

DEADLY CHOICES: WOMEN'S RISK FOR HIV INFECTION IN A TRUCK
STOP-TRADING CENTRE IN RURAL SOUTH WESTERN UGANDA.

By

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DEADLY CHOICES

ABSTRACT

This document is an ethnographic product of a study funded by the International Development Research (IDRC) called "Talking About AIDS: The Lyantonde Study Group." This research project has been located in Lyantonde, a truck stop and trading centre devastated by HIV/AIDS. The study is a "deeply qualitative endeavour" involving an interdisciplinary team researching toward the development of culturally compelling interventions for persons vulnerable to or infected with HIV1 in rural SouthWestern Uganda. My goal is to elucidate the complexity of risks which confront women in that town on a daily basis. This is achieved through the stories of seven women who are compromised by fear, poverty and suffering. They live in fear of infection, anticipate signs of disease in themselves, and watch loved ones become sick and die.

There is an existing literature - clinical, epidemiological and social cultural - which locates women's risk for HIV/AIDS in a series of risk determinants. Many of these determinants are also revealed in the case studies. These include multiple sexual partners, the history of sexually transmitted disease, proximity to bars or hotels, and

the effects of poverty.

Unfortunately, however, this literature does not reveal the dilemmas that arise daily in these women's lives, or explain how they became compromised in the struggle between traditional expectations and their own personal wants and needs. Caught in situations of high risk, the grave decisions these women make for themselves and their families really are not decisions at all; they are **choiceless choices, deadly choices.** The case studies lend credence to the theoretical framework posited by Willms and Sewankambo (1994) who suggest that risk is better understood in a series of interconnected domains, namely, the **risk reality, the risk situation, and the risk event.**

The potential of intervening in a community so heavily devastated by HIV/AIDS lies in finding ways -- via multi-sectoral strategizing by community facilitators and external resource people -- to accommodate both ethnographically grounded understandings and ethnographically driven models of risk.

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GLOSSARY OF TERMS

Abbreviations

AIDS- Acquired Immuno-Deficiency Syndrome
ARC- AIDS Related Complex
HIV- Human Immunodeficiency Virus
IDRC- International Development Research Centre
NGO- Non-Governmental Organization
RAIN- Rakai AIDS Information Network
STD- Sexually Transmitted Disease
TASO- AIDS Support Organization
TMP- Traditional Medical Practitioner

Glossary

Acquired Immunodeficiency Syndrome (AIDS)-The severe manifestation of infection with HIV characterized by weight loss, chronic diarrhoea, prolonged fever, enlarged lymph nodes, and opportunistic infections.

Chancroid-An infectious venereal ulcer caused by a specific bacterial infection.

Incidence-The number of new cases of a disease in a population in a given period of time. For example, a city may have an incidence of three new cases of AIDS per thousand population per year.

Malaya-Is a Swahili word meaning 'not married in church.'; now it is used interchangeably to imply sexual looseness and prostitution.

Matoke-The staple food crop in Central and South Western Uganda. It is a strain of banana usually sold in bunches and is served steamed.

Perinatal-Before, during or after birth; ie. from the 28th week of gestation through the first week of delivery.

Prevalence-The number of cases of a disease or condition in a given population at a specific time. For example a city may presently have a 1% prevalence of seropositivity.

Seroconversion-The initial development of antibodies to an antigen, whereby someone who is seronegative becomes

seropositive.

Seronegative-The absence of antibodies in one's blood serum.

Seropositive-The presence of antibodies in one's blood serum.

Seroprevalence-The number of seropositive persons in a given population at a specific time. For example, patients presently in a given hospital may have a seroprevalence of 5%.

Serosurveys-Studies in which a sample population is blood tested for the presence of antibody.

Silimu-The vernacular term for AIDS. More than likely associated with the English expression "Slim Disease."

CHAPTER I

It was a hot and dusty afternoon and we had ducked into Moonlight Hotel to escape the burning sun. The waitresses, usually chatty and fun, greeted us in very low spirits. Gloom had invaded the place. We noticed that Faat, a very popular girl with these mobile men, was crying. She and Mary just had just fought because Mary had stolen Faat's man, a cattle trader. Rumour has it that Mary was "an AIDS widow from the other side of Kampala and had gone with many men who were already dead." Faat felt afraid for her life, but was also humiliated. "We are malaya (prostitutes), but do they think we do not have emotions? We are malaya, but how can they go with other women from the same place?" Faat felt very vengeful. "He has a friend who has been wanting me for some time, I am going to go in for sex with him, and I am not going to use a condom, even if it kills me, there is no use ... you see everybody in Lyantonde town is infected ... in this place it is known that everybody is dead "(Field Diary, 1993).

Lyantonde is one of many small towns in Rakai District, South West Uganda, that has been devastated by the HIV/AIDS pandemic. Residents in town believe that Acquired Immunodeficiency Syndrome (AIDS) came as a sign of the wrath of God. The scourge was sent as a form of divine punishment, and they, like the residents of Sodom and Gomorrah -- the biblical place where burning sulphur came raining down on the people of God -- were being punished for their "indiscretions" and "abominations". Among "the punished" were many, many women who died horrible and painful deaths.

Early observers of the epidemic associated high mortality

among women in Lyantonde with the town's history as a "sexual" service centre for truck drivers and tradesmen traversing East Africa. Bar girls and businessmen were among the first to die. Today, more than a decade after "people started to die", seroprevalence rates are astounding. There is now serological evidence to suggest that not only are there more women than men who are infected with the virus, women are becoming infected at a much younger age (Wawer, 1991).

In Lyantonde today, many women, including bar girls, refer to themselves as "*the walking dead*." Full of anguish and despair, this popular expression exposes one of the hidden truths of this HIV/AIDS epidemic in Uganda. Women know how to remain uninfected, but the conditions of their lives make it difficult to avoid the Human Immunodeficiency Virus (HIV) (Reid, 1993). As part of a larger social scientific study, my interests were to ethnographically examine the question, "why is it that women are aware of their risks for HIV/AIDS and yet continue to partake in high risk sexual activities?" What we came to find, and what I seek to demonstrate in this thesis, is the fact that the lives of women are filled with compromises, contingencies, and contradictions with respect to HIV/AIDS. Their life experiences, and the moral dilemmas that characterize them, are not easily explained in the existing risk discourse.

In what sense is this so? Existing epidemiological,

clinical, and social cultural literatures yield substantial explanations and understandings of the connections between women's health-related risk and sexual decision making (Worth, 1989). Recent epidemiological studies conducted in the district of Rakai, for example, demonstrate specific relationships between risk behaviours and the context of risk for HIV transmission. They suggest that multipartnerships or proximity to bars and hotels enhance the possibility of virus transmission. Clinical studies identify several biological factors including genital ulcer disease and other sexually transmitted diseases as strong influences for the likelihood of HIV transmission. By demonstrating the relationship of extreme poverty, polygyny, and female migration with high risk activity and behaviour, the social cultural literature identifies the importance of locating women's behavioral risks in political, cultural and economic contexts.

Given the epistemological differences between disciplines, one might expect that the epidemiological and clinical discourse regarding women's risks would vary substantially from social scientific explanations. This is not the case. The separate contribution of each literature, including the social cultural, is undermined by a tendency toward deterministic and linear explanations. The tendency is to reduce women's risk to an equation, whereby this particular "high risk" behaviour, combined with this "high risk" context,

leads to the transmission of HIV. In many respects, these combined understandings provide an integrated view of HIV transmission and are the sets of evidences used by those working in prevention programming. To date, these evidences appear to be the only available data bases informing program design and policy. So what is the problem?

The problem lies in the fact that despite mass media campaigns, women are becoming infected at alarming rates. These mass media campaigns teach essential facts about HIV/AIDS, promote "sexual health" behaviours, and are designed to increase condom use and decrease the frequency of partner change. From a practical viewpoint, it must be acknowledged that there is a gap between what is currently understood about women's risk and what kinds of evidences and understandings are needed to design more effective HIV/AIDS prevention programs.

"Deadly Choices: Women's Risk for HIV Infection in a Truck Stop-Trading Centre in Rural SW Uganda" is an ethnography that exposes the meaning and experience of risk for HIV/AIDS of women living in one of the most AIDS devastated regions in Africa. Deeper understandings are gained by listening to the voices and stories of women, which in turn reveal the contradictions and compromises that characterise their sexual lives. This ethnography of HIV/AIDS is often eclipsed by the experience of human suffering. To

anthropologically communicate these troubling and horrifying experiences, the "life story" -- as ethnographic process and product -- seemed to be the only appropriate way to implement and record both these realities.

The life stories of seven women residing in Lyantonde town between 1992 and 1994 are the heart of this dissertation. Their stories impart the gravity of their dilemmas and those shared by other women situated in similar circumstances. Through their voices, we have come to understand that at one level, risk is about multipartnerships and proximity to bars and hotels. These explanations, however, are further advanced by understandings that elucidate the moral dilemma experienced by women who are sexually compromised. We found that the realities of women's lives propel them into situations where they are caught in the struggle with poverty, fatalism, tradition, and personal need. The decisions they are forced to make about their lives, and the lives of their children, really are not decisions at all. They are choiceless choices. They are deadly decisions.

The attempt to understand how it happened to be that women become so compromised by deadly choices -- and through the ethnography, to design culturally compelling HIV/AIDS interventions -- led to a new way of theorizing about risk. The conceptual framework of risk offered by Willms and Sewankambo (1994) is a welcome addition to risk

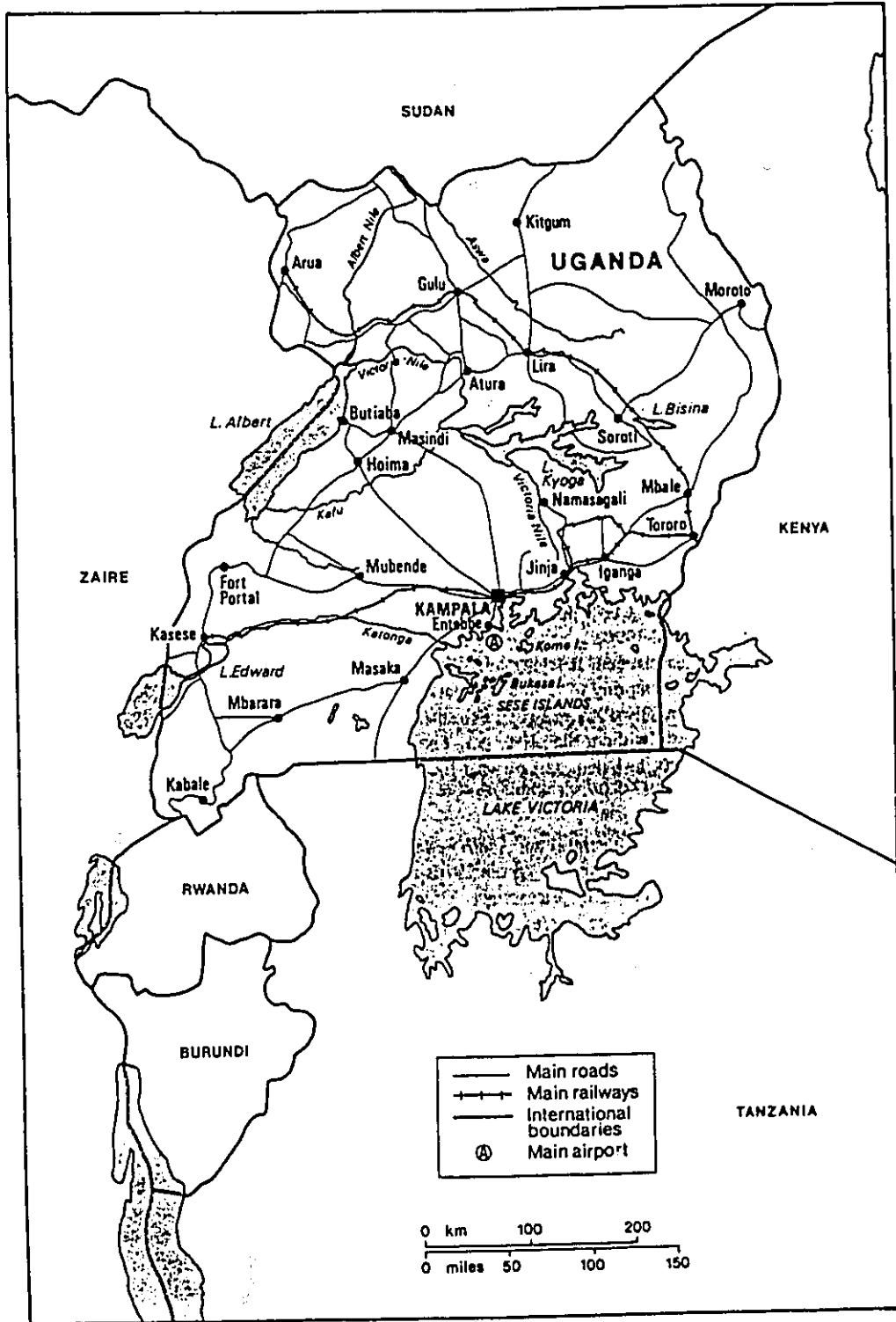
understandings. The promise of this ethnographically driven framework lies in the ability to translate the experience and meaning of risk into programs and appropriate action.

Women have shared with us what it is like to be robbed of the choice to live. To hear their testimonies without acknowledging the profound implications their stories have on strategizing for future preventions would mean that we were not really listening. Our indifference would be a form of violence; a violent act (Sheper - Hughes, 1994).

Under the shade of a tree, overlooking her field of sweet potatoes, Maama Grace told us that after having six children, she was not going to produce any more. She exclaimed: "tuffa tugawawo, abaana tunabalekera anni", we are dying and getting finished. Who will we leave these ones (children) for?"

Figure 1.

Map of Uganda



CHAPTER II

The Story of a Caretaker:

Sitting on a bench in the shade, with our backs against the dried mud wall, we listened to the wind whispering its way through the banana leaves. Just below the banana trees, in the shadows of the bunches, was a grave. I shivered. Janette and I were in Kyabazala, a small village just south of Lyantonde. Literally translated, Kyabazala means the one (village) that produced us. Now it is a burial ground. The ssenga (paternal aunt)' who cared for and buried our friend Gorette and her cousin sister Dorothy, explained that it was her husband who was interred beneath the weathered mound of dirt and carefully placed rocks. "He died of the same sickness, 'the thing' that killed a lot of people at that time, the ones who owned many plots in this village." Now, most of the land has been sold to people who reside in Lyantonde urban, and it is said that the only ones resident are widows.

This man, her husband, had altogether sixteen children. With their children in tow, the other wives left the village. Including Gorette's child cradled in my arms, the paternal aunt was the caretaker of six orphans. Dorothy's child was buried just a few weeks ago, his life ending at the age of two. Dorothy and Gorette were both Banyarwanda; their families found refuge in this area during the civil war in Rwanda in the 1960's. They both worked in Dembe, a bar in town, and lived in the same compound. When Dorothy fell sick, she went to live with her real sister in Lukaya, another trading centre on this trucking route. By running her shop and continuing in trading dried fish to Zaire, she was able to care for Dorothy for a little while. Then she herself fell sick and they were left alone caring for each other. Dorothy returned to Kyabazala first. After, closing her business, and selling belongings, the trader followed. Dorothy died three days after she returned to the village. By the time Dorothy died, her sister, the trader, had to be carried to the burial because she was so weak. She died a week

later.

Goretti's burial was a difficult one for our research team. It was so poorly attended that Godfrey was the one who was asked to help lower her body into its resting place. Adison shovelled the soil, providing her with shelter. With no kin, and neighbours and friends from the bar conspicuously absent, this burial was, of all that we have attended, the most emotionally difficult. Now there is only Mariette, the little one in my arms, struggling with a "rash which brings omussujja (fever), chronic diarrhoea, whooping cough." Only the wind seemed to know how long she would live.

This is a story of family tragedy with heart wrenching human dimensions. What follows are a number of evidences -- social cultural, epidemiological and clinical -- which provide explanations for the level of tragedy and suffering this caretaker's family has experienced. These evidences are products of different disciplines of research, each discipline having a different way of explaining disease progression and conceptualizing the determinants which put women at high risk for HIV1 infection.² Because each discipline has its own way of knowing, certain tensions exist when it comes to agreeing upon ways to ameliorate the problem. One such tension is the perpetuation of the epidemiologically evidenced notion of "high risk group."³

Evidences: The Epidemiologic

Epidemiologists are interested in explaining the distribution of diseases throughout populations. They delineate the factors that put groups of people at high risk for HIV infection by identifying populations thought to be distinctive along parameters that increase their risk. The interest is in patterns, trends and rates of infection. In addition to highlighting trends specific to HIV/AIDS, ie., prevalence and incidence of the disease, epidemiological surveys generate figures to explain these trends. These figures come to be explained in relation to risk factors or determinants that prevail in certain environments (Sewankambo and Willms, 1993), or those which characterize each population in terms of the presence or absence of disease.

Distinctive global epidemiologic patterns of HIV infection and AIDS have been described by the World Health Organization (WHO). The explanation for the existence of these patterns includes differences in temporal spread of HIV among different populations, as well as differences in behaviour, sexual practices and intravenous drug use (Sato, 1989). Of the four patterns of the HIV and AIDS pandemic modelled by the WHO, there is total agreement that Sub Saharan Africa is an area currently classified as Pattern II.

Transmission is predominantly heterosexual, involving vaginal penetration, and because the male-to-female ratio has been found to be close to equal, paediatric AIDS is common (Chin,1988). It has become clear that HIVI infection is presently concentrated in the Central and Eastern parts of the continent: the Central African Republic, Republic of the Congo, Zaire, Burundi, Rwanda, Uganda, Zambia, Kenya, Tanzania, Malawi and Cameroon. The remaining three quarters of the continent has to date remained relatively unscathed (deZaluondo, 1988; Larson, 1990).⁴ As expected with any pandemic, rates of infection and mortality vary greatly from one place to another. Because of this variability, it is perhaps more instructive for the purposes of this dissertation to note both the national trends of mortality and seroprevalence in Uganda, and specifically those for Rakai district, the research locale of "Talking About AIDS: the Lyantonde Study Group."

