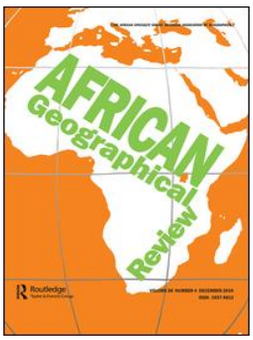

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Covid-19 pandemic: lessons from the HIV/AIDS epidemic in Southern Africa

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ABSTRACT

Using Malawi as a case study, this commentary takes a retrospective view of the HIV/AIDS epidemic to draw lessons about the spread of, and government response to, Covid-19 in Southern Africa. With the legacy of colonialism and the distortions wrought in by structural adjustment programs still alive, we argue that the same factors that propelled the spread of HIV/AIDS in Southern Africa continue to shape vulnerability and response to Covid-19 in decisive ways. Understanding the geography and political ecology of HIV/AIDS is key to discerning the social and political determinants of Covid-19, which provides direction regarding appropriate social policy responses.

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HIV/AIDS; Covid-19; Malawi; Southern Africa; geography; political ecology

Introduction

The Covid-19 pandemic has spread to nearly every country of the world. As of the 20th of August, there have been 22 million confirmed cases and a million deaths. Untold social and economic dislocation have occurred, all in a span of few months. Despite recent breakthroughs on the vaccine front, it is clear that lockdowns, social distancing, masks, and hand sanitizers will continue to characterize our preventative efforts given that immunization is not a magic bullet. But even the promise of existing public health measures and the expectation of a vaccine should not recuse us from looking deeper and asking difficult questions about the fragilities in our world that make disease epidemics such as Covid-19 such a humanitarian disaster in the first place. There is now growing consensus that the pandemic has exposed fundamental flaws in the very foundation of our society and that unless these cracks are addressed, the world remains prone to the ongoing pandemic and other similar afflictions in the future (Mbembe, 2020; Oldekop et al., 2020; Pirtle & Laster, 2020). While many of these flaws are global in nature, they take specific regional forms that vary geographically. For instance, the fight against Covid-19 will be an uphill battle for most countries in Sub-Sahara Africa in part because of the detrimental impact of World Bank and International Monetary Fund (IMF) structural adjustment programs on national economies and healthcare systems in the continent (Forster et al., 2019; Pfeiffer & Chapman, 2010). The impacts of these programs have also been highly gendered; they have pushed women and girls deeper into poverty and more dependent on men for their survival. Recent reports of over 5000 teenage girls in Malawi having fallen pregnant since March when the government closed schools as part of its national response to Covid-19 attest to how this pandemic has exacerbated and magnified preexisting structural inequalities (The Star, 2020).

This commentary takes a retrospective look at the dynamics that drove the spread of HIV/AIDS in its early stages to seek context and lessons for understanding the emerging patterns of the spread

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of Covid-19 in Sub-Saharan Africa (SSA). We use Malawi as a case study because this former British colony has one of the highest prevalence levels of HIV/AIDS in the world at 9.2% of the adult population (see UNAIDS, 2020) and because it is currently teetering on the edge of a Covid-19 spike. HIV/AIDS and Covid-19 are both infectious diseases, but their etiology, mode of transmission, and epidemiology are radically different. The kinds of behavioral changes required to reduce the spread are also different. However, these differences should not prevent us from stepping back and assessing the broader dynamics that set the context for the spread of disease epidemics. Disease-causing pathogens, in themselves, do not constitute a pandemic. It is the conditions prevalent in society at a given time that facilitates their spread (Kalipeni et al. 2004). We argue that at the very least, a reflection on the HIV/AIDS experience draws a sharp parallel with our current fixation with masks, handwashing, vaccines, and related techno-managerial strategies. Hence, paying attention to the geography and political ecology of HIV/AIDS in its early stages can provide a glimpse into the social forces implicated in the spread of Covid-19 in developing countries.

