas, 2008). While gossip about witchcraft and witchcraft

accusations can be used to deflect processes of stigma away from a person¹, they can be damaging to individuals and communities (Ashforth & Watkins, 2015; Thomas, 2008).

Ashforth (2005) argues that witchcraft is a subject and product of gossip. Goody (1970, as cited in Ashforth, 2005, p. 66) distinguishes between gossip and accusations concerning witchcraft. She explains that gossip about being bewitched generically serves to explain a misfortune without identifying the culprit. Accusations occur when 'a witch is named as responsible for a given attack, and some form of publically sanctioned counteraction follows'. This distinction is important, as Ashforth (2015, p. 10) has remarked that while fears and suspicions of and gossip about witchcraft are common in sub-Saharan Africa, 'open accusations of witchcraft are the exception in most African communities; still more rare are actual assaults on suspected witches'. Although only one of the cases centres on witchcraft, both reflect extraordinary moments when gossip turned into accusations to inflict harm on the incriminated.

Ethnographic context

The fieldwork was conducted in a trading centre located in the western highlands of Rift Valley Province, and along a major highway. The larger location in which the community is situated had a population of approximately 11,000 inhabitants who represented a broad mix of Kenya's 42 diverse ethnic groups, but was predominately home to those who identified as Kikuyu² or Kalenjin³. With ample parking along the two-lane highway and a small strip of commercial buildings, both the physical layout of the community, as well as the goods and services available helped to accommodate the needs and desires of those living in and around the place and hundreds of truck drivers passing through. This trading centre also boasted a thriving sex industry and a substantial population of commercial sex workers (CSWs).

In stark contrast to much of the Kenyan landscape, which is predominantly arid savannah, the western highlands consist of fertile land and a climate suitable for productive agriculture (Kamungi, 2009). Perhaps as a consequence, this area has been a place of considerable migration, displacement, and ethnic/political conflict since (at least) the colonial period (Lynch, 2011). Serious tensions and competition over land and business persist in this region, epitomised by episodes of ethnic violence almost every five years, and alongside nearly every democratic election since 1992. While Kenyans experienced devastation and displacement in 1992 and 1997, the worst effects occurred when lawlessness erupted following the disputed 2007/2008 presidential elections (Kamungi, 2009; Lynch, 2011). Between January and February 2008, over 1,300 people were killed, numerous houses, businesses, and farms were burned and/or looted, more than 600,000 people were displaced, and 12,000 individuals fled as refugees to neighbouring countries (Ashforth, 2009; Kamungi, 2009).

¹Local politics always surround who can and cannot reasonably make claims of having been bewitched (see Thomas, 2008).

²The largest ethnic group in Kenya.

³A linguistic, sometimes political, social category that actually incorporates several different ethnic groups (Lynch 2011).

According to Ashforth (2009), while the 2007/2008 post-election violence (PEV) fighting took on distinct forms across the country, Kalenjins engaged in the ethnic cleansing of Kikuyus contributed to the majority of deaths and displacements. It is perhaps not surprising then that the study community—with high percentages of individuals from both groups—was at the epicentre of the destruction. Most residents had experienced the PEV. The effects of and tensions produced by the conflicts were still visible during fieldwork (e.g., charred remains of houses/businesses), and the community was characterised by spiralling inequality, corruption, political and economic insecurity, high rates of unemployment, and an increased reliance on competitive informal/illegal economies (e.g., prostitution). To further contextualise the cases, the country was headed towards its next general elections. An overall sense of uncertainty characterised the ethnographic moment of fieldwork.

HIV/AIDS

At the time of this study, an estimated 1.6 million adults in Kenya were infected with HIV (KAIS, 2009), and women had a prevalence rate nearly twice that for men at 8% and 4.3%, respectively (NACC, 2010). Despite a reduction in the national prevalence rate to 5.6% (NACC & NASCOP, 2013), the number of new infections remained high, with an annual incidence of HIV double that of the number of people enrolling in ART programs (USAID/PEPFAR, 2011). In Kenya, the disease is predominantly acquired through heterosexual sex, with 44% of those infections occurring within the marital union/primary partner context (NASCOP, 2012). Efforts at the field site, however, focused heavily on CSWs and truck drivers.

Clinical evidence suggests that those living with HIV under good viremic control do not transmit the virus (Das et al., 2010). This has prompted HIV/AIDS testing and treatment to be top priorities for global health programs, policies, and funding (PEPFAR, 2012). In 2010, a rigorous home counselling and testing (HCT) campaign was launched in Kenya (CSIS, 2009). The goal of HCT was to go door-to-door to offer free and confidential HIV rapid tests to individuals, couples, and families living in selected areas. People who tested positive were immediately referred to a Comprehensive Care Centre (CCC). The community described in this paper hosted a CCC, and throughout the research, HCT teams were making their way in and around the area.