The first cases of AIDS in Uganda were reported in 1982 when 17 traders from the small port of Kasensero, on the western shores of Lake Victoria, died of this disease. Although attempts to gauge disease progression and devastation were frustrated by low intensity warfare affecting different parts of the country, Uganda was among the first African nations to coordinate a surveillance system to follow the

progression of the epidemic. Primarily hospital based, and organized around a clinical case definition of AIDS adapted for the Ugandan situation, the system includes a detailed reporting form and extensive training workshops for District Medical Officers and their assistants (Berkley et al, 1989). By 30 June 1992, a total of 33,971 cases of AIDS had been reported to the Uganda AIDS Control Programme (ACP). Of these, 31,190 (91.81 percent) were among adults (12 years and above), and 2,781 (8.91 percent) were children aged 11 and below. Some suggest, however, that these figures represent only the tip of the iceberg, as the accuracy of the surveillance system can be undermined by a number of factors: reporting fatigue, misdiagnosis, and the fact that many do not seek therapy at government hospitals (Barnett and Blaikie, 1992; Berkley et al, 1989). Regardless of these pitfalls, it has been estimated that by June 1992, 1.5 million people -- in a total population of 17 million -- were infected with HIV. Many of these people do not know they are infected, and many will most likely die of AIDS within the next five to ten years.

In the absence of national serosurvey data, small serosurveys have been conducted to establish differential AIDS infection regionally and among different groups of people. As in many other parts of East Africa, the epidemic in Uganda has to date been constructed as a relatively urban phenomenon

(Larson, 1990). Although urban bias does exist, explained by the fact that many serosurveys have been based in urban areas and clinics with non-representative groups (e.g., urban based prostitutes), it is still clear that mortality and prevalence rates remain higher in urban areas than elsewhere. Repeated in serosurvey publications are the terrifying statistics of studies that are based in Kampala, the capital city of Uganda. The percentage of women who are HIV positive attending antenatal clinic in Kampala, for example, rose from 10.6 in October of 1985 to 24.1 in February of 1987 (Carswell, 1989).

Paradoxical, however, is the fact that Rakai District is a predominantly rural district, and yet the populace of Rakai has experienced unprecedented levels of devastation due to AIDS. According to Barnett and Blaikie (1992), the seroprevalence rates recorded for this particular district are the highest recorded for a general population living in a rural area anywhere in Africa (Barnett and Blaike, 1992).

However rural Rakai may be, it is criss-crossed by major roads carrying lorry traffic to Tanzania, Kenya, Zaire and Rwanda. Late in 1986, early cross sectional surveys were conducted in Rakai. In a survey of 186 bar girls in Lyantonde, our research site, 76% were found to be seropositive for HIV infection (Namaara, 1988). Concomitant investigations among lorry drivers and their assistants traversing the very same international trucking route

indicated seroprevalence as high as 35.3% (Carswell, 1989). These investigations supported views expressed by Piot et al (1987) that, although prostitutes may have high levels of infection, it is the contact with travellers from other parts of Africa, initially confined to trading routes, that act as a "port of entry" for the AIDS virus to and from African countries. Taken together, the truck drivers and prostitutes perpetuated the heterosexual route of the infection from high risk groups into the community (Carswell, 1989). In November of 1989, the results of a Ugandan National Serosurvey reported that 12% of the adults aged 13 and above in the South Central region were infected with HIV. Rakai District and Lyantonde town are situated in this region (Sewankambo, 1994).

Given that almost 70% of the population of SubSaharan Africa live in rural areas, it was deemed critical by researchers associated with the Clinical Epidemiology Unit of Makerere University to ascertain differences in rates of infection within rural Uganda, and to clarify the association of seroprevalence with community characteristics and behavioral risk factors (Wawer, 1991). Consequently, the Rakai Project, a collaborative undertaking of the Ugandan Ministry of Health, researchers from Makerere University, and Columbia and Johns Hopkins Universities was launched in 1988. It is to date one of the largest serosurveillance efforts in East Africa.

In 1989, a population based cohort was established in 21 randomly selected communities in Rakai. By 1990, this cohort population was enlarged with the addition of ten new community clusters and an increase, to 120, in the number of households sampled per cluster. As of 1990, all consenting subjects (adults aged 13 and over) in 1860 households were followed annually to assess HIV prevalence, incidence, risk factors, progression to disease, mortality, fertility and knowledge and behaviours (Sewankambo, 1994). Of the 31 community clusters, 5 were located in Lyantonde town.

Early observations indicated that Rakai's population of 385,000 lived in three geographical strata: main road trading centres with shops, bars, and hotels, and hotels that serve domestic and international traffic; rural agricultural villages; and a third intermediate group of rural trading villages. Typically, these trading villages receive no international traffic but act as foci for local communications and trade. Emergent from these data, and of primary importance to "Talking About AIDS" is that seroprevalence rates vary substantially according to proximity to commercial centres and tend to follow lines of communication along main and secondary roads (Wawer, 1991; Sewankambo, 1994). Accordingly, 1990 prevalence rates were lowest in agricultural villages - 11.8%, and highest in main road trading centres - 35.0%. The prevalence rates of trading villages fell somewhere

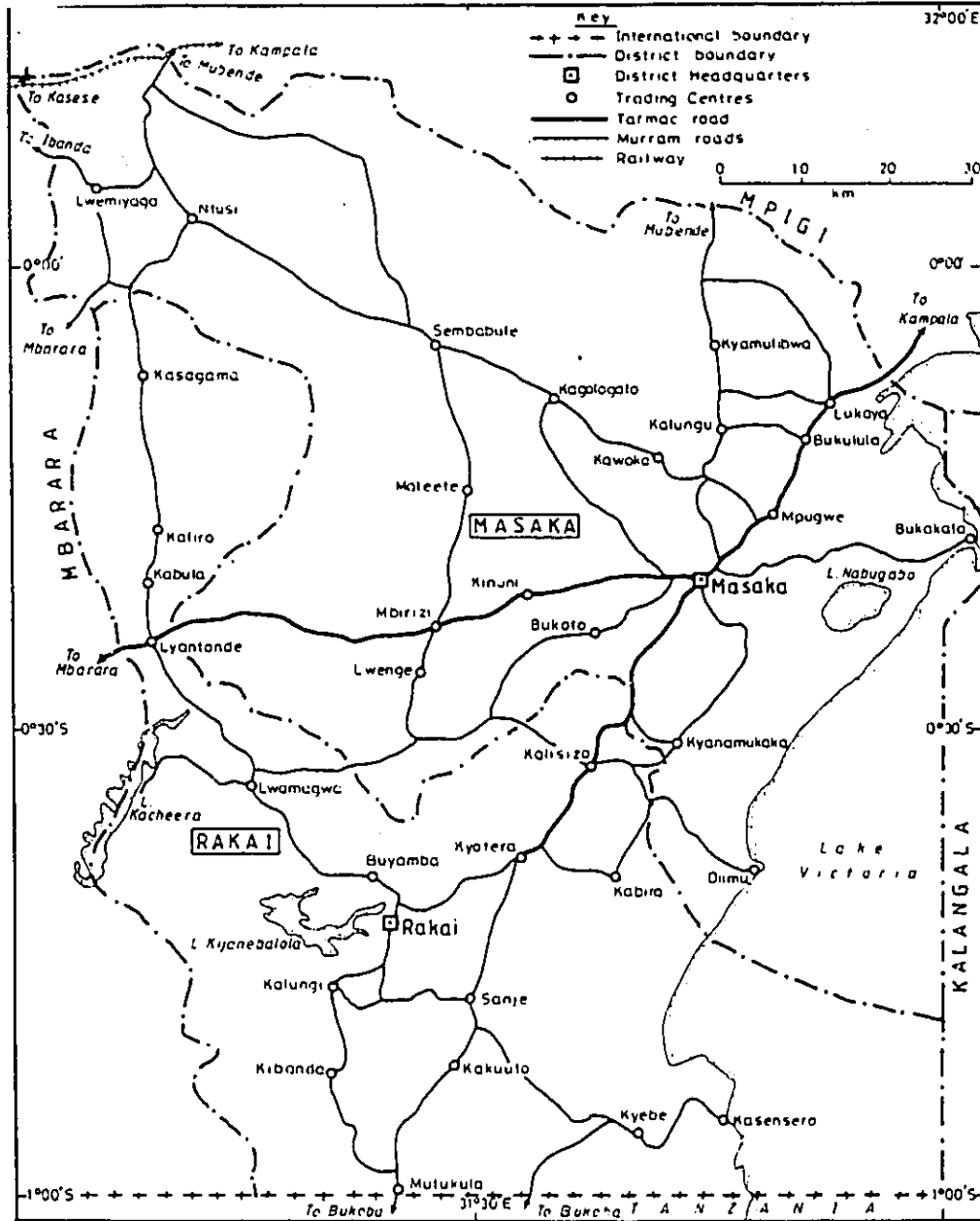
in between - 23.1% (ibid).

Prevalence is strongly associated with the type of cluster. Wawer (1990) observed that lower seroprevalence was directly related to the percentage of the population involved largely in agricultural work at the village level. Higher rates are found among those who reside in trading centres, tend to travel more, have multiple sexual partners with associated STD histories, and have had some education. In light of this gradient of prevalence between clusters, Serawadda (1992) suggested that multiple sex partners increases the risk for HIV acquisition in all areas, yet for any given level of sexual activity, the risk of HIV infection is increased if the background prevalence rate in the community is high. These characteristics parallel many other hypotheses generated concerning differential infection elsewhere in Africa.

Recent data suggests that women are infected and die at a younger age than men (Chin, 1990). Ugandan findings suggest that women are more likely to be seropositive than men (Berkley et al., 1989). In Rakai, seroprevalence is higher among women aged thirteen through nineteen, and twenty through to twenty four, particularly in the roadside trading centres, and the higher rates are more than likely linked with proximity to bars and hotels (Wawer, 1991).

Figure 2.

Masaka and Rakai Districts



In fact, in the trading centres (as opposed to the trading villages) relative risk for infection is significantly increased for women but not for men. Additionally, the protective effect of rural residence for women may be countered by several factors. Among the factors that increase risk are two or more sex partners in the last five years; having travelled to Kampala or foreign countries; and reporting injections in the past year (Ibid).

For Rakai district, and for caregivers like Goretta's aunt, these prevalence rates are paralyzing. Even more numbing, however, are the rates of seroconversion. Seroconversion means the percentage of people of the cluster population who tested negative when the Rakai Project survey team came through the first time, but subsequently (a year or so later), came up HIV positive. Of the 774 subjects who at the time of the baseline survey were seronegative, 2.7% (21) became positive between surveys (Wawer, 1994). Consistent with rates of infection which differ along gender lines, seroconversion occurs at younger ages in women than men (ibid). Inevitably, however, those who have seroconverted and those who were already infected at the time of the baseline survey will die. A recent publication gauged HIV mortality rates for the study population (Sewankambo, 1994). In short, HIV related mortality may account for approximately 58% of all adult deaths in Rakai district.

According to Sewankambo (1994), HIV related mortality was most common in adults aged twenty six through thirty nine. Of the deaths occurring in this age group since the baseline survey, 87% were HIV related. In addition, as data from Rakai supports hypotheses concerning differential infection, deaths in HIV infected women also occur at younger ages. Of female deaths, 56% occurred between the ages of fifteen and twenty nine years as compared with 37% of males of the same age group.

One of the biggest tragedies of HIV is the degree to which children suffer. When I last saw Goretti alive, which was in March of 1994, she was incontinent and wasting away. But Marriette was still a healthy child. When I held her in September, she was sickly and withdrawn. The adults suffer, but so too do the orphaned and HIV positive child.

Chin (1990) estimates that by the late 1980s at least 2.5 million females in Africa were infected with HIV. These women had in turn given birth to about 2 million infants, of whom 500,000 were estimated to be infected with the virus. By the end of 1992 (remembering that "Talking About AIDS" was under way by February 1993), it was estimated that 4 million children would be born to HIV infected mothers and that at least a quarter of these children would be infected as well. Preble (1990) estimates through 'low' and 'high' progression models that at the very least, the SubSaharan region could

expect 1.4 million additional infant under five deaths due to HIV/AIDS during the decade of the 1990's. This represents a 12% increase of under-five deaths projected by the United Nations (UN) prior to the pandemic. In Rakai, infant mortality rates of children born of uninfected women is 112 per 1000 live births. While that rate is high, the rate almost doubled for those offspring born of HIV infected women. The rate was 210/ 1,000 live births (Sewankambo, 1994). The effects of such high Under-Five Infant Mortality rates (U5IM) are profound. Symptoms of AIDS resemble common child health problems and hence when children do die, people are not necessarily aware of the real cause of death. Issues of differential infection, perinatal transmission, and concomitant rates of seroprevalence are an important part of exposing the spectrum of risk which affects women's lives in rural Rakai.

The original objective of the Rakai Project was to unravel the dynamics of infection in rural communities. In the field, the serosurvey field workers came to our home for a meal or to chat about work. They also went to Goretti's home to draw her blood, complete the survey, and provide both her and her family with treatment, one of several intervention related activities provided by the Rakai Project. In addition to serological screening, counselling, and treatment, the project included health rallies, community education through

village health workers, and provision and distribution of condoms. Part of the frustration of the survey teams in the field and the directors of the project, however, was that these intervention efforts directed at the cohort population over a four year period were not making significant differences behaviorally or in the reduction of disease incidence. Paradoxically, despite access to condoms and knowledge about the disease, incidence is recorded at 2.1./100 person years, and this is considered to be a conservative estimate.⁵

Evidences: The Social Scientific

Because it is generally recognized that AIDS is a social disease, social scientists prefer to emphasize social cultural explanations of risk by acknowledging the importance of norms, values, beliefs and situations in understanding the dynamics of HIV transmission. The cause of risky behaviour is seen to be embedded in the intersection of culture, economic conditions, and power relationships.

At the same time the Rakai Project was dispensing drugs, completing surveys, and taking blood, we were interviewing women who considered themselves lucky to be alive. Images of abandonment, stigma, and fear over loss of bodily function

haunted their memories.

There was a woman the children found almost dead on the football field ... She was only about 23 ... but with this disease, when you fall sick you look like an old woman ... We found her there wrapped in a bed sheet - urinating - she was going to lie there until she got the energy to continue the journey home to her village ... I was fearful ... I thought it could be me or one of my relatives one day ... She was like a skeleton, I told my boy to pick her up and take her home by bicycle ... and when he arrived there the people at home refused to help her off. They said: "who has brought this ghost?"... who told you to bring her here?"

This woman - whose name we do not know - was dying. AIDS is construed as a disease of prostitutes (DeBruyn, 1988) or a disease affecting affluent males (Biggar, 1988). We could assume that she was likely a 'prostitute', working the truck stop, and only returning home to die.

There is convincing epidemiological evidence which supports the suggestion that urban prostitutes are indeed a major reservoir of infection throughout East and Central Africa (Carswell, 1987; Kreiss, 1986; Moses, 1991; Plummer, 1994). Bassett and Mhloyi (1991), however, suggest that in terms of epidemiological investigations, this has meant an emphasis on the study of female prostitutes to the exclusion of other women.

Currently, regardless of the high levels of infection in these 'core groups', many acknowledge that the emphasis on urban prostitutes as 'key transmitters' has led to misleading

interpretations.⁶ That is, some have assumed that without them the epidemic could not sustain itself (Ibid). One of the ramifications of this interpretation is that the direction of blame for spreading the disease is to bar girls and waitresses in urban and peri urban areas and those working in truck stops along trans African highways.

"Prostitution" in Sub-Saharan Africa is an enormously complicated issue. One of our friends in town complained that "no matter what we do, if we are bar girls, waitresses, or if we sell charcoal or alcohol, they (men) still call us malaya."⁷

For some women, cities and towns represent an escape from the constraints and burdens of rural life. The migration of single women was always seen as a problem by colonial authorities and male migrants. In order to pay tax expected in cash, men, in much of colonial Africa were expected to migrate to administrative, industrial, and agricultural centres and become labourers. Families were discouraged from migrating, since it was deemed infeasible by authorities, as there were few employment options available for women. Instead, women and children remained behind and cultivated the family land for subsistence. Such a large concentration of temporarily separated and unmarried men generated a huge demand for prostitution.

Most East and Central African countries have taken measures to restrict the activities of urban women. In fact, all female migrants are branded as "prostitutes" or "loose women" intent on satisfying the sexual needs of male migrants (Obbo, 1981: 27-34). Some authorities mandated repatriation. In the 1950's in Kampala for example, officials rounded up all single women found loitering in urban areas. They were incarcerated if they did not leave the city. Some cities actually bussed women back to their rural homes.⁸

Urban women have come to symbolize avarice. But as Larson (1989) points out, the intense ambivalence expressed towards urban African women is not only the result of colonial proscriptions against female employment. The social changes that have occurred with rapid urbanization have made both men and women uncomfortable.

The modern woman ubiquitous in offices, on the street, and at night clubs is equated with urban evils because she serves as a highly visible symbol of a loss of tradition. Sexual hostility toward women is a public expression of a deep wish for tradition. The viewpoint being expressed is that men cannot be expected to return to traditional ways but society would remain pure if women did (Larson, 1986:718).

In this light, depicting African "prostitutes" as reservoirs of infection has resounding implications. First, already unequivocally evil, urban women become the disease

scapegoat. "Women are Satan" is a common refrain uttered by men in Lyantonde. Women, regardless of "commercial sex status," do call themselves "the walking dead." Second, assigning blame leads to oversimplified, unreasonable, and impatient understandings of women's risk for HIV infection in Sub Saharan Africa. Recently, the tendency of early observers of the epidemic to equate the "casual" sexual encounter with the licentiously wanton and urban "African female" (Packard and Epstein, 1992) has given way to a more thoughtful treatment of the social and cultural differences in sexual expression (Ulin, 1992). Currently, there is a competitive discourse, involving a few authors, which addresses the unique problems which intensify women's risk for HIV transmission. These authors confront a whole spectrum of issues; in content, they are fairly similar and vary only with reference to the analytical lens employed. Typically, discussions weave together three key concerns: female migration, that is the flow of women into the urban areas; the "feminization of poverty"; and social structural concerns which include polygyny.