Malawi is a small, landlocked country in southern Africa with a landmass of 118,000 km^2. The United Nations classifies it as one of the 'Least Developed Countries,' with an estimated per capita income of 320 USD and with over two-thirds of the population living on less than US$1/day (World Bank, 2018). Malawi also has one of the highest HIV prevalence levels in the world at 9.2% of the population aged 15–49 (Malawi Government, 2016; UNAIDS, 2020). When Malawi wrested independence from Britain in 1964, it remained a one-party dictatorship for 30 years until 1994 when it transitioned to democratic rule. The recent presidential election (23 June 2020) saw the country's opposition secure a strong majority, which took place after the first round of polling was annulled by the country's constitutional court following allegations of widespread rigging by the then ruling party. The election activities took place against the backdrop of an already rising tide of Covid-19 pandemic. In fact, it is now widely believed that the nationwide street protests and political rallies held in the run up to the election intensified the spread of Covid-19, including fueling its diffusion into rural areas where community spread is now beginning to gain traction (*NyasaTimes*, 2020).

Epidemics as social and political processes

A close look at the genesis of Covid-19 in Malawi evokes memories of the initial spread of HIV/AIDS, with globalization as a key factor. To cite global connectivity as the driving force behind the spread of a disease in a country that barely registers on the global economic and geopolitical map, seems somewhat far-fetched. However, such is the power of globalization that it brings even the poorest and remotest geographic enclaves into the world's economic, social, cultural orbit (Ferguson, 2006). Furthermore, the efforts to promote globalization have influenced policies and driven economic reforms around the world. To that end, Malawi introduced its Structural Adjustment Program in 1981, 4 years before its first official HIV case, with a view to improve economic conditions, but it led to negative consequences, particularly for wage laborers (Chilowa, 1991). Notably, these reforms also resulted in the decline of a broad range of health indicators as the health system deteriorated (Kwengwere, 2011).

Geography played a key role in the HIV epidemic in Malawi, particularly in relation to the movement of migrant workers. As Manda et al. (2015) and Nutor et al. (2020) have shown, HIV prevalence in Malawi varies significantly, based on where one lives, with relatively low prevalence rates in northern and central areas and high rates in the south. Notably, as Manda et al. (2015) point out, this correlates more with population density that it does with rates of poverty. Nutor et al. (2020) find that people living in urban areas had a 2.2 times greater risk of being HIV-positive compared to their counterparts in the rural areas. From a historical perspective, the experience of the HIV pandemic is also gendered. The migrant workers who went to work in the mines of South Africa where prevalence rates were high, tended to be young men (Johnson, 2017). However, the gendered burden shifted with time and today the prevalence of HIV is much higher for women than

men at 10.8% and 7.0%, respectively (Nutor et al., 2020). Early indications suggest that Covid-19 in the country may follow these same geographic and gendered trends (UN, 2020).

The first case of HIV/AIDS in Malawi was officially reported in 1985. At the time, the first cases were mainly high-profile globe trotters such as politicians, bureaucrats, businesspersons, including a beauty queen who allegedly contracted the virus on one of her frequent trips abroad (Lwanda, 2004). However, the epidemic quickly went down societal fault-lines and became synonymous with poverty. Similarly, the first Covid-19 case in Malawi was reported on 2 April 2020. This case was a wealthy Malawian businesswoman who had just returned from India. She then unknowingly passed it on to her housemaid, who in turn is thought to have spread it through the poor suburbs of Lilongwe where she lived with her family. On April 4th, a man who had just returned from the UK and another man who had returned from South Africa (on March 16), tested positive for Covid-19. As was the case with HIV, the government's initial response was marked by policy inaction. Also reflecting elite political responses during the early years of the HIV epidemic in southern Africa (notably Mbeki in South Africa), the existence of the virus was denied, or its seriousness down-played. The very first response by the then one-party regime when HIV/AIDS arrived in Malawi was denial. HIV/AIDS, like any contentious political matter that challenged the ruling party's myth that Malawi was a 'land of milk and honey', and thus was never openly acknowledged or discussed. Knowing that HIV/AIDS risked busting his political party's myth, the then president, Dr. Hastings Banda, a medical doctor himself, orchestrated a perception that Malawi was free of the virus. Although Covid-19 has arrived in a different political climate, it is no less political.