Case study 1: A sex worker bewitched

‘I did not hear people discussing HIV today. People think my friend is a witch and tried to kill her. I did not go into the [trading] centre all day’. These were hand-written words in a notebook, one entry in Njeri’s⁴ conversational journal. On the days leading up to Njeri’s refusal to go into the centre, Wanja, an unmarried Kikuyu woman, became ill. Her symptoms were described by another local woman, Mary, who had witnessed the suffering firsthand: ‘The stomach became big, like a woman about to deliver [a baby], and all of a sudden, it disappears. ... And then the legs became big. She was in great pain. She screamed!’

⁴Njeri and all other names are pseudonyms.

Gossip about Wanja's illness spread throughout the community, as did the belief that she had been bewitched. Everyone knew that Njeri's friend Maggie was jealous of her. Wanja was a known lover of Maggie's husband James, and witnesses had previously spotted the two women in a hostile confrontation. Kamau, a Kikuyu man and friend of James explained the logic behind the jealousy:

[James] loves a lot of ladies, and those women are the prostitutes of this area. ... [Wanja] is a carrier⁵ [of HIV]. You know, most of the women [in this area] are carriers because they sleep with men from all over Africa, and with locals. So [Maggie] came to envy [Wanja], so she bewitched her. It was like [Wanja] was about to take over [Maggie's] family. So [Maggie] put a snake in the stomach.

As Kamau demonstrates, the concepts of HIV/AIDS and 'prostitution' constantly evoked each other, thus rooting Maggie's retaliation not only in her envy, but blame for the spread of HIV.

When asked how people knew that Maggie was responsible for Wanja's illness, some cited mounting evidence, which included details that two public hospitals had denied Wanja treatment and officially declared her condition witchcraft. Mary, who had escorted her to the hospital, recalled, '[At] the hospital, the nurses refuse[d] to treat her. They said, "There is nothing we can do about this because this is witchcraft". ... They could not understand what was happening, so they said, "Go and solve [the problem] in your home!"' Wanja also named Maggie as the person assaulting her as she pleaded for the pain to cease. Mary went on, '[Wanja] was saying, "No, stop [Maggie]. Stop harming me! I'll leave your husband alone"'.

A group of single women, outraged at the harm being directed towards Wanja, united into a violent and frenzied witch hunt. Kamau recalled, 'The fellow prostitutes demonstrated—they wanted to kill [Maggie]'. As circuits of gossip were legitimated, a contagious sense of panic consumed an even wider diaspora of residents. Maggie initially found refuge at a nearby police station, and later in a distant city, while the crowd grew in size. Prompted by police force and tear gas, the multitude thinned. When people learned that Wanja was still ailing the next morning, a mob resurrected to issue a stern, verbal threat to local authorities: 'If you are not going to take any action, then we will take the law by our hands'. As leaders deliberated the case, the heightened sense of panic was described by eyewitnesses as miraculously calmed by a Pentecostal pastor when he prayed for and successfully rid Wanja of her suffering. Soon after, Wanja was commanded by police to leave: being bewitched had threatened the peace. The message was clear that Wanja's continued presence might (re)provoke violence in an already volatile region.

Though peace was restored before Maggie was physically assaulted, the accusations of witchcraft were socially destructive to her. She temporarily moved, but the time away did not repair her blemished reputation; the story that Maggie was a witch/devil worshipper and a person to be feared and avoided became solidified. Several interviewees said they were

⁵A term used to describe an HIV-negative partner of a discordant couple and/or a person capable of spreading the virus, but who does not get sick.

leery of socializing with her and supporting her business. A gendered variant of social death befell James, described by Kamau as

an embarrassment [to James]. People are saying, ‘Ah, your wife is a witch.’ Even [their] kids don’t interact with other[s]. You see, he was a Christian, although he was evil. He is the cause of all of this, being a prostitute! He [is] now a hard drinker [After the ordeal] they [Wanja and James] fought direct in daylight! Then the fellow prostitutes came and were shouting at [James] like a child, embarrassing him in public! I told him, ‘You have a wife, land, money, and your kids are educated. What else do you want?’