Although the literature regarding women and risk is scant, and in some ways defies generalization, it is now considered axiomatic that the limited control women have to determine their own lives is the significant determining factor fuelling the spread of the scourge. Priscilla Ulin

(1992) provides a social structural framework within which this epidemic is unfolding. She takes the position that HIV transmission is inextricably tied to the issue of women's status: these women experience the brunt of the adverse effects of development, structural adjustment, and rapid urbanization.

The balance of decision-making in male-female relationships varies across class and culture, but the majority of women in the developing world do not have access to the resources for development, nor do they believe they have equal status in decisions that concern either female or male sexuality. Control is thus an important dimension of women's power. Lack of access to and control of resources for decision making, particularly in the sexual relationship, appears to be one key to the vulnerability of women and children in the AIDS epidemic (Ulin, 1992:64)

Using Kenyan examples, Ulin argues that a two pronged process has contributed to women's progressive loss of status. Firstly, national development schemes have only served to reinforce gender distinctions and widen the opportunity gap between men and women. With the introduction of agricultural equipment, for example, men assumed control over crop planning including determining what would be planted for subsistence and for sale, effectively severing women's control over important household decisions eg., medical treatment options and family nutrition. Secondly, not surprisingly, is linked to the new wage sector introduced with colonialism.

Though women were the backbone and muscle involved in

cash cropping, colonists interacted only with men in doing business. The shift from subsistence crops to cash crops (tea, coffee and cotton) altered women's roles, and inevitably their control over domestic affairs, self esteem, and influence on family health and nutrition (Ulin, 1992:65).

Though elusive, the connection between the colonial past, the developing present, and risk for HIV is explained using the example of maternal morbidity and mortality which is considered to be one of the neglected tragedies of East Africa.

The direct causes of maternal mortality are well known ... these problems do not begin in pregnancy, nor does the risk of HIV infection begin with a single sexual act. The real causes are inherent in the social and economic pressures that leave women with fewer options and little influence on decisions that ultimately determine their place in society (Ibid, 65).

This concept of restricted options - resulting from the accumulated impact of a century of urbanization and labour migration - sheds light on the evolution of large numbers of female-headed households (36% - 46% depending on the district) and subsequent increases of isolation and poverty.⁹ For both men and women, the net result of poverty is an overriding preoccupation with economic survival. But as Shoepf has indicated in a series of papers written from her experience of women and risk in Zaire, economic crisis affects women

differently than men (1988:176).

Brooke Shoepf was the director of Project Connaisside, Kinshasa, Zaire. The project was implemented in February of 1985 and continued both research and prevention activities until 1990. The project aimed to develop a broad understanding of the spread of infection, the cultural construction of AIDS, and the impact of the syndrome on the population of Zaire's two largest cities, Kinshasa and Lubumbashi (Shoepf, 1991). It was largely an ethnographic effort with researchers living and working in their own communities. Concurrently efforts in prevention were made in the form of "risk reduction" workshops (Shoepf, 1988a).

Although the study was urban-based, Shoepf's largest contribution to the study of women and risk is the connection she makes between various "interpenetrating forces (which) act to constrain change (Ibid:189)." These forces proliferate from the intersection of macro-level issues -- political, economic, and social systems -- with micro-level issues -- social interaction, internalized cultural prescriptions, and individual psychodynamics. Stated in concrete terms women are strangled by poverty as East and Central African countries juggle declining per capita food production and subsequent income disparities. Their options for support - kin and/or marital partners -- diminish as respective families try to cope with the squeeze. Women often flee to urban areas

seeking economic success, but eventually join the ranks of those already overworked and underpaid.

Without question, the flow of young uneducated women to cities and trade centres increases the potential for HIV infection, as women enter into both casual and stable multi-partnerships to survive. Ample evidence exists which suggests that exchanging sexual favours for badly needed support is not only limited to commercial sex workers. High levels of unemployment in the formal economy, encourages participation in the informal sector, in efforts to alleviate poverty through self-employed income-generating occupations such as selling alcohol, cooked food, or petty trade items like used clothes.¹⁰ Inadequate incomes often become supplemented by the provision of occasional sexual services.

Like Ulin, Shoepf objects to the ways in which lingering patrilineal notions of female dependency and male domination/responsibility obfuscate the "extent to which both rural and urban women have been major providers of their own support and that of family members (1988b:179)." Also, like Ulin, she understands many health care resources and services to be artifacts of colonialism, class oriented, and urban biased. Consequently, the cumulative effects of chronic disease, including sexually transmitted diseases, and of malnutrition, frequent childbearing and constant physical

labour, undermine the quality of life of many women and children. Women must provide, and somehow they do. Thus the emergence of Shoepf's catch-all phrase "What once appeared to be a survival strategy has turned into a death strategy" (1992:276).

The "macro" interpenetrates the "micro" at the level of culturally and socially imbued meaning. Women are blamed for the introduction of a sexually transmitted disease (STD) into a relationship. The mixture of semen and blood are fraught with tremendous symbolic significance; they represent the continuity of life, clan, and lineage. Interrupting "meeting" is a complex and confrontational cultural decision. Condoms have come to mean a way for men to protect themselves against women, indicate infidelity within marriage, and are barriers to procreation. Fertility gives women significance. Perceived to be non-negotiable in marriage, condoms elicit fear, hostility, and suspicion outside of it (Shoepf, 1988a; 1992). Considered together, these issues serve to illustrate the vulnerability of women for HIV infection.

Choosing to emphasize the "feminization of poverty," Shoepf briefly discusses cultural variances in attitudes toward divorce, extra- and pre-marital sex, and polygyny. It is assumed that the practice of polygyny is widespread in all social classes. Neglected wives may seek recompense elsewhere, and husbands do not always restrict their

activities to socially recognized partners. Larson (1989; 1990) demonstrates that polygyny, as a marriage form, has been altered by labour migration. Informal polygyny is a term often used to connote the propensity to arrange for both a wife in town, and a wife in the village. Although these relationships do differ considerably from the polygynous unions of traditional cultures, in terms of domestic priority, rural families are typically marginalized, and their subsequent loss of remittance leads to deleterious conditions of malnourishment and neglect.

Maxine Ankrah is one of the first published scholars to address women's risk for HIV acquisition in Uganda. To Ankrah, women's risk is to a great extent linked to female powerlessness with regard to marital sexuality, which is an aspect of a broader powerlessness. Drawing on a pilot study in Kampala, Uganda, Ankrah reported that women spoke of their vulnerability:

Among these areas [where they lacked any control] were the lack of decision making powers in matters of sex, their susceptibility to infection from husbands to whom traditions permit multiple partners, the necessity to use sex as an economic resource, and a sense of helplessness because of ignorance of ways to change the situation (Ankrah, 1991:971).

Ankrah also quotes the conclusion of the First International Workshop on Women and AIDS in Africa, held in Zimbabwe, that women have "limited power to negotiate or enforce strategies

to reduce their risk for HIV infection." Like Ulin and Shoepf, Ankrum sees this situation as arising from "the low status of the African woman..."

The rural woman in particular may find herself economically dependant upon her husband, but without any leverage at all, such as an independent income. Lacking the right of ownership, control over, or adequate access to land and cash, the rural African woman is highly disadvantaged ... (Ibid).

Husbands who have migrated to towns often set up new households and establish new sexual liaisons. At the same time, they can still demand their matrimonial sexual rights whenever they return to the household.

Barnett and Blaikie (1992), in the development of a risk focus for Rakai district, confirm that the broad powerlessness that women feel in their daily lives is directly linked to the control of land and other resources by men. While land tenure reforms, early in this century, made this option more available to women who had the cash to invest, generally the case remains that women have only land-use rights through their relationship with a man, either through marriage or consanguinity. Articulating with this access to resources, is the expectation that they must provide their husbands with sexual services.

This dependency upon resource, however, is mediated by the fact that many marriages, particularly among the Baganda of the South Central Region, are considered to be fragile.

Women are not necessarily welcome home after a separation from a husband; they are not guaranteed access to farming land on their return, and neither their own families nor those of their spouses will expect them to bring their children (Orubuloye, 1992). Larson goes so far as to assert that because interlacustrine marriage and family systems do not promote stability, the traditional expectation that marriages would not last led to the promotion of relationships that were casual and low key. "At any one time most unmarried men and women and some married will have several lovers (1989:723)." Larson concludes that "Ganda women were comparatively free", because they "often make their way to Kampala on their own, get a job if they can, find a lover, have children, live permanently with a man, all without special permission from their brothers or parents (Ibid)."

As Shoepf and Ulin observe, this apparent lack of access to economic resources, independent of men, combined with insecurities which surround marital continuity, creates situations in which women must rely on sex to survive. As Barnett and Blaikie note, these already existing economic tensions in women's lives are exacerbated by processes of social change which contribute to escalating rates of infection. Civil unrest and the black-market economy also created real discrepancies between men and women in terms of access to resources.

During the Amin period, the existence of illicit economic activity in the area had a seriously destabilizing effect on the already unequal balance between men and women. Those men who participated in the trade were in receipt of grossly inflated incomes ... Women's landlessness and the general insecurity of title meant that they could not share directly in the economic boom. One of the few ways they could gain access to the new cash and goods appearing in the system was through sexual relationships (Barnett and Blaikie, 1992:76).

In Rakai District, the popular success of these women traders was well known: they bought land, invested in property, and started their own businesses. In so doing, they avoided the economic exploitation which might have occurred in other available roles (Shoepf, 1988). However, as Mandeville (1979) demonstrates in a study undertaken in an urban slum in Kampala in the early 1970's, many women sought varying forms of partnerships and concomitant support since it was necessary for urban survival. It did not make them rich.

Some East African writers see these liaisons -- quasi-domestic arrangements, "short time" services -- as a gendered form of work (Bujra, 1975; MacGaffey, 1986; White, 1986, 1990). They view finding employment in a town -- which is likely to include some sort of domestic or sexual servicing -- as decisions made with varying degrees of autonomy, representing escape from repressive structures (Seidel, 1993).

Emphasizing the popular success or "freedom" of these women overshadows the indignities, sexual coercion, and ill health related to transactional sex for many women. This is

the case for most women who have sex to ensure payment for a meal, or to pay the rent. Concentrating on benefits of autonomy in such sexual decision making is a huge contradiction, because it is women's autonomous decisions which are killing them. Ulin comments:

The exchange of sex for subsistence needs careful study. There are no reliable data from which to estimate the magnitude of risk to women from this practice. To the extent that such practices erode the health, self esteem, and personal growth of women ... [they] may represent another example of the unintended consequences of development. AIDS and other sexually transmitted diseases are indeed, a high price to pay for education, subsistence, or a place in the job market (1992:66-67).

Evidences: The Clinical

The clinician's interest in "risk" lies in better understanding what it is about the biological body which increases or decreases ones receptivity to the virus, or alternatively, what increases or decreases ones infectivity if one is already infected. Clinicians are currently interested in understanding the role other sexually transmitted diseases play in HIV transmission. The changing nature of marital and extramarital relationships influence both the transmission of AIDS, and other sexually transmitted diseases. The link between sexually transmitted diseases and AIDS is twofold. They serve as a marker of sexual activity outside of the family unit -- their presence indicating likely areas where

AIDS may spread -- and in addition, it is now generally agreed that sexually transmitted diseases, particularly ulcerative ones, are a significant co-factor in HIV transmission (Pepin et al., 1989; Plummer, 1994). Concurrent infection can enhance ones risk for HIV infection, and at the same time, increase ones infectivity if one is already HIV positive. Chancroid is of particular concern and common in Africa but not in the West. The significant role of such ulcers in HIV infection is biologically convincing. Disruption of the mucosal barrier, and the presence of infected white blood cells and shedding of HIV1 in the female genital tract, explain increased likelihood of infection and infectivity (Bassett and Mhloyi, 1991; Plummer, 1994) In addition, women are considered to be disadvantaged because of their lack of access to health care facilities, and evidence of long delays before they seek treatment. Disease manifestation in women is also more subtle, with symptoms not appearing for some time, or go undetected because they are not painful.

An Amalgamation of Determinants: A Problem of Evidence

Many in the social sciences express their unease at using purely epidemiological evidences to organize intervention research. It is the view of Packard and Epstein (1992) for example, that one must question the utility of epidemiological

mapping, and in addition, study the complexity of risk and the impact of suffering. For Packard and Epstein, and many others, the social sciences provide a more comprehensive understanding of what puts women at risk for HIV infection.

At the same time, epidemiologists themselves are questioning the utility of constructs born of epidemiological evidence. Wawer (1994) expresses her unease with current epidemiologically driven intervention protocols. She emphasizes that "although incidence may have been higher without the educational interventions, existing programmes have not curbed transmission." In addition, she states that "these findings reflect the difficulties of implementing effective interventions in communities and underline the urgent need for better strategies."

The work of critical medical anthropologists like Shoepf, Ankrah, and their colleagues provide a social cultural and economic slant to the interpretation of risk, a context which is missing in most epidemiologically driven studies. Problematic, however, is the fact that much of the theorizing -- the feminization of poverty and women's powerlessness in their sexual lives -- become contextual determinants of risk, just as predictive, determining, and "flat" as epidemiologically evidenced trends and factors. An example may serve to illustrate this point. Serawadda (1992) asserts that regardless of the amount of sexual activity, risk becomes

higher in highly prevalent areas. At the same time Ankrah (1991) states that women are more vulnerable because of traditions which permit poly-partnerism. Lyantonde is a high risk environment. Polygynous marriages within a highly prevalent area would appear to pose a significant threat for disease acquisition for all partners involved. While these are significant explanations of the risk context and environment, these "determinants", as constructs, do not provide opportunities for authentically understanding how it happened that women end up in situations so compromising, that "they give in their lives." It is by understanding how women navigate personal lives on a day to day basis -- faced with converging dilemmas of hunger, threats of rape, living and dying-- which promises a much better understanding of the acquisition of HIV for women in this truck stop in South Western Uganda.

Who is at Risk?: A Problem of Theory and Practice

Upon perusal of the social scientific literature on women and risk for HIV infection in SubSaharan Africa, it emerged that most authors are opposed to the construct "high risk group." For the anthropologist, the process of differentiating populations of women because they are seen to share attributes which increase their risk for HIV infection is similar to a

process which delegates the origin of disease to a "cultural other" who is seen as different, immoral, and highly contagious. The social scientist rejects the epidemiological logic of "high risk" because not only does it lead to the assignation of blame, but also obstructs a better understanding of how this epidemic is affecting all women, including "prostitutes."

Herrel (1991) Standing (1991), Shoepf (1991), and Packard and Epstein (1991), all denounce the initial concept of the "target group" as a risk category because of a lack of social cultural content and context. In their view, the notion of "risk group" leads to a superficial assessment of risk, because it assumes, rather than reveals, groups of people who are also at risk (Standing, 1991; Seeley, 1994). Researchers are expected to study, not the context or behaviours of transmission wherever they occur, but specific limited groups considered to be at risk and seen as distinct from the general population in both behaviour and identity. What is thought to distinguish them from the general populace is their culture. The study of HIV transmission, then, becomes the study of the culture of "risk groups," a cultural determinism that is reified in the risk category "high risk group" (Glick-Shiller, 1992;1994).

The epidemiologist seems to require categories of risk, organized and informed by trends and factors, to make

successful, cost efficient intervention related decisions (Moses, 1991). As such, risk constructs are critical to disease prevention. Frankenburg (1989) uses a train metaphor to explain the predicament of the epidemiologist. Intervention epidemiologists use risk factor signals to indicate at which points it is possible or necessary to change tracks. The identification of risk groups is seen here as a moment in the process of identifying risk factors and takes second place to the recognition of categories of a population which may share risk factors. Understood this way, prostitutes, long distance truck drivers and male migrants are high risk groups for HIV infection, whose sexual relationships are the critical bridge for transmission into the wider heterosexual population.¹¹ Promiscuity and polypartnerism are descriptors of behaviour assumed to be characteristic of these groups. Because they are used to explain such high rates of prevalence and incidence, it is assumed that disease can be contained by targeting these high risk cohorts through prevention programs.

Frankenberg (1994) also contends that faced with the problem of new diseases or changing medical practice, some epidemiologists will be tempted, having identified risk groups in an abstract way, to remain with them and to lead themselves astray by neglecting to advance concepts of risk and

behaviour. The question becomes, "what will be lost if this idea of 'high risk group' is dropped altogether?" If it is dropped, is there an alternative model, one which can accommodate a number of evidences of risk, and one that can also be used as a bridge for pragmatic policy-making and programmatic strategizing? Shoepf (1988) stresses the need to derail existing prevention strategies in which messages are aimed at "target groups." Most social scientists appear to agree with her, and with the goal to discard the construct of "risk group."

Social scientists accuse their epidemiological colleagues with reifying constructs of risk, constructs which do not accommodate the realities of women's lives. At the same time, however, these same social scientists have not worked very hard at the provision of alternative models. Willms and Sewankambo (1995) offer a conceptual framework of risk predicated on ethnographic insights gained from the project "Talking About AIDS: Lyantonde Study Group." The promise of such a model lies in its ability to accommodate the meaning and experience of risk existing in women's lives, in a manner which may translate into program policy and design.

ENDNOTES

¹ The ssenga is the paternal aunt. She carries a significant amount of power in family relationships, particularly in the formulation of an arranged marriage.

² HIV is a slow acting virus able to reproduce itself using genetic material from the cells of its host. As with many other viral disease agents, it readily mutates making the development of a vaccine or a treatment very difficult. Infection with HIV leads to profound suppression of the immune system, destroying the body's defence mechanisms. The virus does not kill people directly, but it paves the way for other clinical conditions and infections to manifest, thrive and eventually kill. The types of opportunistic infections which eventually invade the body are typically those which abound in normal disease environments (Biggar, 1988; Barnett and Blaikie, 1992). As such the diseases that eventually cripple women in Uganda, may not be the same as those that overtake the bodies of women in Canada. In recognition that many African countries did not have the laboratory facilities to launch full scale serosurveillance efforts, the World Health Organization (WHO) proposed a clinical case definition for identifying adults with AIDS in an African disease environment. While the efficacy of such a definition has been questioned (Gilks, 1991; Sewankambo, 1994), fever or diarrhoea for more than one month combined with weight loss of greater than 10% are clinically considered to be the major signs of AIDS. Minor signs include persistent cough, generalized pruritic dermatitis, herpes zosta, oropharyngeal candidiasis, ulcerated herpes simplex and generalized lymphadenopathy. Often if women live in constant fear of infection and see signs of disease in themselves -- persistent diarrhoea and rash -- they will conclude that " I must be slimming, I am already dead." These conclusions are often reached without ever having a confirmatory HIV test or clinical confirmation by a clinician.