The Covid-19 outbreak in Malawi quickly became a political tussle. However, unlike the case with HIV/AIDS, this time around it was the government's apparent overreaction to the pandemic in the middle of an election year that sparked criticism and controversy. Although there was a sense that Covid-19 had arrived, the prevalence estimates that the government provided came under heavy scrutiny because they were believed to have been grossly inflated. As a result, it was not surprising that when the government announced a total shutdown of the economy, there was public outcry. A court injunction a few weeks later led to the suspension of the lockdown. But for many Malawians this was just another example of a political maneuver by a government desperate to hang on to power, as more cases were confirmed. Convinced that the attempted shutdown was a ploy by the ruling Democratic Progressive Party (DPP) government to gain access to donor money and maintain its grip on political power, more and more Malawians doubted the Covid-19 figures put out by the government. Public health officials, however, dismissed these doubts, chalking them to ignorance and misinformation that needed correction, instead of seeing them as an apt reflection of the lived reality of the majority of Malawians, who have over the years been victims of abject poverty and constant state intrusion (see Kalipeni et al. 2004).

Despite the political bickering, Covid-19 remains an ever present public health threat in Malawi. The daily number of new cases remained very low at the beginning of the epidemic in February and March but eventually picked up pace in June and July, reaching an average of 100 new infections a day. The incidence has since reduced to a few cases a day but the fear prevails that the actual figures may be much higher because of lack of widespread testing.

Migration histories

The parallels between HIV/AIDS and Covid-19 in Malawi run even deeper when viewed from a historical perspective. British commercial and colonial expansion in southern Africa created labor migration patterns that have been deeply implicated in the spread of both HIV/AIDS and Covid-19. Lacking mineral resources at the time of British rule, Malawi's viability as a colony was seen by Britain as primarily residing in its successful integration into the Southern Africa economic landscape as a source of cheap labor for mines and plantations in Rhodesia and South Africa (Mandala, 1990). Thus, for more than a century, Malawi has been a source of migrant labor, particularly for estate and mineral extraction. Initially conducted on ad hoc basis, labor recruitment later became more organized and systematic, with

the South Africa Chamber of Mines establishing satellite recruitment offices in Malawi and other parts of the region to ensure steady labor flows to the mines (Chirwa, 1996). The lack of opportunities and vulnerability experienced by wage laborers at the time was connected with the structural adjustment reforms already noted, which like the colonial experience, were externally driven processes that negatively impacted the lives of Malawians. Migrant work remains a lifeline for many Malawians. For instance, estimates show that more than 100,000 Malawians currently live in South Africa as migrant workers (Voice of Africa, December Voice of Africa, 2019). Between 1988 and 1992, about 13,000 Malawians working on the mines in South Africa were repatriated back to Malawi after testing positive for HIV (Chirwa, 1988). Upon arrival, the returnees simply melted into the communities, especially rural areas where, without appropriate HIV/AIDS support services, they helped spread the virus (Chirwa, 1988).

Being one of the most-impacted countries in Africa, and indeed the world, South Africa implemented a lockdown on the 26th of March, 2020 in response to the Covid-19 pandemic. The decree left thousands of Malawian migrant workers stranded, mainly in the streets of Durban, Johannesburg and Cape Town. Back home, social media scenes of multitudes of Malawians languishing on the streets of Johannesburg and in relief camps, placed enormous pressure on the government that was in the run-up to an election. Looking for a chance to restore its image after the court struck down the decree by the government to impose a nationwide lockdown, the then ruling DPP regime sent buses to bring Malawians stranded in South Africa back home. These migrant workers knew they were coming back home to a country that was in an even deeper economic crisis, and whose health system itself badly needed to be placed on the ventilator. The DPP regime set aside an old soccer facility located in the middle of Blantyre, the country's commercial city, as a site for quarantine, prompting critics to question the public health wisdom of locating a Covid-19 quarantine facility at the heart of a densely populated business city. Like other countries in Africa, state-driven quarantines have deep roots in colonialism in Malawi, and often invoke memories of repressive state practices. Barely a week after arriving back in Malawi, media reports of returnees breaching the precincts of the quarantine camp and blending into the crowds in the immediate vicinity started surfacing, reflective of the historical forces and policy lapses that had set the stage for the rapid diffusion of HIV/AIDS four decades earlier.