Kamau holds James responsible for his shameful inability to maintain control of the women in his life, and Kamau uses the term *prostitute* to describe the greedy behaviours of James. As locals reflected on this witchcraft event, a shared moral lesson emerged:

It has made the CSWs fear having relationships with men who are from within this centre. So now they just stick with the truck drivers ... because the married women have been saying, ‘Now we know what we will be doing to them [the CSWs] if they snatch our husbands!’

As Mary proposes above, residents interpreted the effects of this localised panic as reinforcing the power and gender dynamics and conflicts between women in the trading centre. It is worth noting that while this public accusation of witchcraft was unusual, tensions between women were common, especially as they competed not only for scarce resources—financial and emotional—of men, but for status and reputation.

Case study 2: A list of wives

Around the time that Wanja was bewitched, a scandal erupted as nefarious gossip circulated that ‘a list of 200 women⁶ has now been confirmed true because the first name on the list just died and the church has refused to bury her’ [conversational journal entry, October 2011]. Initially, gossip about the list was characterised as hearsay, until the first woman died and church leaders refused to perform her funeral, thereby corroborating the notion that the woman had behaved immorally. A key informant suggested the woman had committed suicide: ‘She died of shame—that stigma! The family members, especially the husband could not be associated with her after the doctors revealed her [HIV+] status. So she refused to eat’ (Pfeiffer fieldnotes, October 2011). During fieldwork, four women died, their tragic deaths credited by locals to the shame of having been included in the list.

While a tangible list was never substantiated through research, stories about the list (and its potent effects) were documented across the wide range of data-gathering techniques. With the exception of one health care provider, not one other respondent questioned the existence of a list, as evidenced by the response of one woman: ‘[Lists] are very real! I have heard of three. One in 2002 There was one in 2008. ... And there was a recent one—have you heard?’ (Pfeiffer, fieldnotes, 2011). Given that the reality of the list was generally not

⁶The actual number of names in the list cited by locals varied widely, ranging from over 100 to as many as 600.

disputed by those at the field site, we took explanations of the list seriously and interpreted them as a public health panic.

In the views of the people living in the trading centre, three things connected the lives (and deaths) of the women listed. First, being in the list implied that the women had been intentionally infected with HIV by a man who allegedly died of complications associated with AIDS in early 2011. There were differences in the way the deceased author of the list was described, but the underlying message and accusation was that women had engaged in transactional sex⁷ with the man. Some people accentuated the man's role as a *boda boda* [motorbike taxi] driver. In these versions, the man included the names of women who had accepted 'free' rides from him, in exchange for sex. In other accounts, the author corrupted his temporary position with a humanitarian organisation after the PEV. His job during that time, people stressed, was ironically to create a list of names of those who had suffered substantial damages during the PEV and were eligible for relief money. It was explained that to receive compensation for losses, some women had sexual relations with the man. One woman recalled the situation during a casual conversation: 'This man left a list He used his position in the IDP [internally displaced people] camp to misuse and infect women who felt they could get favours from him after the PEV'. Indeed, locals frequently described the PEV as fuelling changes in local gender, marital, and sexual roles and relationships, as well as aggravating poverty, corruption, and HIV. A Kalenjin man described the relationship between the PEV and HIV during an interview: 'I think clashes in 2007 increased the spread of HIV because the family structures were broken down. There were no proper rules, so those who had HIV could access immorality PEV made HIV rates to be around 70% of the people'. This man was not alone in his drastically inflated perception of HIV prevalence rates.

A second theme linking the lives of the women in the list was a belief that they were hiding their HIV statuses. When asked during a semi-structured interview about the last time he heard someone talking about HIV/AIDS outside a clinic setting, one man incorporated a story about a woman in the list: 'I heard about HIV yesterday. ... We all recently attended a burial [of] a wife I was told was HIV+ and hiding [her serostatus]. Even the husband never knew. This is very shocking to us'. The final thing that unified the women in the list was that they were all 'very well-known mothers' (respected and married). This was troubling to residents for reasons that were spoken concisely by a key consultant: 'Everyone believes that HIV is a prostitute disease. So everyone is wondering how it could be that a married, church-going woman could get HIV, especially since the husband is a church elder'. The women featured in the list were not described as dying directly from the virus, but rather 'before their days were near' (prematurely) from a consuming sense of shame. During a semi-structured interview with a woman working in the health sector, the topic of the list unexpectedly emerged as she clarified what she meant by 'spreading sprees':

People go on spreading sprees. Mostly it is commercial sex workers. They just have sex to infect everybody But recently this motorbike driver was doing it [sex]

⁷A term used in HIV/AIDS literature to emphasise the everyday norm of economic exchanges for sex in sub-Saharan Africa and to eliminate the stigma associated with notions of prostitution (Hunter 2002; Kaufman and Stavrou 2004; Poulin 2007).

purposefully! He left a list. That list has taken effect. Imagine a list of names has already killed three women. This man did not want to die alone with his AIDS. The women here are being consumed by stress and embarrassment.