³ It is not my intention to perpetuate or reify already existing tensions which are reflected in the literature (Please see Chapter III). It is important to note that while these tensions do exist, interdisciplinary approaches (which demonstrate the complementarity of various qualitative and quantitative methods) if pursued with care, can be fruitful and produce results which can be cross validated (Seeley, 1994).

⁴ It has been suggested that countries in the East and Central parts of Africa experiencing large health tolls are merely situated closer to the 'epicentre', that is, closer to the source of the epidemic; this explains the highly variable distribution between countries (Larson, 1990; Barnett and Blaikie, 1992). Discussions of disease origin, however unfortunate, quickly turn to blame assignation of blame, the cause of the international furore in the late 1980's.

⁵ For example, knowledge about the virus is high. Ninety four percent of responding adults know about AIDS and understand that AIDS is almost exclusively sexually transmitted. In addition, the proportion of subjects admitting to having two or more sexual partners in the previous year increased from 8.9% in 1989 to 12.3% in 1990 (Wawer, 1994).

⁶ This accompanied by warnings that "we may expect (that) the virus will continue to be spread throughout the African continent by men serving as vectors of infection from one community of urban prostitutes to another" (Kreiss, 1986: 417).

⁷ Malaya is the Swahili word which means a woman not married in the church (Obbo, 1981:39); now it is used interchangeably to imply sexual looseness and prostitution.

⁸ Even today in Lyantonde, the migration of young girls is monitored by Resistance Council (RC) members. Examination of papers and referrals by RC's in their previous place of residence is required.

⁹ Ulin finds the isolation and burden of work particularly relevant in terms of subsequent lack of access to resources and health services.

¹⁰ Outside of agriculture, in which women find some employment at extremely low pay, few jobs are available to women without secondary school diplomas. Shoepf (1991) suggests that although sex discrimination in employment is illegal, the structure of employment opportunity, inherited from the colonial period when women were allocated the tasks of social reproduction, still persists.

¹¹ It should not be forgotten that there is sound epidemiological evidence to support the construction of these groups as "high risk."

CHAPTER III

Our friend is now suffering from dysentery - once it starts and does not stop people get really scared - and it appears that she is now afraid to die. Once the diarrhoea starts and does not stop, people get really scared. She has started to sell her property -her bed, her dresses, her radio - to raise money to transport her family back to the village. It is very difficult to see her in such pain (Field Diary, 1994).

Ethnographic research on HIV/AIDS in East Africa is an uncharted journey (Ankrah,1989). It is both methodologically challenging and emotionally draining. Researchers -- epidemiologists, ethnographers, clinicians -- make methodological decisions knowing that today or tomorrow, a trusted informant may become infected and another one may be dying. Watching an informant slip away and die is difficult since she may have become your friend. Regardless of what is done with your data she will never come back. So you continue your work in her memory because you were witness to the ravage of her body and the impact her death had on her family and her children.

Beginning with an Ethnographic Approach: Our Original Objectives

In August of 1992, I was invited by Co-Principal Investigators (Dr. Nelson Sewankambo, Makerere University, and Dr. Dennis Willms, McMaster University) to join an interdisciplinary team in the development of culturally compelling interventions for persons vulnerable to or infected with HIV in rural Uganda. The research project [funded by the International Development Research Centre, Ottawa, Canada] was and is in Lyantonde, a truck stop devastated by HIV/AIDS. The project is now entitled "Talking About AIDS: The Lyantonde Study Group."¹ For the purposes of a dissertation, my interests were in exposing the different layers of risk which women in Lyantonde confront on a daily basis. The voices of women reflected in this thesis are the foundation upon which my analysis of risk is built. What follows is a review of how this study is a product of both the research and methodological aims of "Talking About AIDS." Certain methodological challenges that accompany research with women at risk for HIV infection are also highlighted, and a "history of risk" for women living in Lyantonde town is also developed.

Lyantonde, Rakai district, was chosen as research locale for "Talking About AIDS" for a number of reasons. With a prolonged and lucrative history of prostitution, this town has gained a local and national reputation as being a "hotspot" for HIV transmission in Uganda. In addition, epidemiological

evidence supports this assumption. Located on both a trans African highway and a feeder road that leads deep into the villages, the town has developed as both a trading centre and a truck stop. Many people converge here from other districts to complete trade transactions. These include coffee marketing, and matoke (staple food) and cattle trading.

Lyantonde is a town of national repute because it is situated along the main paved highway which extends from the Indian Ocean port of Mombasa, Kenya, through Uganda, to landlocked countries like Rwanda, Burundi and Zaire. The town is a very popular stopover point servicing the needs of lorry and transport truck drivers. These services may include lodging and commercial sex. In fact, rumours in the early-to mid-1980's suggested that Lyantonde was considered a centre for commercial sex. People would travel from as far as Kampala or further specifically for these services. 1984-86 are the years people remember vividly, because, "that is when things started to change." People started to die. Currently, seroprevalence rates (the numbers of people infected with HIV) in trading centres like Lyantonde are astounding.

The impetus to ethnographically study this Ugandan town came from both the knowledge that there was little published information on HIV/AIDS in the context of culture, and also from the frustration of knowing that people understood the causes of HIV transmission but continued to engage in these

high risk sexual behaviours.² An ethnographic research design was developed that might offer sociocultural context to these high risk behaviours.

In 1988, serological studies indicated that prevalence rates among bar girls in Lyantonde were as high as 76% (Carswell, 1988). This evidence provided the initial "targets" for ethnographic research: bar girls and their clients, particularly long distance truck drivers and people who frequently contract sexually transmitted diseases. Considered key transmitters of the virus, these groups were considered at particular risk for infection (Carswell, 1989; Kreiss, 1986; Piot, 1987).

The ethnographic study of HIV/AIDS in the Lyantonde context initially focused on the following objectives. First, we wanted to qualitatively assess the nature and distribution of sexual behaviours among persons recognized as being at high risk for HIV transmission. Second, we wanted to identify social cultural factors which motivate and influence unsafe aspects of sexual behaviour. Third, we wanted to ascertain how the AIDS pandemic has affected the sexual health of adolescents and young adults in this Ugandan town. Finally, we wanted to develop a counselling program targeted at bar girls and patients with sexually transmitted diseases (STDs).

The research design for this project was necessarily

flexible, since we were committed to the eventual development of a culturally informed intervention in partnership with community members. In the early stages of the research, we discussed using a participatory-action research (PAR) approach, one that engages community members in a collective effort to analyze and address identified problems (Hall, 1992; Tandon, 1981). However, shocked by the gravity of the situation in Lyantonde and by stories of death, hopelessness and despair, we were naive to think that a community initiated movement was initially possible. We decided that it was necessary to discover different layers of "evidence" before thinking through steps of community participation.³ In summary, based on the results of the longitudinal study, resources would be developed to inform intervention strategies. However, the success of the resources and accompanying strategies are inextricably linked to a participatory component (Sewankambo and Willms, 1994). From his experience with clinically and community based serosurvey/cohort work Sewankambo made these comments:

It is very clear to me that programs already in place are not making an impact on HIV/AIDS. I am not saying that there is no change in the community [because of these existing programs], but I would like to see much more behaviour change especially with respect to HIV transmission. Focusing on clinical studies alone is inadequate. That is why I got interested in qualitative approaches to the problem since clinical and KAP [Knowledge, Attitude and Practice] studies are not enough. Looking at

interventions, we need the participation of the community, so at the end of the day, we have in place complementary approaches: anthropological studies first, followed by participatory approaches (In Spittal and Willms, 1994).

It is noteworthy that at the time the grant proposal was submitted to IDRC, none of the AIDS related studies being carried out in Rakai were qualitative in nature (Sewankambo, 1990). At the time this interdisciplinary effort was being established, pieces started to appear in social science journals which indicated academic tension between the biomedical and social sciences. Many believed (and sometimes raged) that anthropological contribution to AIDS research had been subsumed and coopted by medical researchers (Herrel, 1991; Packard and Epstein, 1991; Turner, 1988).⁴ Furthermore, anthropological contributions had also been misinterpreted and misused (Shoepf, 1991). One consequence of such tension between disciplines is the polarization of quantitative and qualitative methods, and subsequently exclusively associating them with different disciplines (Standing, 1992).⁵

Ankrah (1989) urges that it is necessary to determine ways of transcending this established compartmentalization of disciplines. To do this requires willingness on the part of biomedical and social scientists to work together against an enemy about which a great deal of ignorance still exists. As Sewankambo implies, quantitatively designed studies alone are

not eliciting the types of evidence needed to design and implement intervention. The situation, then, has demanded methodological reassessment. For this study, this has meant giving priority to the necessity of the "deep qualitative endeavour." As Turner stresses: "efforts to control the AIDS epidemic and cope with its consequences will depend crucially on upon the paradigms, data, and methods of the social sciences" (1988:250).

Project Implementation

Dr. Sewankambo, as Principal investigator, hired four Makerere University graduates with degrees in the social sciences. Mr. Godfrey Mukasa, Mr. Adison Lwanga, Ms. Barbara Mutagamba, and Ms. Janette Nakuti were trained by Dr. Willms in qualitative data collection techniques and data interpretation and management. Godfrey, Adison, and Barbara are all Bagandan from Central Uganda. Janette is a Mugesu from Mbale District. Barbara left in October of 1992 to pursue graduate studies in England.

The project began in February of 1992 and was expected to continue for 18 months. I joined the team in August 1992, and left in September of 1993. I was able to return the following March for three weeks, and in August of 1994 for another four

months.⁵ We all lived together in a home rented by the project located on the outskirts of Lyantonde.

This research team is in many ways truly exceptional. Town life offers people a certain degree of anonymity, which accounts for the commonly held belief that all the women there are "AIDS widows," having left their own communities when their husbands perished. At the same time, however, we were able to create and sustain relationships throughout the town, and into the villages nearby.⁶ Each of us had our own interviewing style; we were all different in personality, which made us a better research team and contributed to the accumulation of exceptional data. Most importantly, we offered each other support when the field demanded extreme emotional commitment.

Encountering despair every single day was invariably difficult and at times crippling. When our close friends were dying or had lost a child, interviews were difficult to do. Attending burials became part of what we did everyday. I remember a time when we went to visit a neighbour and her dying daughter. She was, as was commonly said, "dying any time."⁷ It was the first time Janette and I had ever seen anybody so wasted. Her skin had been invaded by dermatitis, and her hip bones seemed to puncture her skin. She was on the edge of death. We came home and cried together. I remember

Janette exclaiming, "if there is no cure for this by the 2000's, it will mean the end of the world!"

Getting Started

We started initially by utilizing classic ethnographic techniques such as in-depth interviews (unstructured and semi structured), focus groups, and participant observation, in order to understand the social cultural context of high risk behaviour in the town. What we have generated using this combination of qualitative methods is non numerical, experiential sets of evidence. By "sampling (convenience, snowball networking) to redundancy" -- combining different methods; different interviewers (the team of four research assistants talking through the results on a daily basis) over a long period of time -- we were able to triangulate evidence. Evidence which we believe represents the community's experience with the disease.

Each team member began research with a study of the town itself, daily recording various details about ethnic composition, political economy, religious affiliations, gender tensions, and womens' associations. This part of the evidence has provided an important backdrop to understanding how AIDS is experienced in Lyantonde (Sewankambo et. al, 1993). In addition, we had the opportunity to get a sense of the

Figure 3.

"Talking About AIDS" Research Team



J. Nakuti, A. Lwang, G. Mukasa, and P. Spittal with Tamule
(From Left to Right)

"participatory climate" of the community; for example the town's history as a truck/lorry stop, with small shops and stalls erected in response to the demands of drivers, generated an economic environment of transient commercialism. Women and men came from village to town to perform unskilled jobs with specific short term goals in mind.⁸

During the prolonged drought of 1992, for example, many men came to Lyantonde to become water vendors.⁹ They became "temporary" inhabitants of town. A culture of individualism pervades the place, as "home" is really in the villages. In planning a participatory process towards the promotion of sexual health, we would have to accommodate the heterogeneous nature of the community.

When I arrived in Lyantonde, the team had been advised by Dr. Willms to move away from the more general description of "life in Lyantonde" to more directed interviewing aimed at generating case studies of people representative of the population of Lyantonde. Originally, these composites of "representative types" were to be reflective of the "targets" delineated in the initial proposal -- focusing on bar girls and truckdrivers -- however, the net soon expanded to include other groups. These case studies form the body of this dissertation.

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The Case Studies

In the past decade, many have lauded the contribution of the life history -- both as text and process -- to gerontological, feminist and hermeneutic scholarship. For those decrying the "person in absentia" (Frank, 1979; Watson, 1976) in anthropological texts, the life history represents a social construction, a product of a person's relationship with other significant individuals. Feminist anthropologists take this lack of personhood in anthropology a lot further and assert that traditionally knowledge, truth, and reality have been constructed as if men's experience were normative, as if being human meant being male (P.N.G., 1989). Geiger (1986) asserts that a woman's life history is a primary source for the content of women's lives. She recommends the life history as a method for a broader and deeper understanding of women's consciousness. We felt the life history was a method of mapping, through meaningful exchange, a realm of personal risk. As sufferers, caretakers, mothers and widows, women experience AIDS differently than do men.

Janette and I followed the lives of seven women over a period of eight months. Each one had her own relationship with HIV/AIDS. For some, their seropositivity was confirmed by testing. For others, AIDS was like the wind, elusive but gusting in and out of their lives.

My relationship with these women developed differently from theirs with Janette. Janette was fluent in Luganda,¹⁰ I was not. I really worked hard on nuances and finding ways to communicate caring, appreciation, humour, and respect in ways other than speaking. Without Janette, I could not have functioned. I became the probe, and she, in her own language, had to find ways to delicately address and draw out issues not usually discussed in everyday conversations. Interviews could take as much as three hours in one sitting, because many expressions about sex and associated body parts are communicated metaphorically. English is considered a somewhat "dry" or rude language, particularly with reference to sex. Sometimes the woman knew a bit of English and felt obligated in my presence to use it. However, conversations around sexuality were awkward, because they found it difficult or embarrassing to speak to these issues. We decided we would try to run all interviews in Luganda.

Because of the sensitivity of the issues, taperecorded interviews were not a consideration. Janette and I evolved a pattern of interviewing. By the time I left the field, I could understand the subtleties of a conversation and she could virtually anticipate my next question. We wrote our field notes and logs together, debriefing one another to reconstruct the passages. I became responsible for remembering

the topics, structure and chronology of the conversation. Janette keenly remembered detail.

For the most part, one case study meant at least five to seven interviews. The relationships had to evolve to a point of unconditional trust before real triangulation of risk detail could occur. Our relationships with these women were consolidated via participant observation and "the casual encounter," through which we were privy to other parts of their lives. On any given day, for example, we could be seen walking for miles to the village to help Kanniffa weed her beans. Her land had been left unattended as she had been very sick in town. Or the team would go to a hotel at dusk and "hang out" with the bar girls we had interviewed during the day. We felt truly satisfied the day these girls began to join us and visit, unabashed, even when prospective "clients" were around.

There was a time when we, as a team, would decide on an almost daily basis which burial we would attend. Often, our strategy was to split up, so we could be a part of them all. The government doctor in the community once asked me about our participation at burials and customary overnight gatherings for men to mourn death:

There are people here who tell us that those boys (Godfrey and Adison) even go and stay with the bodies. They talk about how good they are. Do they have to do that? Is it a part of your work?

I was unsure of how to respond, but I was really proud. We tried to help out in the burial process, whether it was providing/peeling matoke for the feast, or actually reading out the condolences at the graveside. People took note of our presence. Janette and I felt that our friends appreciated our involvement because they knew, and could trust, that we would be there, even in death, for them too. For the most part, relationships were founded on the rights of each woman to dignity and respect, in life and in death.

Details about people's lives were held in the strictest confidence. Although many of our experiences were shared with the rest of the team, they never, ever, left our compound. We firmly believed that if we broke peoples' trust, then a participatory process could not succeed. The fact that people have remarked to the team, that they "know that they can trust us", and "that you do not participate in rumours", has been a major accomplishment.

Our purpose in the field was simply data accumulation. Each of us interviewed community members as opportunity afforded. Participation simply meant a willingness of individuals to share the stories of their lives, including the sexual aspects of their lives. Many referred to AIDS, as "our disease", indicating its incorporation into the fabric of daily life. But as with the spread of other STDs, women do continue to shoulder the burdens of both blame and stigma.

This certainly affected women's decisions to participate. In some cases, stigma made participation very difficult or painful. Regardless of how we explained our presence in the community, people still called us *basawo* (doctors). Sometimes, other townspeople thought that the people we visited were sick even if they were not ill and/or known to be HIV positive. The fact that I was not a Ugandan did not help matters much. I was a very visible individual (*muzungu*) associated with the project, and by extension, quickly associated with the disease. Numerous times when we were seated with friends, men on bicycles would ride by and say. "that one must be slimming" or "you go with them and get tested."

On one occasion, a friend of ours agreed to be interviewed. She was an HIV positive woman whose alcohol selling business was quite lucrative. We went to visit one day. The next day the relationship had gone cold. She still greeted us cheerfully in public, but would never agree to meet in private again. Much later we found out her co-wife had just moved across the way. This was one of a number of frustrating situations.

The Story of Two Neighbours: Juliette and Josie

We were introduced by a friend to Juliette, a cooked food

seller in the evening markets. She lived in a place known to us as the AIDS compound.¹¹ At first Juliette was really kind to us and chatty. But after the second and third visits, our presence in the compound was obviously very difficult for her. When she saw us coming, she would go to the market to buy tomatoes for matoke sauce, and not come back. Or, as we found out later, she would instruct her child not to talk to us. This pierced my heart. Janette and I struggled with this change, asking ourselves if we had offended her. In fact, we ourselves felt offended.

Embarrassed and determined, Juliette's neighbour, Josie, came to explain Juliette's "badheartedness":

Juliette talks to women around here and says that she does not want anyone around here to associate her with you. She had herpes on her back and told people it was syphilis. A year ago she had a baby. It took a few breaths and died. So every time you came to find her, she did not want to meet you. This is why she locked her door and went away.