Globalization and urbanization

The Covid-19 virus left Wuhan in China and diffused around the world lightning speed through the very dense global transport network, the hallmark of globalization. It is not coincidental that New York was one of the cities worst hit by Covid-19, given its ranking in the global urban hierarchy. There is a dialectical relationship between Covid-19 and globalization, in that the pandemic is having a restrictive and retracting effect on open systems of trade, finance, and mass travel (Gereffi, 2020; Tsegaye, 2020). As was the situation for HIV/AIDS, globalization underpins the spread of Covid-19. Population density, distribution, and mobility hence become key factors fueling local spread. Public health measures such as masks and social distancing represent an effort to separate individuals, recognizing that congestion fuels the spread of the virus.

Experience with HIV/AIDS and other pandemics shows that high urbanization also makes the fight against pandemics more difficult (Cromley, 2010; Huang & Smith, 2010). However, many of the ways urban conurbations make the struggle against pandemics difficult have hitherto not been properly discussed in social commentary and academic debates about Covid-19. Urban settings are usually marked by weaker levels of voluntary engagement; a reliance on individual self-discipline and a personal sense of civic responsibility to reduce the spread of Covid-19 can present great challenges (McKenzie, 2008). This is particularly the case in countries already grappling with multiple forms of socio-political divisions and inequality. Cities have been hit hard by HIV/AIDS in Malawi, but the disease is still most ferocious in urban spatial enclaves with poor social integration, where residents are more tolerant of deviant social and sexual behavior, and where

sense of mutuality is low (Kalipeni et al. 2004; Mkandawire et al., 2014). Existing studies have shown that certain groups of urban youth, such as orphaned girls, are at high risk of HIV/AIDS because social norms of mutual support that provide a cultural safety net for youth without natal parents against sexual exploitation in rural areas are largely weak or absent in urban centers (Mkandawire et al., 2014). This contributed to the spread of HIV/AIDS in Malawi in certain people. The urban burden occurred despite a positive urban bias in health-care provision and other services such as education and transport.

Some of these issues are not specific to Malawi; indeed, the spread of HIV/AIDS and Covid-19 has raised questions of social divisions and inequality in countries around the world. For instance, fervent appeals to people's sense of community and mutual obligation by political figures and public health authorities as part of efforts to foster public adherence to recommended Covid-19 measures have at times fallen on deaf ears. Due to high levels of urbanization, and the resulting lack of social cohesion within such environments combined with low levels of social control, authorities increasingly rely on coercive means to ensure that individuals and businesses act in ways that do not place others at unreasonable risk of Covid-19. In addition, urban populations are more mobile geographically, which undermines their sense of psychological connection with neighbors and other members of the community, making it more difficult to cultivate a sense of voluntary social engagement or personal sacrifice to the degree required to effectively deal with Covid-19.

In Malawi, rapid urbanization in recent decades has similarly, but not to the same extent, led to the weakening of social ties and norms of mutual reciprocity. In addition, like other countries in Africa, the postcolonial state in Malawi has only exercised tenuous control over its people, organizations, and key public activities within its jurisdiction. Laws and regulations are not enforced with certainty and/or are not always obeyed. These issues undermine the ability of the government to respond to pandemics.

The response to governmental and international messaging on behavior change for HIV/AIDS was complex, and at times ill-suited to the context. The generic, technical direction did not always align with the experiences and transmission routes within the socio-cultural setting of Malawi. It took time to consider the role of migrant labor, polygamy, and wife inheritance. This is also the case for Covid-19. Preventative isolation and social distancing can work when there are resources or government support to enable it, but when people earn their living on a day-to-day basis, such requests are not only infeasible, they also demonstrate the disconnect between Malawi`s political elite and the lived experiences of everyday people.

Depressed economies

Poverty is both a driver and result of disease epidemics. The effects of economic dislocation take less vivid forms on the poor than physical violence and conflict, yet they are just as devastating where the spread of epidemics is concerned. Although the very first cases of HIV in Malawi were mainly observed in the wealthy sections of the population, the poor who quickly became synonymous with the disease and have continued to bear the brunt of the epidemic. Explanations of how poverty drives disease epidemics, however, tend to privilege economic or material aspects of deprivation, and this worldview continues to dominate our understanding of why Covid-19 exacts a huge toll on the poor. Of course, market concepts of poverty shed important insights into issues of ability to pay and they impinge on the ability of the poor to protect themselves from disease. However, economic definitions of poverty leave out other important dimensions that are vital in informing the ethical and practical dilemmas that Covid-19 presents, especially in a resource-constrained country like Malawi.