To reiterate, sex workers were presumed responsible for the spread of HIV. The list disturbed this assumption, thereby inciting a sense of panic. Furthermore, the discourse about individuals who 'did not want to die alone with their AIDS' was parroted by residents and used to describe people living with HIV who were so bitter that they deliberately infected others.

Discussion

The public accusations made during the bewitching of Wanja and the scandal of the list were extraordinary events in the trading centre. In both instances, processes of stigmatisation erupted during moments when power arrangements and gender dynamics were perceived to be threatened and disrupted. While each case could be interpreted as providing a temporary sense of justice in the community, they culminated in social and/or physical deaths, damaged the lives of those involved, and perpetuated local gender politics and HIV/AIDS-related stigma. Collectively, four themes emerge across the cases: 1) fears, 2) scapegoats, 3) keeping people in line, and 4) panic drama. Literature suggests that gossip/rumours in sub-Saharan Africa can be used to interpret and reflect on ways that biomedical knowledge, practices, technologies, and programs are resisted, manipulated, and rendered local (White, 2000). As such, the two cases illuminate the intertwining structural and interpersonal factors perpetuating HIV/AIDS stigma to influence HIV scale up.

Fears

Anthropologist James Howard Smith (2011) explains that in the Kenyan context, public accusations of witchcraft/devil worship differ across the country, depending on the particular circumstances afflicting each community. Elsewhere, Smith (2008, p. 17) argues that witch finding offers a visual representation of the collective fears within a society at a specific moment in time. As case 1 shows, gender relations were contentious, and shifting power and gender dynamics were producing anxiety in the trading centre. The two cases reflect violent struggles for power, not only between men and women, but among women, which evoked a collective sense of fear. It was through Wanja's bewitching that a group of women successfully dismantled the good fortune of James and (temporarily) destabilised the gendered status quo. Likewise, stories about the list not only fuelled the idea that married men were purposefully spreading HIV, but that respectable, married women were engaging in transactional sex—and behaving like single women—to get ahead, which disrupted local understandings of 'proper' gender roles and behaviours, fuelled anxieties about the moral breakdown of society, and challenged the assumption that prostitutes were responsible for the spread of HIV.

The accusations and blame circulating during these exceptional moments blurred and complicated the lines between categories of people (e.g., victim/perpetrator, wife/prostitute, good/evil), but also further cemented and dichotomised them. Consistent with previous research, this study demonstrates the importance of addressing gender inequalities alongside

HIV/AIDS scale up. This analysis extends our understanding of how this might be accomplished. Efforts to improve gender relations cannot be limited in a focus on heterosexual relationships or between sex partners, but must also attend to the inequalities that plague other interpersonal relations, such as between individuals with differing economic, social, and marital statuses.

Scapegoats

Maggie also faced devil worshipper accusations, which Smith (2011, p. 11) suggests evokes a sense of failed development in an area and serves to supply a 'personified sacrificial scapegoat for complex social problems, including the growth of illegal and/or informal economies and spiralling inequality'. Maggie, a wealthy, Christian wife, emerged as a symbol of the greatest threat to the future stability of the community, at least from the perspective of the CSWs leading the charges against her for employing illicit mechanisms of social control to greedily keep limited resources to herself. It was police officials however, who ultimately determined that Wanja was an even greater threat, evidenced when they commanded her to leave. A combination of these two reactions echoed across case 2, as respectable and married women in the list—exposed for secretly behaving like prostitutes—surfaced as community scapegoats. Together, the two cases serve as a critique of the economic, political, and social inequalities that prohibited/limited people from engaging in the 'ideal' gender, marital, and sexual practices and roles.

These public scandals offer more than commentaries of strained gender relations. As C. Cole (2007) astutely observed of popular culture in Ghana, gender is often a carrier for a range of cultural anxieties. Specifically in the Kenyan trading centre, they reflected angst over the interethnic, intercommunity violence and political insecurity that had occurred during PEV and might (re)occur in the future, as the country was fast approaching another election. Stories about the list that accentuated the role of the author corrupting his position as a humanitarian worker make this explicit, and suggest the list served as an idiom for communicating about the inequitable, sometimes corrupt distribution and acquisition of wealth and other economic, political, and social resources in the community. The two cases point to the limitations of global health programs to eradicate HIV and stigma during a period of increased services, if economic, political, ethnic, and other social and structural arrangements and inequalities are not simultaneously addressed.