We did not know, however, what the rest of the women in her compound seemed to know -- that Juliette was very sick.

In time Juliette did want to talk. She told us how worried she was about her mother in the village. Two of her sisters had travelled long distances so that they could care for her properly. But now, Juliette continued:

My sister in town has died, and the one in the village looks sick. It seems she got "our disease."

Our mother is really old now. Who is going to keep her? I wish God could make it so that the old people die first. These days it is mostly the young ones who die first and the old ones die with no help.

Juliette eventually went to the village to bury her sister. When she finally returned to town, her own fears were realized; the disease was destroying her. She refused to allow people to come and visit her. She was being cared for by an older daughter who had come from Masaka. Because we did continue to work in the AIDS compound, we watched Juliette slip away. I remember interviewing in the room next to hers, feeling sad knowing this woman we barely knew was dying. I wrote in my field diary, "AIDS is eating my soul."

Because stigma did factor significantly in our relationships with people, we had to trust that if one interview did not work out, another would. In fact, I believe that "getting around" these problems had the effect of making our relationships richer. We tried our best to be able to answer basic questions which pertained to women worrying about "risk" and AIDS. These questions usually revolved around birth control, perinatal transmission, STD's, and immunization. As a result, we became "sounding boards" for these women who were on a daily basis working through moral dilemmas with regards to risk. For example, one of our friends, Josie, had lost two children in the previous two

years. We helped her through decisions about birth control. For her and many others, condom use was not a perceived option. But eventually she stopped using the pill and became pregnant. In spite of warnings by the HIV counsellor about both perinatal transmission and the danger that pregnancy does immunocompromise, she wanted this child. In addition, knowing she was positive, with no support and a sickly child, she entered into bar work, using condoms with some men, but not with "permanent partners."¹² How could we help her through this? These were difficult times. We assured her that we would never judge her or the decisions she made.

Dilemmas: Personal and Methodological

The research milieu of Lyantonde is numbing. It is a place of need, grief, hunger, and death. This environment has led us to reflect both on our own lives (with an increased reverence for life) and about the way we feel about HIV/AIDS prevention. When the project first got under way, community members knew that previous AIDS researchers in the community used questionnaires and drew blood. These activities set precedents for the community's perception of what "research" is. Sometimes people would meet us in a village far from town, and comment that "that is what they do, they go

walking." Our activities - open ended interviews, "hanging out" and listening for hours to one persons narration of risk - were very puzzling to them. After two years, community members in town began to ask, "Are things changing?" and "What are you going to do for us?"

We had listened to their stories, mourned their losses, and shared their suffering. The ethnographic process of "data extraction," was weighing heavily on our ethical consciousness as a research team. Our intent had always been participatory, but the process had not. We had mined the stories, and all the while the community waited. At the time of writing, the team had been in the field for over three years. Currently, we are finding it exceedingly difficult to justify our presence. In the field it has almost become too difficult to find ways to explain to people that we want to know how they think and behave and yet in the same breath explain that there is nothing tangible for us to give. Our friend Maama Mali once implored:

You give us our rice because I am going to die before you do anything for us. If it is rice you will give out, give me my share now before I die. By the time you do something for the community, I will already be dead.

We could not forgive ourselves if we packed up our field notes and left the community without giving something more. As Janette remarked:

It is even more difficult now, because we have created all of these relationships, are very close to our friends and have seen them through difficult times. It makes me feel like there is something missing. It makes me feel guilty. How can we leave? It will be like exploiting them for information.

A History of Risk for Lyantonde Town:

Lyantonde was and still is considered a hub for HIV infection. This reputation is rooted historically in political and economic developments which occurred decades ago: economic policies (the magendo economy) implemented by the military dictator Idi Amin, subsequent civil war; and, more generally, waves of migration related to civil unrest, land pressure, and labour movement. In turn, these developments provided the economic and communications infrastructure of AIDS in Uganda generally, and Lyantonde specifically.

The rural and urban areas of Lyantonde were originally lands which belonged to the Kingdom of Ankole. In the late 1800's, the Banyarwanda (Rwandese) were prepared to annex all of the lands of Ankole, located in South West Uganda. The king of Ankole pleaded to the King of Buganda for military support.¹³ As a gift for the bloodshed he gave Mwanga (the Bagandan King) lands which belonged to Ankole but bordered Bagandan territory. Lyantonde, already an established centre for trade, became an administrative town for the Bagandan King.¹⁴ It is said that much of the land surrounding Lyantonde

was virtually uninhabitable, as the sun could shine all year. The people were hunters, agriculturalists and cattle keepers, mostly Baganda and Banyankole.

Over time, colonial authorities coopted the ruling class of the Baganda by establishing a new system of land tenure (mailo system) which converted the feudal tenure of the kingdom of the Baganda to individual tenure. This meant that all Bagandan power holders from King to Chief were given parcels of land measured in miles. These power holders became landowners, and the people who inhabited their lands became tenants. The basis of this system of social, economic and political domination was the cash crop, coffee and cotton (Barnett and Blaikie, 1992). In Lyantonde and the rest of Rakai, Asian traders provided the formal exchange and organized the distribution of cash crops and other commodities. They provided people from surrounding villages with basic goods - salt, sugar, clothes, soap, vaseline, safety pins and some medical supplies - in exchange for beans, coffee, hides and skins, and some cotton.

The town did not begin to flourish as a truck stop until the 1960's when the road was paved; it had been constructed by the colonial administration to link Central Uganda (Kampala) to the South West (Kabale, Kisoro).¹⁵ Previously, only lorries could negotiate the roads to bring goods to land locked

Rwanda. With Asian investment, many of the semi permanent market stalls and hotels were revamped with galvanized iron sheets replacing thatched roofs. The hotel business, primarily Asian owned and run, became lucrative, and there was need for more permanent housing for migrants. This led to the appearance of mud and wattle, single-room, row housing. Lyantonde became a bustling service community, a resting place for truckers and a meeting place for the rural market economy, including itinerant market and cattle traders. There was electricity, petrol stations, and prosperity.

By the late 1960's and early 1970's, racial tension between the African petty bourgeoisie (the newly wealthy cash croppers) and the Asian middlemen had escalated. The latter had become a commercial class in and of themselves and had even been offered Ugandan citizenship to consolidate their positions. At that time, the African agriculturalist/merchant could not compete with them commercially as their lands could not be bought nor sold to provide the needed capital. At the same time the prices of coffee and cotton, the economic mainstay of many African farmers, plummeted in the international market. The state responded by a rash of banking laws and nationalizations which served to strengthen the power of state personnel, a power which was exercised through patronage and payoffs.

Deciding in 1966 that the governing bodies were clearly favouring the political sway of the expatriates, the African petty bourgeoisie looked to the military for support. By 1971, Idi Amin had overthrown the government lead by Milton Obote. He had been supported by African petty bourgeoisie who viewed the coup as a way of defeating state personnel and the Asians. Both groups, they believed, had frustrated their interest in moving from being petty bourgeoisie to grand bourgeoisie. As a result, over 70,000 Asians were compelled to leave Uganda (Barnett and Blaikie, 1992; Lamb, 1987). With these expulsions, exchange and distribution arrangements both domestically and internationally broke down. By 1975, the formal economy had collapsed and had been replaced by an underground economy which, according to both Barnett and Blaikie (1992) and Bond and Vincent (1991), is directly related to the development of the risk milieu in Rakai.

Amin's economic policy froze agricultural prices, drawing a large proportion of crops into the black market. These included the market green products of the South West, and produce - Irish potatoes and onions - from areas surrounding Lyantonde. Cities such as Kampala and Jinja became dependant on the black market as many of their food needs were supplied from surrounding districts. The illicit operators of the black market were able to spread magendo into the primary food producing sector of the economy by gaining a monopoly over

road transportation (Sathyamurthy in Vincent and Bond, 1991).¹⁶ Smuggling was the backbone of this economy; coffee, paraffin, sugar and gold were shipped out of the country; spare parts for vehicles were brought into the country; and food staples distributed within the country. The profits were invested in land, housing and commercial buildings. Lyantonde, a centre for trade and trucking, could not fail to thrive from all of the money made from illicit activities.¹⁷ The town benefited from the night trade on Lake Victoria where fishing villages became thriving hubs of activity, with heavily-armed high-powered launches running coffee to Kenya (Vincent and Bond, 1991).

Lake Victoria was the scene of intense smuggling during the 1970's because it connects Uganda, Kenya and Tanzania. During the day, traders and porters waited in fishing villages and neighbouring towns. Every night fleets of fishing canoes converged on the villages along the shores of Rakai. Young men were employed to row and unload the canoes. Some young men worked as porters to quickly whisk away the goods to hideaway places in neighbouring villages. Traders who were well off would have the trucks to take the goods to the capital, but middling traders used bicycles to move their goods to townships and urban centres (like Lyantonde) (Obbo, 1993).

Goods were also smuggled by road via towns like Lyantonde and many trucks were outfitted with submachine guns. As Southhall observed:

The basic supply route from the port of Mombasa, though Nairobi, to Uganda, ran like a great artery

of corruption from Western Kenya to Kampala, on North to the Sudan, on West and South to Rwanda, Burundi and Zaire. Long stretches have been beaten to pieces as hundreds of trailer-trucks pound continuously up and down the roads. The tough drivers and crews, who are paid overtime and danger money, changed their Kenyan shillings at the border. They are often delayed for days, drinking in the bars, eating in the hotels ... sleeping in the brothels that line the route. From this main artery corrupting tentacles of the black market with its illicit deals and violent transactions penetrate into the Ugandan countryside, pulling into its stream the desperate, the destitute and the down and out (1980: 627 -56).

All of these activities created a demand for food, lodging and sex at truck stop townships, border towns and smuggling villages. These were the times when women were known to move up and down the main road in Lyantonde, "like schools of fish." Some who have watched the changing faces of life in Lyantonde town remember a time when women who were married were regarded with pity and disrespect. This was because "It was fashionable to be a harlot ... it was a source of money."

Sex was for enjoyment, women were just like shops, the goods were there for sale, and everyone was free to buy. The woman never feared the man, because she was in a business. We would buy, and, if it was good, we would tell our friends to go.

Those women who were married were afraid.

Lyantonde then was a commercial town and girls would hide during the day and come out at night around 9 pm; they would do their faces with cosmetics. Their hair, and the way they dressed, they were so beautiful, we used to be so afraid that they would take our men. They would move up and down the streets in groups of two, or groups of

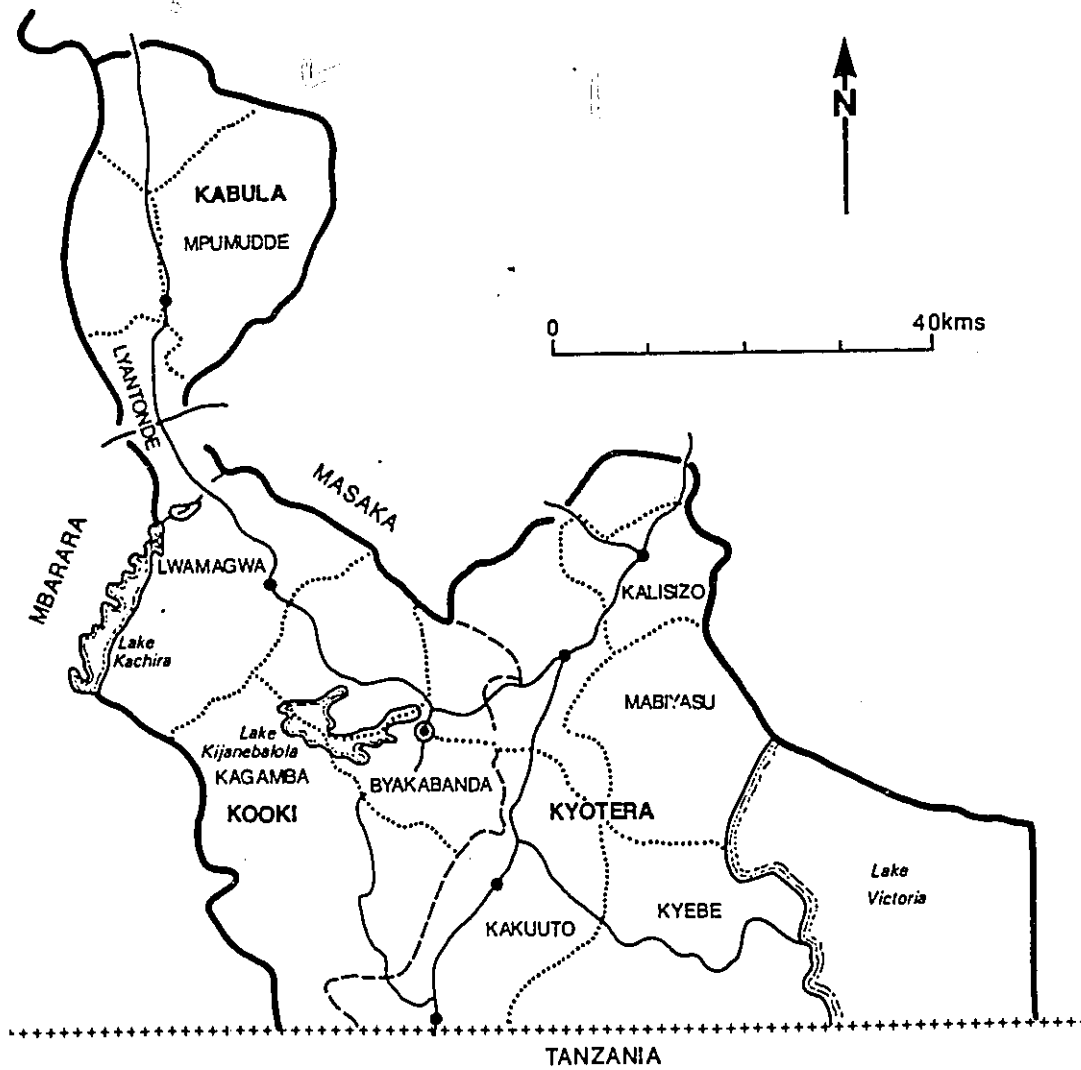
four. Some would move and stand under the street lights as if they were on display.

Others say that it was these women who used prostitution to buy land and invest in businesses who were among the first to die. Eventually, when people began to understand that AIDS was transmitted sexually, it was these same women who were reputed to be the ones who were killing people. These testimonies set the stage for understanding how the socioeconomic structures which appeared during the magendo (black market) period provided a fertile ground for the appearance and dispersal of AIDS in Rakai.

Soon after the Liberation War of 1979, when the Tanzanian Army overthrew Amin and reinstated Obote, AIDS cases began to appear in Rakai. Lakeport traders involved in smuggling began to fall sick and die in 1980 - 81. But the Obote regime more than matched the economic mismanagement and terror of the Amin regime. The state continued to decay, and the illicit economy continued to thrive as a part of peoples' survival strategies. It was not until 1986 when Yoweri Museveni, the head of the National Resistance Army, defeated and expelled Milton Obote and took office as President of Uganda, could researchers even begin to assess this new disease called silimu.

People remember the "good" times, when even a bicycle trader was considered rich by normal standards, discos ran every night, and big businessmen started to build permanent

Figure 4 SubCounties, towns, roads, the Rakai District, Uganda



- +++++ National boundary
- District boundary
- County boundary
- Sub-county boundary
- Roads
- ⊙ District headquarters
- Trading centre

Note: Some sub-county boundaries may be inaccurate since their reorganization

two storied buildings with garages. They also remember what happened when people in Lyantonde started to fall sick. As one elder comments:

In 1979, when the Liberation forces came from Tanzania, that is when AIDS started spreading in Uganda, first in Mutukula (see insert) then Kyotera, Kalisezo and along that route to Kampala. In Lyantonde people started dying in late 1980 and those people were the well to do and mostly business and mobile people. When they died talk went around that these people went to Tanzania and stole merchandise from a group of people, the Kalibwe, well known for witchcraft. Relatives of the victims believed these people had been bewitched, so they went to witchdoctors for treatment and protection before they went on business journeys. Others looked for good luck charms. At that time local herbs were very popular in the markets. People thought AIDS could be got from money or clothes of someone else, the cloth or hands of people associated with smuggling. In fact, when some business people travelled from Rakai to Kampala for goods, people would not sit near us, they thought an 'egg' would be left on our clothes or on our seats.

Women sold themselves to men especially those truck driver and businessmen. They bought clothes, cosmetics, and shoes, in fact, the men who were dealing in goods for women were just swimming in cash.

There was a lot of fear in business at that time but not in sex, because people had no idea that this disease was through promiscuity. So, of course, as they went on business trips the men changed women like clothes and vice versa. When they came back to their wives and husbands at home, the disease continued to spread. Lyantonde had so many people, but now it is a ghost town, with unfinished buildings ...

Death and uncontrolled sexual behaviour went on until 1984, when we realized that there was something different. We started hearing about a disease of skin rashes, fever and diarrhoea, which made people lose weight. So many started dying; the friends that have died are too many to remember. After one or two years you forget, but

when you think of close family, you can start to cry. People said it was caused by sex, but some still believed it was witchcraft. Some who still believed they were infected just went ahead with sex, using their money because they felt they "did not want to die alone."

Now most people here are infected, and in fact those who know they are infected continue spreading. Men are now specializing in school girls. We are all going to die.

There are some who believe that the Tanzanian soldiers brought this disease when they passed through and virtually levelled Mutukula, Kyotera and Masaka, on their way to the liberation of Kampala. This is indeed possible, as disease prevalence in towns on the others side of the border are high (Barnett and Blaikie, 1992). It is difficult to be conclusive on this point as borders are arbitrary and open. People, particularly pastoralists, bicyclists and itinerant market traders have always moved backed and forth between the Ugandan border in the south west and that of northern Tanzania. Hunt (1989), for example, suggests that patterns of sexually transmitted diseases are often a reflection of labour migration. By extension, Rakai district has a long history of labour movement from Tanzania, Rwanda, Burundi, Kenya and other parts of Uganda, which explains the presence of the ethnic mosaic which characterizes Lyantonde town. Although primarily a Bagandan and Catholic place, many, like the Bakiga, have migrated because of land pressures in the West. Or like multiple generations of Banyarwanda, they have sought asylum

from civil war here. Many semi permanent men come from labour pools of the West Nile to work on feeder road or water projects. Both in peacetime and war, people migrate. As Vincent and Bond (1991) warn, any assessment of AIDS in Rakai must account for migrations of people.