Poverty continues to drive the spread of HIV/AIDS in Malawi and early indications suggest it will play a similar role in the spread of Covid-19. For example, the poor are unable to self-isolate when living on day-to-day basis due to the necessity of working; they cannot equally practice distancing within households if a member is experiencing symptoms due to confined living spaces, nor can they equally afford to purchase personal protective equipment and sanitizers as preventative

measures. This has strong parallels with HIV/AIDS. The preventive measures for COVID through lockdowns and curfews have impacted those in the informal economies and casual laborers just like the most vulnerable – the poor, women, commercial sex workers we adversely impacted by the HIV pandemic. Poverty in Malawi has important psychological dimensions not easily amenable to quantification in economic terms. Beyond lacking financial resources, for most poor people in Malawi the experience of humiliation, degradation, and shame is a daily occurrence that has become widely accepted as part of what it takes to survive. Because of colonialism, economic mismanagement, and the gutting of the state via neoliberal policies, over 70% of Malawians now live under material conditions that seriously undermine their sense of intrinsic worth, and live as though they have been relegated to the realm of the human dregs (see Marmot, 2004). Such an extreme infringement on substantive equality raises the question of how to meaningfully engage people in such a psychological state of alienation in broad-based acts of solidarity that the country now desperately requires if it is to effectively combat the spread of Covid-19. In a situation where most people's sense of dignity has deteriorated so badly as to muzzle individual self-belief, engaging and mobilizing communities in response to Covid-19 becomes much more difficult.

Epidemics without cure or vaccine

HIV/AIDS and Covid-19 share the commonality in that neither of the diseases has yet a vaccine or definite cure. This presents a conundrum for a country like Malawi marked by a dual medical culture. A legacy of colonialism, Western medicine coexists with traditional social medicine. When HIV/AIDS first arrived in Malawi, the lack of vaccine or cure for HIV/AIDS sent people seeking treatment and cure from traditional social medicine. Herbalists and even ritualists quickly filled the gaping vacuum left unfilled by science and they became important sources of 'treatment' for HIV symptoms. Government efforts to dissuade the public proved futile and at times even controversial in the absence of a credible biomedical vaccine or cure. Having lost faith in biomedicine, many people came back from the shrines of traditional healers feeling inoculated or cured and continued engaging in high-risk activities, a practice which only worsened the epidemic. Albeit to a different degree, the arrival of Covid-19 amidst the lack of an effective treatment, cure or vaccine on an epidemiological landscape already steeped in a dual medical culture has reopened the scars of HIV/AIDS, making people susceptible to magical cures and superstitious attitudes. In a culture laden with taboos, an increasing number of people are resorting to *kukhwima*, the practice of using magic to supposedly 'immunize' oneself from CoronaCovid-19. Once 'immunized' by juju, people feel exempted from the necessity to heed public health advice or to quarantine themselves when potentially exposed. Even otherwise simple and basic measures like handwashing have become difficult to enforce among people who no longer feel vulnerable. Because of the tendency for risk compensation, some people even become less careful, and engaging in risky behavior that puts them and others at higher risk for Covid-19.

Like many countries in SSA, religious leaders in Malawi initially interpreted HIV/AIDS as God's punishment for people transgressing sexual norms. The lack of cure or vaccine was not seen as the failure of medical science; rather, it was perceived as a measure of the depth of God's wrath and unhappiness with humanity. Religious teachings denounced 'wayward' ways, advocated for marital fidelity and sexual abstinence, while rejecting condom use outside marriage as sinful. Such religious teaching intensified stigma and discrimination, driving people away from HIV testing, and fueling the spread of the disease. A similar kind of spiritualization of Covid-19 is currently underway. Some religious leaders in Malawi, as elsewhere around the world, view Covid-19 as a spiritual force of evil amenable to defeat by divine protection through relentless prayer and rectifying of wayward ways. Proclamations have been made by some religious leaders that faith, not masks or hand sanitizer, will protect the people from Covid-19. While instilling a sense of hope and mutual care, these assertions also magnify the possibility of noncompliance with science-based public health measures. This reflects the influence of religious values on public health messaging with profound implications for

the spread of the virus, especially in a context where there is no vaccine or definite cure. With Covid-19 this is compounded by misinformation and conspiracies regarding the virus, further enabling noncompliance. It took far too long to fully understand and contextualize messaging and behavior change communication in the HIV epidemics in southern Africa. These lessons learned should inform social and political responses to Covid-19, lest many of these same lessons be re-learned, as generic and technical guidance are presented to people and in places where those messages do not quite resonate or pose impossible dilemmas.