Keeping people in line

Picking up the work of Gluckman and Foucault, White (2000) develops the argument that public scandals reinforce larger social values and rules, and serve to keep people in line when gossip alone is believed to not be working. The social and physical deaths that occurred from the accusations made in each respective case reinforced local gender politics and AIDS-related stigma, thus working to keep people in line, women in particular. Local gossip about who was or was not a CSW or living with HIV/AIDS was rampant at the field site. Indeed, the two concepts were synonymous, and an HIV+ status provided evidence of anyone who had been immoral. As a consequence, gossip was frequently cited as one of the primary motives behind the perceived local need to practice selective concealment. That is, people had to conceal their statuses in the community to preserve their social reputation and

maintain social support from those in their kin and other social networks, yet needed to disclose at the clinic to receive proper care. Moving between the contexts of the clinic and larger community required careful negotiations that have been documented by scholars working in southern Africa (Frank and Rödlach 2013). Accessible ART in the community made concealment easier and contributed to the normalisation of the disease. But this was simultaneously described as anxiety producing, especially in the context of a community where people imagined that the majority of residents were infected. Panic over the list seemed to be one way of expressing local-global tensions and the impact of increased HIV/AIDS-related services in the area. Specifically, accusations articulated anxieties over ongoing, contentious debates/concerns being negotiated among residents about the increased focus on HIV testing and disclosure, and practices of selective concealment of an HIV+ status.

These two cases, coupled with the tendency among locals to have drastically inflated perceptions of rates of HIV in the community, illuminate possible gaps in HIV education messages. Specifically, they expose two faulty assumptions about HIV epidemiology that have been documented by other scholars working in sub-Saharan Africa (Ashforth & Watkins, 2015). First, HIV is highly contagious and that one unprotected sexual encounter will result in infection; second, anyone who has participated in adulterous sex is automatically infected or a carrier and therefore dangerous. These beliefs run counter to scientific evidence about HIV and suggest that it is time to update prevention messages so people know that HIV is a difficult virus to contract (Ashforth & Watkins, 2015, p. 254).

Panic drama

Fairchild and Johns (2015) use the notion of a 'panic drama', to develop the argument that contemporary panics often repeat previous ones through 'scripts' that allow a panic narrative to be maintained over time. This concept is useful for thinking about how and why HIV/AIDS-related stigma persists. Indeed, while both cases represented extraordinary moments during the research, people could recall previous accusations of witchcraft and having seen lists in 2008 and 2002. Similarly, residents spoke of personally knowing a deviant individual who 'did not want to die alone with AIDS'. This latter phrase was documented early during the AIDS epidemic (see Whyte, 1997). The recycling of panic dramas, phrases, like witch finding and gossip unified residents and fostered a productive sense of community building and belonging (Ashforth, 2005; Gluckman, 1963; Smith, 2008). Indeed, residents were united in the pursuit of justice during these outbursts of panic, accusation, and stigmatisation. As case 1 illustrates, however, the community-building efforts accomplished by the witch hunt had limitations in that it ultimately perpetuated (rather than resolved) the hostile interactions between wives and CSWs and moralizing discourses about HIV. Similarly, the panic generated by the list was both produced by and cemented existing gender inequalities and differences and HIV/AIDS-related stigma. It also reinforced the notion that people living with HIV were dangerous and when provoked, maliciously infected others. In these ways, the gender politics of panic complicated the community social order and solidarity needed to tackle myriad social and health inequalities, including HIV/AIDS and processes of stigmatisation.

Conclusion

Localised panics—including episodes of witchcraft accusations and rapidly circulating gossip—are often dismissed by public health and medical researchers/professionals/practitioners. We suggest, however, that they can be used as a barometer to assess population health and well-being, and to illuminate the distinct challenges facing a particular community that hinder the elimination of the stigma associated with HIV/AIDS, even during a period of increased HIV services. The public health panics described were incited by and fuelled local gender politics, conflicts, and inequalities in ways that affected scale up of services. If the *2030 Agenda for Sustainable Development* goals to end the epidemic of AIDS and achieve gender equality and empower all women and girls (UN 2015) are to be seriously attempted and attained, innovative ways of eradicating stigma are essential. These efforts need to consider the complex and local histories and existing social and structural insecurities and tensions being drawn upon to think about and interact with the epidemic, those infected and/or associated with it, and those imagined to be spreading it. Otherwise, attempts to treat bodies (and AIDS-related stigma) will fail.

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