The people in Lyantonde consider themselves lucky as their homes and shops were not levelled by bulldozers or shelling in the War of 1979, or the protracted bush war that ended in 1986. However, the town did "host" many soldiers.

Many stayed in single rooms with women. Some had children together, others just went there to drink. At first we really feared them; in fact, some packed their things and fled to the village, but some paid for their food at hotels. A lot of women went with them of their own free will. Eventually, people came back.

There are stories of looting, particularly of cattle from ranches near Lyantonde, belonging to Amin's statesmen. When the team came to Lyantonde, hushed conversations about fear, stigma and death characterized research. The imagery of war,¹⁸ between the state and rebels, was replaced with images of war between people and disease.⁵ As revealed in the following phrases, sex was considered as if it were war: "AIDS is like war: whoever fights badly is the one to die of a bullet;" "Put on a 'combat' (condom), do not go naked;" and, "If you are going for sex, do not forget your weapons (condoms)."

In 1992 and 1993 there were stories of families selling plots to provide treatment for their sons and daughters, and of father's deciding not to sell cattle to treat themselves so they would have beasts to leave their families. Bar girls were dying alone in their own rooms, and it is said that when the bodies were returned to the villages, relatives would refuse to bury them. People spoke disparagingly of marriage regulations of other tribes, saying for instance: "It is because the Baganda are polygynous that this disease is spreading. It is because the Bahima share wives with brothers and fathers that so many are dying." But in the end it was "women who were Satan, the leopard who was to be killed, before it killed me", a belief supported by the notion that women fled to Lyantonde from Kyotera, when their husbands perished.¹⁹

When the project team first arrived in Lyantonde, the town was experiencing a severe economic recession. In 1988, the Kampala - Masaka - Mbarara - Kabale highway was rebuilt. It no longer took truck drivers a full day to negotiate the huge potholes in the forty mile stretch between Masaka and Lyantonde; they no longer needed to stop in Lyantonde town. This was compounded by internal strife in Rwanda. Museveni, charged with supporting the Rwandan Patriotic Front (RPF) ordered the border to be closed. As a result, tractor trailer

traffic dwindled. The subcounty was also experiencing the worst drought in many years. With little to harvest, farmers were selling land to get money to buy food for their families. There was little money for new clothing, alcohol, or school fees. Townspeople expressed concern about the physical safety of young girls and women who had to queue in line at boreholes (wells) late into the night to ensure their families had water the next day.

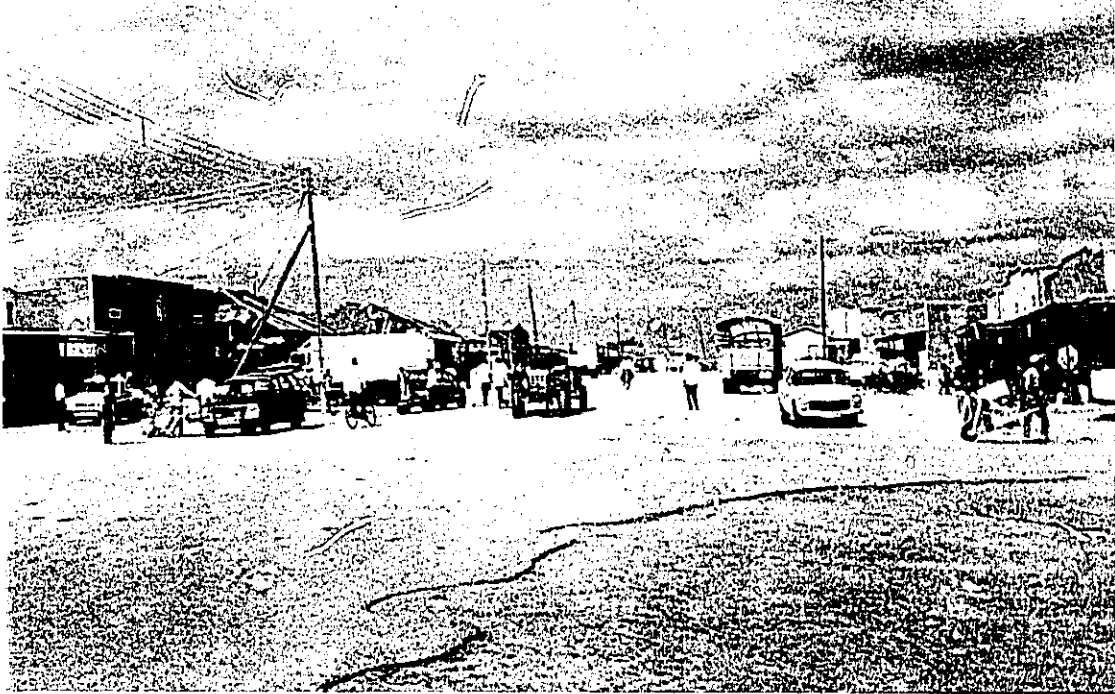
In addition, in 1992, bovine pleura pneumonia, a very contagious degenerative lung disease, hit the area. Many herds were lost. The state implemented a ban on the movement of cattle to markets, which killed the economic life of the itinerant markets, the subcentres for the exchange of goods and services in rural areas. Being the nearest trading centre to Kaliro market, Lyantonde and its bars and hotels lost the business of transient traders and buyers who lodged there after cattle sales.

When I returned to Lyantonde in August of 1994, the outbreak of the Rwanda civil war had marked the beginning of a whole new economic boom for Lyantonde, as the border was reopened. Lyantonde was once again a bustling place. Trucks once again could be seen triple parked on the main road. The difference between the Lyantonde then and the Lyantonde of the black market years was that the trucks carrying goods to Zaire and Rwanda were carefully monitored by the Uganda Revenue

Authority and there was little opportunity for illegal trade activity. Trucks, however, meant there were girls too. We witnessed very young girls walking around town in small groups, looking to rent rooms. Varying forms of commercial sex began to emerge once again. Women started to hop on the trucks and travel with these men as far as they were needed. Many coordinated their work to include "hanging out" at drinking places run by alcohol sellers. By the time I left, in December of 1994, formal prostitution was once again a lucrative activity.

Bibianna, Maama Somalia, Medina and Betty, Josie, Maama Mali and Kanniffa lived in Lyantonde town and are a part of its risk history. Their voices and stories that follow form the heart of this thesis. The views of these women about their "risk" for HIV infection demonstrate how grounded ethnographic studies generate essential understandings about HIV/AIDS, including alternative ways to consider modelling risk which will strengthen the design of culturally compelling interventions for HIV/AIDS.

Figure 5.
Lyantonde Town



The main road of Lyantonde.



Tractor trailers parallel park beside the shops; at dusk the street is packed with trucks.

ENDNOTES

¹ Originally entitled "The Lyantonde Behavioral Project."

² In 1989, 86% of the adult cohort surveyed correctly identified sexual intercourse as a risk factor for HIV transmission (Musgrave in Wawer, 1994).

³ The importance of embracing PAR was always a concern. We were also documenting the existence and structure of circulating credit associations, religious and ethnic tensions and influential people amongst various 'target groups.'

⁴ In their stinging commentary, Packard and Epstein (1991) locate this tension in "the clash between a dominant and successful medical paradigm, and a weaker less widely known social science perspective that attempts to expand the focus and methodologies of investigation."

⁵ These polar associations may be misleading as many contend that epidemiological method is an important instrument in the social scientist's methodological tool kit.

⁶ Both trips were funded by the International Development Research Centres' Young Canadian Scholars Award.

⁷ Our only means of transport were by foot and by bicycle.

⁸ It must be remembered that few are actually admitted to hospital. They go home to die. Few are actually diagnosed as having AIDS. And depending on the availability of shillings, some get treatment to ease the onset of opportunistic infection. Others do not.

⁹ This is called "target migration" (Obbo, 1981).

¹⁰ Instead of going to the borehole themselves, many hire a water vendor. They may charge as much as 300 shillings/jerrican.

¹¹ Lyantonde straddles the border of Rakai district and Ankole. Rakai is predominantly Baganda (agriculturalists) and Ankole predominantly Bahima (cattlekeepers). Luganda is the language of the Baganda; Lunyankole the language of the cattlekeepers.

Most Baganda in the district can understand Lunyankole. Most Bahima are fluent in both languages.

¹² The AIDS compound was located in a very impoverished part of town. In it were many households headed by females. Basically an area of mud and wattle row housing, with iron sheets providing shelter, many women who have lived there have also died there.

¹³ See Josie's case study for further elaboration on the distinctions between "daily men" and "permanent partners"

¹⁴ By the time the British established a protectorate in 1894, Uganda had developed five centralized and prosperous kingdoms: the Buganda, Bunyoro, Busoga, Toro, and Ankole.

¹⁵ Buganda was by far the dominant power among the smaller kingdoms and chieftain societies around the northern and western shores of Lake Victoria. They, were ruled by a Kabeka (king) and represented about 20% of Ugandas population.

¹⁶ Britain proclaimed a protectorate over Buganda in 1894 which extended to the rest of Uganda by 1896. Uganda gained independence from Britain in 1962.

¹⁷ Mafutamingi, translated to mean 'fat ones.'

¹⁸ When the Asians left, many people who occupied the shops in their place sold what was left and closed up. In Lyantonde, however, many others took over the shops and business continued to thrive.

¹⁹ Vincent and Bond (1991) found in their work closer to the Tanzanian, Ugandan border that war was foremost on people's minds. AIDS seemed to be just another tragedy.

²⁰ One of the very first towns levelled by war and disease.

CHAPTER IV

The Case Studies

***Bibianna:
The Story of a Stone Crusher***

Silimu? I already have it, when it enters you, you do not feel it; maybe you can give me ideas so that I do not die?

Bibianna was not originally on our list of cases to evaluate, however, we feel her inclusion in this dissertation is justified by our discussions surrounding who is and who is not in the Lyantonde context a 'commercial sex worker'. Upon consideration, the conceptual difference between the life situation of the bar girl and the woman who chooses multiple survival strategies seemed to grow smaller and smaller. Her story, though brief, illustrated to us that the threat of AIDS may not be the greatest concern when compared to the pressing need for food, shelter and water.

Bibianna truly lived in a world of women, partially because she 'kept' herbal knowledge passed to her when she was very young. Often a saucepan of herbs could be found steeping on her charcoal stove. Women and girls would move in, fill their mugs, and go. In such a 'public' place interviewing was difficult, but to be a part of the bustle there was exhilarating.

We had been walking on the Kaliro side of town, and branched to 'the rock', to find shelter from the scorching sun.¹ We were looking for shade and Bibianna offered to share the shadow of a tree. Bibianna was a stone crusher. With perspiration pouring down her face, breath smelling like alcohol, hands covered in dust, she showed us the most efficient way to wield the crudely made mallet. Many women, much like Bibianna, come here in the very early morning hours with their children, to gather up the rocks in big piles, and crush them to make smaller piles of fine gravel. This gravel, would be transported by lorry towards the construction of power lines to Tanzania.² From sun up until sundown, she crushed, and it could take almost two days to crush one profitable pile. At that time, each pile went for 500 shillings.

Her eyes told us about toil, weariness and the experience of poverty. Her story shocked us into the realization that some women, not just those originally delineated as 'target groups', must use sex to survive. Bibianna arrived in Lyantonde in August of 1992. Her explanation of why she ended up there was dubious, and perhaps not entirely truthful. It was a hazy story about a journey for treatment that included consultations with herbalists, diviners, and Western practitioners. It ended in Mbarara, forty kilometres from

Lyantonde, where she was treated and recovered from a serious eye problem.

After recovery, she said she was advised not to work, which meant no fetching water and no digging. If she returned home, she would be forced to work for her children. She had left her children in the care of her father, and with the money he gave her, she went to settle in Lyantonde. Bibianna had lived there once before, and in fact delivered a child there. That was in 1978, when she was still with one of her late husbands, whom she had married when she was just a child.

Her family is Banyarwandan. They went to Uganda to escape the political and ethnic furore in Rwanda during the 1950's and 1960's. Soon after they had settled in Nakivali, a Red Cross refugee camp located on the Ugandan/Tanzanian border, her mother died of rabies. Bibianna and her younger sister were raised by their paternal aunt. But when she turned nine her whole life changed.

A son of my mother's paternal aunt (her mother's cousin) came to visit. He saw me and he said "Let me take this girl, and I will teach her to work, instead of just sitting here looking after cattle."

This man was a military policeman in the army, so he took Bibianna to the barracks, where he and his second wife resided. Life there was fair.³ "I was fed, and I learned how to cook and clean." But there was tension in the household.

Every time this woman had a child, the husband would insist that it was weaned and taken to the wife in the village. And oh she would cry. Eventually, after the birth of the last born, they quarrelled over the weaning, and she deserted him.

Bibianna was left in charge of the baby and took him to the village where her uncle later joined them. After a couple of weeks, they returned to the barracks in Mukono district, close to Kampala. Her uncle's paternal aunt and a daughter of his first wife, accompanied them there.

After a few weeks Bibianna noted that 'her uncle' was preparing for some sort of party. He even bought suitcases of women's clothing.

I had been told that I was going to help the wife in the village, so I thought the preparations were for a going away party. He was buying busuti's (traditional dresses), skirts, blouses, I thought they were for the wife in the village. To myself I thought, can a woman as old as that accept wearing these ?

Instead, these things were for her wedding. One evening army men started arriving and drinking enguli (harsh gin), whisky and beer, began

I really did not know. I drank with every one else. It was the first time I had ever taken alcohol. I was fourteen. I was drunk, and his daughter helped me to undress. I woke up and felt a person pushing me, and a beard was piercing my face. I started alarming (screaming), I thought it was a soldier wanting to 'catch' me. I was shouting the name of my uncle to come and help me. When I saw it was him, I lost all my strength.

Her uncle in a matter of hours had become her husband. Bibianna believes it must have been the second co-wife who informed him of the beginning of her menses.⁴ At that time "He was fifty seven. He even had children who were older than me." Like many 'brides', she was cloistered, kept in the 'bedroom' for three months - and was expected to emerge pregnant.

Her father, said Bibianna, was absolutely furious. No arrangements for bride price had been made and the problem was compounded by the fact that he was four times her age. Traditional drink, tonto, was delivered to him through the military authorities stationed in Mbarara. Arrangements were made for the exchange of six cows, but Bibian insists that she truly felt cheated. It was very soon after her marriage to this man that the witchcraft evoked by the co-wife in the village began. She believes that the witchcraft affected her capacity to bear and raise her children.

Bibianna did not conceive until a year and one half later. The co-wife, in her opinion, took the life of her first child. This first death was related to a bundle comprised of a mixture of herbs and heads of safari ants left under their bed.⁵ This mixture caused the husband to go 'mad' and try to kill her with a machine gun. He was treated by a traditional medical practitioner and warned.

When the baby was only a month old, Bibian had to organize a visit to the maternal side of the family, to give the baby a name. Omukazi omukulu (the first wife) again visited and requested to know the date of departure. She then, according to Bibianna, sent 'mayembe' ('horns').⁶ On the way to Mbarara, the taxi flipped and her baby was killed instantly. Bibianna was badly hurt. This tension between the co-wives continued throughout their marriage, affecting successive pregnancies. She believes that if she and her husband had not gone to the traditional practitioners for help, she or her children would have been killed.

Each time her husband was transferred from barrack to barrack Bibianna was expected to follow. Finally, when he was transferred to Iganga, in Eastern Uganda she said she decided she had had enough. She was a 'grown' woman and wanted to go back to the husband's village, be in her own home, and look after a plantation. Coexisting with the first wife who cared for thirteen of his children was not easy. She did take some personal pride out of the fact that he treated the co-wife "like a son-in-law treats a mother in law." He was not 'meeting' with the co-wife; he just paid the children's school fees. All told (including the two children conceived when she would meet him in Iganga and born when she returned to the village) she had three children, one of whom died of a head

injury at two and a half. The husband died in 1985, as a guerilla fighting for Museveni's army. As a fairly young widow in a family with many brothers, Bibianna ended up resisting her father in law by refusing to become part of 'the inheritance.'

If I wanted to marry, it is up to me to decide who I am to marry. If I want to be alone, it is for me to decide to be alone. He cannot decide for me.

She refused, adamantly. With the last born weaned, she was making her own living by selling alcohol in the weekly village markets. One day when she was gone, the in-laws seized her belongings, dumped them in the courtyard and insisted that she vacate the premises. In addition, they demanded that she leave without her children.

I did not know what to do, so I took the main keys to the house, locked myself into the three backrooms, and cooked supper. I refused to emerge. They were so angry with me.

Her in-laws escorted her to the local authorities. She had previously reported the nature of the threats against her to the Resistance Council member (RC) responsible in their village.

They (in-laws) were insisting that at the time of the late husband's death, he had already chased me (divorced). That we were no longer relating (sexually). Everybody knew that this was not true. We were married. I was ready to die on my land. I thought to myself, "If these men want to kill me,

then kill me there. I will not leave the house and the children to suffer because of these men."⁷

The RC supported Bibianna, a decision which was not accepted by the in-laws. She says they challenged the integrity of the decision. "You are being biased, You want her around so that she becomes your malaya (prostitute). It is because you want to be going to stay in her house." As a result, the battle went higher, to the RC at the sub county level, and again the decision was in favour of Bibianna, "I stood in court against six men. I told them I have three children. Where could I take them? They have to remain on their land." She said they told her that she could stay and live on the land without having to marry one of the brothers. However she could never sell any of the land. It had to be left for her children.

Relations in the village continued to be strained. "They hated me so much they would pass without greeting me. They never came to my house, and continued rumours that I had been chased. Her father, in Tanzania, had by this time caught wind of the conflicts. He came and advised her to end the dispute. Since they were the 'fathers' of her children, she had to be 'good' to them.

At this time the father-in-law offered her a bull, a traditional offer of reconciliation. Her father returned to Tanzania, where relations with the 'real' brothers were

maintained. They had discussed events at home. One of the late husband's real brothers did return to Uganda. When he got home, he found a second wife. At first he came just as a visitor, as a brother-in-law. Eventually, Bibianna and he, produced three children. For Bibianna, the decision to remain in the village was definitely influenced by pressure from the in-laws.