Conclusion

The geography and political ecology of the HIV/AIDS epidemic provide an interesting set of lens through which to better understand the vulnerability and responses of communities to the Covid-19 pandemic in Southern Africa. Historical investigations into the impacts of colonialism, and structural adjustment programs on migration patterns, poverty, health-care systems, and urbanization are pivotal to understanding emerging regional patterns of the spread of Covid-19. However, the highly geographic and regional nature of these patterns defy 'one size fits all' approach. For instance, while lockdown may work in some parts of the country, they may be needless or even detrimental in others. This means that efforts to reduce the spread of Covid-19 in SSA will require keen understanding and attention to variations in local socio-political and historical conditions in different parts of the country and formulating responses that are place- and time-sensitive.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Paul Mkandawire is a medical geographer whose research is broadly located at the intersection of global and public health and human rights. Paul's is predicated on the premise that the promotion and protection of human health are intimately linked to the promotion and protection of human rights and social justice. He apply qualitative and quantitative methods to the investigation of dimensions that link the environment and human health, and of synergies between public health and human rights. Paul is also interested in providing a better understanding of how state and non-state actors mobilize responses to epidemics of global proportions and human rights and social justice implications of global health policies. Paul supervises graduate student research in areas relevant to my research interests.

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References

Chilowa, W. (1991). *Structural adjustment and poverty: The case of Malawi*. DERAP, Development Research and Action Programme, Chr. Michelsen Institute, Department of Social Science and Development (p. 14).