If they see that she is still young and capable of having more children they (in-laws) make sure she stays in the family. The father-in-law will always insist that you are our daughter, you have to stay in the family until you die. This family paid bride wealth. The cows given to your father, could have come from the corral of any one of these men, so they say "Decide. Choose one, stay here, and marry.

Like many other women, she preferred to remain with her own children, instead of leaving them 'to be mistreated' in the care of another wife.

One weekend in February, 1990, she was in the village and this 'brother-in law', had taken a trip to Kampala. He fell sick while there, and was admitted to Nssambia hospital. He died of meningitis, immediately after his admission. He was seventy eight. "I ran to the bush and cried and cried." Because he had 'chased' his first wife, the body was brought back to Bibianna's home. After he was buried, Bibianna remained in this village. Eventually, another brother-in-law of the most recent deceased arrived with a few expectations. "At that time I used to be sickly ... He used to understand my

problems and he used to help me. We used to 'eat' (have sex) but not so much ..."

By August of 1992, she was living in Lyantonde, crushing rocks and selling charcoal illegally out of her single room, located at the end of a crumbling row of mud and wattle housing. Very few women can afford to buy charcoal in large sacks. A woman like Bibianna will invest in a sack and women will buy their charcoal from her, every day, in small amounts. Bibianna charged them between 100= and 200= per plastic plate.

Bibianna's biggest problem is depending on a boy from the village to bring her charcoal. Sometimes she would sell a sack in one day. If the boy did not come, not only is she out of money for a few days, she herself would be left without charcoal, unable to cook, eat or pay rent. But at that time she was getting some support. Her latest brother-in-law came to visit at the end of October. She says she thought of taking him to a lodge in town.

I wondered what this man would think. We shared the same mattress. When he asked for sex, I had nothing to do but to accept.

This man, a migrant worker in feeder road construction, had a wife and two children in the village. He stayed for a month in October and Bibianna asserted, "that everyone around here knows him as my husband." After bringing a lot of money at Christmas, he left her 2,000 shillings and promised to

return quickly. But she warned, "If he delays coming back I will have to get another man."

For Bibianna, Lyantonde was a much different place, compared to the time when she was here previously. She associated AIDS with urban life. In her opinion 'wife inheritance' was not a threat, but living in a town was.

I never saw anybody sick in the village because most there who died of AIDS lived in town, died in town, and their bodies would be brought back for burial. Now I know we all have to die. There is no way we can fight AIDS.

Living in this compound also meant watching people die.

She was an old woman, so sick and thin - with diarrhoea, coughing and wounds. This disease kills badly. For me, if I die from AIDS I would rather get all other diseases but diarrhoea. When I saw that woman that is when I felt that I was going to die.

Bibianna insists that she will die. She does not know where the brother-in-law has been.

The man has assured me that he does not have any other woman than me and his wife. He says I should trust him because "if he is to die it will be me or the wife in the village that kill him."

There was a time when she asked him to use 'obupira' (condoms).

He said "No, I cannot, for me, I am a good man. I fear if I used it, it would remain in the woman's body." He is a kind man. He wants "body to body." If he does not feel that then he believes it is not sex.

After all of this Bibianna said she did trust him. But the man delayed coming.

How many things have I eaten? I could have eaten that (the virus). I have another one I'm eating but these days I am also fearing him. He comes at night, because I fear the neighbours will tell the village man (her brother-in-law). He is a Tata (lorry) driver between Lyantonde and Kampala. This man knows I have a husband, so he comes at night. Sometimes every night. He stays for some time and then he goes.

He has two wives in Lyantonde. One is a Munyarwanda with many children. The other is a close friend of hers. She met him while she was visiting with her. "He started visiting me secretly at my home ... He helps me ... He promises to help with many other things ..." But Bibianna is afraid of this man, because of her distrust of other women.

Can a Muganda woman in this place stay there married without having another man? His wife can decide to go with another man and their blood would mix. When she comes back home, her blood would mix with his (the husbands) and then when he comes, our blood would mix. There is nothing I can do. He is helping me.

ENDNOTES

¹ 'The rock', is a place to which the team retreated to work, read or think. The view of rolling hills, cattle being watered at their dams, paths leading to the villages and of beautiful African sunsets is spectacular, a stark contrast to the squalor of town.

² There was an abandoned rock crusher at the site. It had been used when the Italians were pouring the Masaka - Mbarara Road. The rock was still blasted by dynamite, and the shattered debris was crushed into gravel.

³ He was of the Bafunbira, a tribal group whose territory straddles the Rwanda - Uganda border.

⁴ There are many we spoke to in Lyantonde who seemed to share this same experience, marrying much older men, and experiencing the trauma of the first night. They usually speak of blood, pain, and forced sex.

⁵ The co-wife had visited the barracks a week earlier.

⁶ Mayembe are the cause of common problems among families and relationships. Mayembe are manipulated by a traditional medical practitioner (TMP), through a real cattle horn. What is sent depends on both the power of the horn and the demands of the consumer.

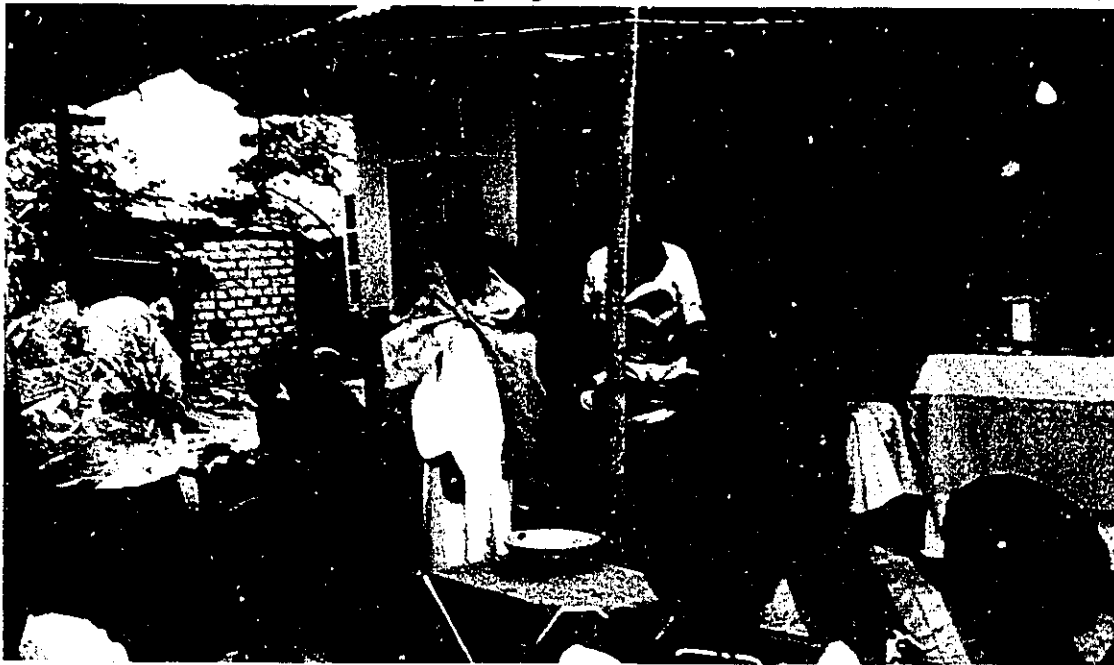
⁷ Bibianna confided that part of her problem with this situation was that these men were cousin brothers of the late husband, not real brothers.

Figure 6.

Death in Lyantonde



Burying the dead.



A picture of an heir receiving his inheritance and
familial responsibilities.

*Maama Somalia:
The Story of an Adolescent Co-Wife*

Janette and I had been greeting Maama Somalia on our way to town, passing her on the path between maize patches, behind the mud oven. Many times we would find her seated outside of her single room, in quite a dilapidated expanse of housing, preparing porridge or mingling 'posso' (maize flour). She was a girl who had been brought from the village to marry in town. Maama Somalia, though seemingly very young, was caring for a child who could walk, yet a child who never smiled. Having heard that we were "AIDS people," she came to our home to pay us a visit, and inquire about testing services in the community. Our hearts were in our throats when she said "I was pushed in for a dead man ..."

Maama Somalia came to us to find solace and information at a time when her world was in flux. Her marriage was failing and HIV was starting to inform the decisions she was making about her future. The snapshot of her life that she did share with us was painful and traumatic. She had come from the village a girl, and now she was doing anything possible to be able to afford to stay in town, as a woman. "Anything" includes prostitution.

Maama Somalia explained to us that her prepubescent years at home in the village were troubled. Like many children

being cared for by stepmothers, she feels she suffered inordinately. Overworked and underfed, she did not get schooling past P4. She is certain that it is her stepmother who persuaded her father not to waste his money on her. "I know," she said. "Why do you waste money on this child? She is just going to school to become a malaya (prostitute) ... What she has learned is enough for her."¹ Although she was hungry and tired a lot, she describes an episode of witchcraft which was to have irreversible effects on her reproductive life.

She recalled that some time previously, her daddy had bought her a new white panty. She had used it for sometime before she started menstruating. She had her period for a few days, and then it ceased coming for over a year. She told her paternal aunties about it and they too, were worried. They believed that if they did not do something, she would never have children. She says she had a feeling something was wrong.

" A feeling came over me like I should be moving, even if it was in the night. I would walk and visit relatives at nine, or even five in the morning. Whenever it came, I would just go." At the same time she realized that her white panty was missing. "I looked and failed ... looked and failed ..." Feeling that she had been bewitched she says, "I explained this to my father and he started moving to a traditional medical practitioner (TMP) ... They all explained that my panty was taken but they could not reveal who had taken it."

Her father got very worried. He got up early one morning and told her to dress up. They set out to find a TMP who lived in Masaka. After consultation, this woman told them that the step mother had stolen the underwear and had bewitched her on an anthill. For treatment, they were required to come back the next day with 4000= and a white hen. They returned:

and she got the money in front of her, passed it around her head clockwise twice, stopped at the collar bone each time and finally when she held it in front of her she started telling us what was in our compound, in the neighbourhood. She knew that the stepmother had tried with others but had failed. We thought, "This woman can work-otherwise, how would she be able to tell us these things? She lives so far. She told my father to go but leave me with her. It was around 7:30 when it started. She cut off the head of the chicken and left it to run around the village and into the bush. She went inside and picked withered banana leaves, herbs and mixed them with water. We walked with it and found the chicken at one empty (abandoned) anthill. The treatment had to be done at an anthill. because the witchcraft had been done at one. We got there and the chicken was lying dead. I was undressed and lying without clothes. She poured the mixture all over the head and body and told me to walk away from the anthill without ever looking back. She first dressed me and then told me to turn. I was given herbs and told to drink and sleep. Around 3 am the bleeding started.

Not surprisingly the extended female kin on her fathers side had been observing the situation. They decided that it was time that Maama Somalia, should leave her father's compound. Accordingly, a marriage was arranged. Her ssenga, a paternal auntie, who was also an herbalist, had to come to town to track down a woman who had not finished paying for her

child's treatment. She enlisted her support. A promise was made between the two women and the very next week the woman walked through the heat to let the relatives of Maama Somalia know that a man had been found. Maama Somalia was not introduced to him until he came to her village.

Maama Somalia adamantly assured us that she had not wanted to go and live in town. Her reasons were both simple and in a way ominous. It was necessary for her to be provided with dresses, and slippers (rubber sandals). She could not go barefoot, with one change of clothes. Maama Somalia felt that she could not go and live in town, as a dignified married, woman without them. On November 8, 1992, having been reassured that "these things will be arranged for you when you get there", an entourage of women escorted her to the man's place. Maama Somalia's father, however, a mobile market vendor, was unaware of these arrangements, and apparently was extremely bitter about it when he returned.

Maama Somalia was forthright about the fact that the man she married was not her first lover. In fact she explained that her first love had been a Christian, and she had tried to elope with him many times. But her family refused to accept them as a couple because of their religious differences. As she was not a virgin, she asked her aunt, the herbalist, for the "things that could bring her girlhood back." She was given herbs to bath in and a bundle that was to be inserted

the day before. When she arrived and used the pit latrine, it was removed.

The first night that we were together he showed much shock that I was a virgin. He said that he did not know these days that there were still young girls. He asked me if I had used herbs to make me tight, because when we had sex, I bled like a girl who had been ruptured. I could easily do that again, but with time a man would know that I had been married before, so he would not respect me if I bled. He would know that I had used those things.

She explained that her auntie was really an indigenous pharmacist, demonstrating expertise in the areas of sexuality (intercourse) and reproduction. She 'ties' (she knows traditional ways to deal with conception and birth), "has the herbs to mix in water to make the woman moist, and has the things that can make a girl go back to girlhood ... in fact she gets a lot of malaya (prostitutes) going from this town for treatment." She could never, however, help her with her problems of reproduction as they were more related to witchcraft than they were to herbalism.

She recounts that only a month after becoming married she was told by her neighbour, also a distant relative on her father's side, that her new husband had already lost two wives to *silimu*. Maama Somalia avowed that she had never ever wept the way she wept the night she found out he had lost wives to the 'thing'. One died in 1991, and one died in this past

January, 1993. "That time I cried because I knew that I was going to die ... I felt I had nothing to do because I already had the virus."

We had the opportunity to hear the same story from Maama Somalia's aunt. As she recounted the tale, she told us she found pity in her heart for such a young girl 'married to a dead man':

His other wife was sick while she (the first wife) was pregnant. She asked for treatment but he would refuse. He is mean (miserly), he provides everything in the house but cannot let his shilling go to the woman for anything, he is the one to buy the sugar and the food. The woman (wife at that time) was worried that if she herself did not get the treatment the kabotongo (syphilis) would grow and affect the child. He was not providing so she went to her parents' village to get herbs for treatment, and gave birth. But she was still so sick, and the baby was also sick, that the father of the woman sent her away, told her to go back to the man. They had sent for the man but he even refused to take food or shopping from the child. So the father sent away (back to town) the daughter and the baby, even though they were all sick. She did not receive anything when she got back to town. She fell even more sick and returned to the village. The father refused the child saying, "I am not going to bury two people." So they both returned to town and he (the husband) provided the child with treatment but not her.

She went on to tell us that the wife's health had deteriorated so much that she had to be returned to the village. The child was improving so she was left there in town. Apparently the woman in the village requested to see her child before she died. Her own father was even the one who had come to town to bring the message, but the man just refused. She died when

her first born, Somalia, was around nine months old. Around the same time, Maama Somalia married into the family.

The knowledge of the sequential burials of his wives, and that he himself was both a widow of AIDS and provider for an extremely sickly child, led Maama Somalia to adapt to her life and relationship a little differently. In direct contrast to the deferential behaviour expected of the newly wed, she became tenacious and defiant.

There are some days when I think all day I am going to die. I worry so when he says he wants [ie.sex], I push him off by saying "You take away your silimu." He keeps telling me the same thing, "Take away your silimu?, who will not die from it? Even if you say that it has already entered you, if you refuse there is nothing to protect" I tried to keep off the man, I tried to put him off by saying "You put off your silimu." I would be so annoyed, he would grab me harshly and say "You think people who have silimu are not people? Me I have my silimu but I am working and eating, even if you say it there is nothing that is going to help you, you are already dead." Sometimes he just grabs me and holds me down and I want to scream loud, but since I am a married woman everyone will hear me and say what is wrong with this woman. I had nothing to do and I accepted. Who does not have silimu on this earth? Everybody on this earth is going to die.

After a few days she returned to the village and informed her father about her husband having women who had died. Resigned, her father responded, " There is nothing you can do ... you have already got the virus." He told her to go back to the man. "You are already dead." When Maama Somalia arrived in town, the last wife had been taken to the village only a few days before. She found Somalia, the step daughter, there

in Lyantonde. The co-wife's last born died a few days after it was delivered. According to Maama Somalia, the family continuously sent messages to the husband to go and visit; he, in her opinion, stubbornly refused to go. Later the ailing co-wife sent for her child as she wanted "to look at the child before she died." Maama Somalia says that he still refused to go. "When the woman died, he was invited for burial."

Maama Somalia believes that he did not attend for a number of reasons. He decided that he could not leave his new wife to fare for herself when he was gone. For Maama Somalia, the primary reason was his obvious "rash." " He would have to feel very embarrassed in front of all those people ... Sometimes he thinks about the dead woman and says, 'Oh my wife has died.' I would ask why she had to go and die with the parents, if he liked her ... He said it was because of his own problems, town problems, which you will go through because you are still young ... I will not go through them since I am going to die."

Upon reflection, she says, " He had a very itchy rash all over the body ... at first he thought it was malaria ...but then it was this traditional disease, 'obusere'... It was caused by worms, and there comes a time when they burn you from the inside. It was treated by smearing ripe bananas twice a day all over the body ... in fact, I used to help him with this thing ... I also believed him." For a month Maama

Somalia cared for both an ailing husband and his child. All of his earnings and savings were consumed by treatment costs, particularly antibiotics obtained in local pharmacies.

It was serious malaria. He did not work. He had promised to buy me clothes and shoes. He would just say "you see now I am sick I am not working. How will I get the money?" He promised to buy me those things when he got better. Now all he is spending his money on is his treatment, his injections. Here I am almost walking naked. He cannot even give me a thousand shillings to buy second hand clothes. The only thing he has bought for me is a lesu (thin cotton wrap).

She had been married for just a few months, when she first arrived at our doorstep. At that time she still carried some hope, although her attitude was grim.

For me, I want to be tested and know the truth. If by luck I have escaped this thing, I will go back to my parents and have nothing to do with men any more. If I am infected, I will still go home. I cannot be weak here for nothing. Even if I am sick I do not want to pile on the virus, add more to what is already there, and die more quickly. But now you see I am a married woman, there is no way I can refuse to have sex with a man I am married to.

Maama Somalia insists that his chronic illnesses did not guarantee that he might be too tired at night to 'meet'. "He is all right in the night until the morning, and it has to happen every night. At that time the husband was down with fever, almost every day, and was in bed by five. "I asked him, 'What sort of malaria is this that you have?' ... He just said 'why are you concerned? You just leave me to die' ..." Like

many others, Maama Somalia, assuming that she is indeed sick, is mentally planning to control the indignities caused by a deteriorating immune system and has decided on suicide. The most virulent part of the wasting, the diarrhoea, is what people fear the most. " When I start getting sick, I am not going to wait to get very sick ... I will just kill myself and there are so many ways to do it ... I will just go to a shop and buy two new batteries to a watch, and swallow them with *enguli* (potent gin). Then I would go to bed and they would find me dead ... They would keep asking, 'What is it that has killed her?'"