Chirwa, W. C. (1988). Aliens and AIDS in southern Africa: The Malawi-South Africa debate. *African Affairs*, *97*(386), 53–79. https://doi.org/10.1093/oxfordjournals.afraf.a007921
Chirwa, W. C. (1996). The Malawi government and South African labour recruiters, 1974–92. *The Journal of Modern African Studies*, *34*(4), 623–642. https://doi.org/10.1017/S0022278X00055804
Cromley, E. K. (2010). Pandemic disease in Russia: From black death to AIDS. *Eurasian Geography and Economics*, *51* (2), 184–202. https://doi.org/10.2747/1539-7216.51.2.184
Ferguson, J. (2006). Global shadows: Africa in the neoliberal world order. Durham: Duke University Press.
Forster, T., Kentikelenis, A. E., Stubbs, T. H., & King, L. P. (2019). Globalization and health equity: The impact of structural adjustment programs on developing countries. *Social Science & Medicine*, *267*, 112496 (1-9). https://doi.org/10.1016/j.socscimed.2019.112496
Gereffi, G. (2020). What does the COVID-19 pandemic teach us about global value chains? The case of medical supplies. *Journal of International Business Policy*, *3*, 287–301. https://doi.org/10.1057/s42214-020-00062-w
Huang, Y., & Smith, C. J. (2010). China's response to pandemics: From inaction to overreaction. *Eurasian Geography and Economics*, *51*(2), 162–183. https://doi.org/10.2747/1539-7216.51.2.162
Johnson, J. A. (2017). After the mines: The changing social and economic landscape of Malawi-South Africa migration. *Review of African Political Economy*, *44*(152), 237–251. https://doi.org/10.1080/03056244.2016.1273826
Kalipeni, E., Craddock, S., Oppong, J. R., & Ghosh, J. (2004). HIV and AIDS in Africa: beyond epidemiology. Oxford, U.K.: Blackwell Publishing.
Kwengwere, P. (2011). Inequality in Malawi (Chapter 2, p. 123-179). In Jauch, H. & Muchena, D. Johannesburg (Eds.), *Tearing Us Apart: Inequalities in Southern Africa*. Open Society for Southern Arica.
Lwanda, J. L. (2004). Politics, Culture And Medicine: An Unholy Trinity? Historical Continuities And Rupture in The HIV/AIDS Story In Malawi (Chapter 2, p. 29–42). In E. Kalipeni, S. Craddock, J. R. Oppong, J. Ghosh (Eds.), *HIV and AIDS in Africa: Beyond Epidemiology*. Oxford: Blackwell.
Malawi Government. (2016). *Malawi demographic and health survey*. National Statistical Office.
Manda, S., Masenyetse, L., Cai, B., & Meyer, R. (2015). Mapping HIV prevalence using population and antenatal sentinel-based HIV surveys: A multi-stage approach. *Popul Health Metrics*, *13*(1), 22. https://doi.org/10.1186/s12963-015-0055-z
Mandala, E. C. (1990). *Work and control in a peasant economy*. University of Wisconsin Pr.
Marmot, M. (2004). Status syndrome. *Significance*, *1*(4), 150–154. https://doi.org/10.1111/j.1740-9713.2004.00058.x
Mbembe, A. (2020). *The universal right to breathe*. https://africasacountry.com/2020/06/the-universal-right-to-breathe
McKenzie, K. (2008). Urbanization, social capital and mental health. *Global Social Policy*, *8*(3), 359–377. https://doi.org/10.1177/1468018108095633
Mkandawire, P., Luginaah, I., & Baxter, J. (2014). Growing up an orphan: Vulnerability of adolescent girls to HIV in Malawi. *Transactions of the Institute of British Geographers*, *39*(1), 128–139. https://doi.org/10.1111/tran.12002
Nutor, J. J., Duah, H. O., Agbadi, P., Duodu, P. A. & Gondwe, K. W. (2020). Spatial analysis of factors associated with HIV infection in Malawi: Indicators for effective prevention. *BMC Public Health*, *20*(1), 1167. https://doi.org/10.1186/s12889-020-09278-0
Oldekop, J. A., Horner, R., Hulme, D., Adhikari, R., Agarwal, B., Alford, M., Bakewell, O., Banks, N., Barrientos, S., Bastia, T., Bebbington, A. J., Das, U., Dimova, R., Duncombe, R., Enns, C., Fielding, D., Foster, C., Foster, T., Frederiksen, T., Gao, P., Gillespie, T., Heeks, R., Hickey, S., Hess, M., Jepson, N., Karamchedu, A., Kothari, U., Krishnan, A., Lavers, T., Mamman, A., Mitlin, D., Tabrizi, N. M., Müller, T. R., Nadvi, K., Pasquali, G., Pritchard, R., Pruce, K., Rees, C., Renken, J., Savoia, A., Schindler, S., Surmeier, A., Tampubolon, G., Tyce, M., Unnikrishnan, V. & Zhang, Y.-F. (2020). COVID-19 and the case for global development. *World Development*, *134*, 105044. https://doi.org/10.1016/j.worlddev.2020.105044
Pfeiffer, J., & Chapman, R. (2010). Anthropological perspectives on structural adjustment and public health. *Annual Review of Anthropology*, *39*(1), 149–165. https://doi.org/10.1146/annurev.anthro.012809.105101
Pirtle, W., & Laster, N. (2020). Racial capitalism: A fundamental cause of novel coronavirus (COVID-19) pandemic inequities in the United States. *Health Education & Behavior, 47*(4): 504–508. https://doi.org/10.1177%2F1090198120922942
The Star. (2020, July). https://www.thestar.com.my/lifestyle/family/2020/07/29/teen-pregnancies-have-surged-during-the-pandemic-malawi-authorities-reveal
Tsegaye, K. K. (2020). Stay at home: Coronavirus (COVID-19), isolationism and the future of globalization. *African Journal of Political Science and International Relations*, *14*(3), 84–90. https://doi.org/10.5897/AJPSIR2020.1252
UN. (2020, September 18). *COVID-19 update, situation update No. 27*. https://reliefweb.int/sites/reliefweb.int/files/resources/Malawi%20COVID-19%20Situation%20Update%20-%2018.09.2020.pdf
UNAIDS. (2020, October 19). *Malawi*. https://www.unaids.org/en/regionscountries/countries/malawi
Voice of Africa (2019. https://www.voanews.com/africa/malawian-migrant-workers-returned-south-africa-get-training
World Bank. (2018). *Malawi: Systematic country diagnostic: Breaking the cycle of low growth and slow poverty reduction.*