I do not want to punish my parents or myself, My mother died when I was young, just two. I was told that when I grew up, it was with a stepmother. When I get sick and weak with massive diarrhoea, can this stepmother clean me up? Your father's wife cannot be helpful when the sickness has gone that far, and if he is caring for me and he has to move to the markets, and it is just her? I will have to stay in the diarrhoea and sleep in it. Why do I have to punish myself like that? These things are for the real mother. She predicts that her father will say "You be sick and die here and I will bury you." You see, really I am the only child at home from the first wife. The step mother had a son who has died, and has just recently produced a daughter, who is only two. If I get sick, my father is going to cry. He has always quarrelled with the auntie. He says, "You, you are the one who has pushed her in for a dead man. You rejoice for you have children, mine is going to die."

Their relationship, the father and his sister, has not been the same since they learned about the husband's sickness and dead wife.

The depth of her mourning can be better understood when one considers the fact that she is a young newly wed who has never borne a child. She said she glared at this man who she believes has killed her and said, " At least for you, you have had children, but me, I am going to die when I am still young and I have not had any child. My name is going to tarnish ... you see, for me, I am going to die and leave nobody behind ... If I could at least die having someone so my name can continue ..."

Apparently Maama Somalia is aware of the risks of having a child and being sick:

If I get a child, the child will die, there is no use suffering for nine months to give birth, and then the child dies. In addition, her husband, she says, finally acknowledged that the presence of infection in his only living child was a real possibility. "He does not like children. He says, 'The ones I have are enough. What is the use of having children who are going to suffer when I die or will themselves die?'"

I did not want to bear children after I had been told by my friends that he had women who had died of silimu. It was then that I decided I would not produce; after all, the child was going to die anyway. It was at this time that she disclosed that she had indeed early in her marriage aborted a child: "I missed two months. By then I knew I had to be pregnant and I did not want it."

She was advised about a root which could be crushed, boiled with water and then taken internally. The very next morning she started bleeding heavily, expelling very large clots. It

was very painful. The bleeding ended up lasting for many days. "The pain would continue and I was saying to myself 'Why did I do it? Now I am going to die here!' ... The man used to see me bleed ... He had seen the herb and asked me what I was boiling ... I told him they were for the premenstrual cramping ... I just told him it was confusing me ... so with time it stopped and I became normal."

What is the use of having children who are going to die? I hear that when a woman has the disease and bears a child, it cannot go beyond six years. A child dies and the mother dies. If I died and left a child it would, of course, suffer and not grow. My parents of course want grandchildren. Who can hate a grandchild? It is me I cannot allow my daddy to lose two people at a go.

We approached the HIV counsellor, about the possibility of having Maama Somalia tested by RAIN (Rakai AIDS Information Network), a local non government organization (NGO). Maama Somalia did not show up at the clinic for the test. It was agreed that maybe it would be better if the counselling for the test was done at home. Unfortunately, for the first time since we had met, Maama Somalia fell seriously sick. There was an aura of sickness that pervaded the whole compound. The neighbour at the door right beside them -- a bargirl at Dembe- - was also down. Her auntie, a malaya from the early 1980's, had genital lesions so badly she could barely walk. It was raining, so the malaria was crippling people. However, for Maama Somalia, this bout was so bad she definitely thought

that she was finished. "I really do not know (what is making me sick) but these days mosquitoes do not bring malaria ... When they start biting you, it is not malaria, it is this virus. " Maama Somalia never did make it to the clinic for a test.

Tension developed in her relationship with the husband and her behaviour, she felt, was justified by her own 'apparent' loss of life. She started spending more and more time at the borehole (well) and water camp. Before the husband fell really chronically ill, he was able to spare money to buy water from a vendor. So it was not necessary for Maama Somalia to have to line up at the borehole. She could spend her time at home, caring for the child. One day when the cash just was not there to buy water, she did go. And the time she spent there was far too long for her husband to tolerate. She says, "The line was very long, and I had no choice but to stand there and wait ... He wanted porridge and there was no water to boil it ... He said that I was waiting there for men ... He did not beat me that time ... though he told me to go and pack my things ... " This had not been the first time he had advised her to leave.

Taata Somalia was the one who had the control over the shillings. He was the one that went daily to the market to buy food for her to prepare. If he did not have any time he would give her shillings to buy the things specifically for

that meal. "He never leaves me much money. I can never decide what to buy, and there is never any emergency money if he is gone and the child gets sick ... When visitors come from the village, I alone have to figure out what to do ... I cannot count on his support."

Sometimes Maama Somalia finds herself immersed in despair and with bouts of anger. Living in town with the support of a man, does have its benefits. "Some times I feel that my life is not so bad ... at least I do not starve ... He eats 'posso' (mingled maize flour) all of the time but sometimes if he has money he will buy me matoke (food), even sukaali (sugar) and porridge for when the child gets sick ..."

She does, however, really feel almost suffocated by the complex of sickness that she is immersed in. The burden of care for such a young girl is astounding. She says she finds the child there in the bed just making diarrhoea, all through the night, then faces the soiled sheets, the washing, the cleaning. "Sometimes he comes home takes tea, and tabs -that is all he swallows- then he is in bed by 5:00 pm ... The baby makes [diarrhoea] all of the time, even where she is seated ... I have to wash all of the time ... and she cries ... Sometimes I just refuse to do it any more and that is when we really quarrel ... I feel just like a housegirl ... Sometimes when it is just me and this child and we are alone, I beat her seriously ... To make things worse, Taata Somalia was quite

aware of what was happening in his compound. As a carpenter, his place of work is on the main road coming from Mbarara, into Lyantonde. The shop is located on a slight incline, so he can see what Maama Somalia is doing and what she is not. It is from there that he could also hear his own child screaming from both sickness and neglect.

This behaviour was certainly not condoned by her paternal auntie who lived across from her in a brick shelter. As extended kin in town, the paternal auntie assumed the role of the mediator in Maama Somalia's relationship. "My auntie quarrels with me to carry her (the child) on the back but I just refuse ... She tells me to just go and cook, but I do not care ... She says he is the one who married me and I have to respect him ... but me, I do not care. Maybe I am the one who married him ..."

One day we happened upon Maama Somalia's auntie washing her things in a basin. We found that her niece was not around, so we chatted for a while. Her comments were very illuminating. She believed that Maama Somalia's defiance was seriously challenging the norms of behaviour expected of a young married woman. The child was not being cared for.

Figure 7.

Children



The future of Uganda.

He used to have a houseboy who cared and cooked for the child when he was gone, but when she came, he went. Now the man has to come around and make sure the child has eaten. She refuses to wash the child's things; she just lets them pile up there beside the door; she says she is tired of washing dung and "I cannot suffer for nothing, Is that my child? Am I the one who produced her?" She is just not humble. She is not supposed to fetch water there at the camp, but she insists on going there.

According to the aunt, Maama Somalia has found a way to get water for free, by getting a man at the water camp.

She stays there the whole day and comes back in the lunch hour when things should be there cooked. She tells men there that "Me I am not a married woman. I am just renting a room," so men come there and 'play' in the house. He (the husband) complained, he told her to stop going for water, but she said to him "Me I am not a married woman ... you did not give me a busuti (dress, typically associated with kiganda marriage custom). If other men want me, what can I do? It is them who like me." Through the night she would quarrel and shout, and people would hear what the quarrel was about.

Her auntie explained why she was so startled by Maama Somalia's public impropriety. "You see, a married couple has an office. They discuss things in bed, and it should end there; they should not bring it out in public." Her auntie also feels that from very early on in the marriage Maama Somalia had never intended to stay. " Even before they shifted to this place ... she took sheets (bedding) from there and kept them with a friend. The man pressed and insisted and threatened her, so she brought the sheets back ... just

recently she has stolen two good sauce pans and glass plates (luxury items) ... She is serving guests in plastic plates ... " This auntie takes responsibility for the marriage lasting as long as it has.

If it were not for me educating her, she would not have lasted two months in Lyantonde. Now she wakes up in the morning and walks (in town). She leaves the compound dirty, it is not swept. There are no clean saucepans; the house has not been kept, she does not wash the bed sheets; no other man could ever manage her character. To my knowledge a malaya (prostitute) should be neat and clean, keep her home clean. If she wants to be a malaya, she is failing. She is very dirty. She is moving with many girls with many men in town. She tells me to find a better wife for the man if I am siding with him so much, but when you are married you do not have to be good because you need to, it is because you have to. In marriage you cannot go so low as to answer back. This auntie was married to a much older Muslim man when she was thirteen, and she says that of course there were conflicts. He had children that were much older than me. If I was annoyed I would hold my breath until I would feel like bursting. He would say, "Wait, Tell me when we go to bed."

Maama Somalia does admit to having a friend at the water camp. She was really circumspect about it. The lines at the borehole by the Catholic Church are far too long, so she goes to another borehole. Her friend from town had made friends with one of the woman from Northern Uganda who had travelled there with her husband and their children. She said she would go to her place to talk with her friend from town and that is how she met Wassawa (from the North, but the name given to twins in Luganda). She told us that this woman was the one

who had access to the tap. She also said that sometimes she would go to this man's room and cook and iron for him. Apparently, she explained with a measure of disdain, he had had a girlfriend, a small woman who eventually left. So he started taking his meals in Dembe bar and restaurant. This is how he came to know the waitress who lives beside Maama Somalia. And it is through her that messages from him reached Maama Somalia. "Sometimes he would come to my room and sit there or send this girl to call me and insist that I go to his place ... or go somewhere to 'talk' ... but me I am a married woman, he wanted to take me out of this marriage, take me up to his village in the North ... so I could stay there and this man would not know where I am ... Every time he said this, I would insist that I am married and I could not accept."

As Maama Somalia's disrespect became more public, tensions escalated. This accumulation of bad feelings and distrust led to a rather turbulent dissolution of their relationship.

I had gone for water up at the SWIP [South Western Water Improvement Project] camp, delayed there, and returned late around 7:00 pm. There was nothing there to prepare for supper, no *matoke*, I asked him to buy something at least. He barked rudely that he did not have any money. He stayed in the room and around 7:30 or 8:00 pm, he went into town to eat at a restaurant. I asked for *sukaali* (sugar). He refused, so I prepared tea without sugar and some left over *catogo* (beans and cassava). When he came I served him this food and he refused, he would not eat. Around 8:30 he decided to go to town again. He stayed there up

until ten in the night. I made the bed preparing to sleep and I saw a big stick hidden under the mattress, and I kept asking myself, "Who is he going to beat?" So I went out and sat on the pavement. When he got back, he asked me if that was where I was going to sleep. He shut and locked the door to our room. I went and slept with my auntie. The next day he woke up and cooked porridge for his own child. After he left I went back over and opened up the house. When he returned he was surprised to find me there, instead of returning to my father's home. "What are you still doing here? What do you want from me? Pack your things and go." A quarrel over the stolen glass plates ensued. I told him, "I know we are poor and we cannot afford these things, but I would not steal your plate for my father." He insisted that I leave then. But it was dark, in the night, so I refused.

The very same scenario happened the second night. But this time the auntie intervened and begged the husband to allow her to stay.

The man told her that he was going to pack up his own things and his child to return to his own mother, because he said that he was dying. She said to him, "So you admit to killing this girl?" He allowed me to sleep on the floor. As I was sitting on the mat he pulled out the stick. I scorned him, asking, "Why are you pulling out the stick? Who are you going to beat? Who is the child here?" He told me to lie down flat and I just told him "Your fellow men use their fists and slaps, how can you beat me like a child? ... He said, "I know why I am using a stick." The flogging started across the shoulders, all the while he was slapping and kicking me. I screamed loudly and my auntie ran over and pushed the door open. That is when he stopped, I slept there on the floor. My daddy arrived very early morning. All the while the auntie was trying to reassure me by saying that men usually do beat like this, and that things could probably be still worked out. My father insisted that I pack my things, and return home with him.

Upon her return she started digging and was in charge of managing a part of his maize plantation. But this did not keep her from walking to and from town every other day, visiting friends, us and trying to find a job that paid real wages. One evening, around dusk, when she was making the trek back home, she was accosted and raped.

The trail back to her village is a lonely one and her assailant was waiting for her behind a tree, about halfway back to her father's compound. Called early the next morning, we found her sitting beneath a tree at the health centre. We barely recognized her, as her face had been so distorted from the beating. Her breasts and thighs had been slashed by a machete. There was a bite mark on her cheek. We could smell the struggle: perspiration, blood, and body fluids. I will never forget what the government doctor at the health centre said to me: "Every woman in Lyantonde should get a tetanus shot."

After the attack Maama Somalia divided her time between both town and village. It was only a few months after that lesions, ulcers, started appearing on her legs and upper thighs. "I am going to die of silimu and the signs are already showing ... I am now just waiting for malaria because I know when a person has the virus and gets malaria she dies very quickly ... The only thing that I have left is to feed well ... My problem is my father does not have money now ... in

fact he has not even worked for this week." She says she is tired of staying at home, in the village, without doing anything, but at the same time she is tired of digging every day. Sometimes she comes into town and helps her aunt, who trades in matoke and runs an alcohol selling business on the side. Maama Somalia is forthright about the fact that her aunt uses sex to supplement her earnings. "She 'serves' any man ... some of the men offer me waragi for 200= or 500= to drink and I accept, but I instead put it back in the jerry can and use the money that they pay for it ..."

Now my problem is I need to do something to look after myself. I even told my father that I was a grown up girl and I needed so many things which you may not be able to provide or which I may be shy to ask you for, like panties and slips, so I have to do something to earn money.

At that time her father wanted her to keep working in the plantation, growing maize until she got a job. She said she was ready for any job, with the exception of being a house-girl.

Many of my friends are trying to convince me to come and live in town. They say, "What are you going to do in the village? How can you live in the village at your age? Why don't you come, rent a room, and stay in town? Don't you know that it is easier to get money in town than in the village?"

Many of Maama Somalia's friends are between sixteen and eighteen. Three of them work in hotels, and two others, she says, "are just malayas. They stay at home and wait for men." What shocks Maama Somalia is that these girls do not work

anywhere but they have things like sugar, meat, oil and creams in their houses.

For me I am here waiting to see how the world is moving. I cannot hurry to get a man or move from man to man and these men take what little strength I have. If it was possible I would buy a "padlock and put" or buy "threads and sew." Some of my friends are even convincing me to find a man and he will give me everything I need, but I know it is just luck to find a man who gives out money. How many women are malayas sleeping with about ten men per day but living very poor lives? It is just chance.

As a young girl, Maama Somalia has suffered. One day after her attack she explained to us the kind of reasoning which brings young adolescent girls into town. She asserts that girls learn about men, money and sex at early ages, at the borehole, getting water, or when they are sent to collect firewood.

Even girls from around 6:00 pm start coming at dark. They use the plantation, banana grove, as a lodge, and it goes on until late ... at eleven you can still hear them. Even young boys will shout at them, "Shame on you ... we see you coming out of the bush." Girls can only come out of the home for firewood and for fetching water. So they deceive their parents. There is no way that a boy can go to their home or send a message through another boy, even at the borehole. There are young girls of age ten, going with men of seventeen, eighteen and twenty. Some are married men and they come to have sex with girls. They keep playing around, asking these men for shillings. They can at one time ask for 100= or the next, ask for a soda. So they behave in ways that attracts these men, so they end up having sex with them. For me, I do not believe there is anything like defilement. Usually it is the girls who want. They see or hear people having sex at an early age. From what I have seen the ages are getting lower and lower.

Maama Somalia explained to us that young girls move to town looking for employment.

You can see young girls moving door to door. They ask, "Do you have any work so I can work for you?" Such girls' parents, either are so poor they cannot help her (dressing, feeding) so they allow her to come without anybody. Or, she thinks within her, things are bad, so she escapes from home. Some girls come from the village to work in order to help their families, to take them back something. The work is not enough, so they get men, take that money back to their homes.

Alternatively some girls are taken from home by visiting relatives, so they go and help them with work. Others are forced to leave because of mistreatment by stepmothers. "The mistreatment may be so much, the father not supporting the daughter and staying on the wife's side ... so the neighbours, other relatives around will encourage her to leave ... They say, 'But you are grown up now. Why do you not go find somewhere to stay - find something to do, so you can look after yourself instead of suffering here? ... So this girl leaves."

Some girls in the village do have good things: good shoes, nice dresses, creams. If they look at these nice things, they tend to admire that girl. So they also move to find these good things. Even within town here, that is why you find very young girls moving with very old men, or men with money, so they can get those things they see that the others have. They think, "If I get a boyfriend, I can also get these things." Not all men give; it is just luck that you find a man who gives. Sometimes the girls who come to town looking for jobs may just be deceived by these men. The man will tell her, "Instead of doing this, why dont you come with me and I will give you this and this and this?" She

will go with this man but he will be deceiving her and after a few days this man will leave her. When he sees her pregnant he will leave her and do the same thing to another girl. Some girls come here to marry. They see they are not giving them what they promised/expected, so they decide to get other men who will give them money. The most painful thing is when he has money, and you ask for some and he says he has not got it, so they go out and move.

Maama Somalia has separated herself from us this past year. We catch glimpses of her moving in and out of town, with friends at her auntie's, or by herself. She did move back to town permanently, renting a single room for herself, raising money for rent by working at a bar in town. Shifting into town and supporting herself was not easy to do, as she had no property of her own. But through bar work she has managed to buy some plates and cups, charcoal stove, and a sauce pan.

She has chosen squalor in town over the drudgery of life in the village. We have found her sick, by herself, not having eaten for a few days, with dirty plates covered in flies, and basins filled with urine because she was too weak to reach the pit latrine. We have watched her beg from her neighbours for soap and water to bathe herself. Each time she falls sick she says that she found herself thinking, " 'I did not know I would get better, I thought my 'thing' was for sure taking me ..."

Now whenever she does fall sick she sends a message to her father in the village for help in the form of both

shillings and food. When she cannot work, she cannot treat or feed herself. Her father instead advises her to move back to the village. "But I cannot go and get sick there. People in the village will start saying that I have AIDS ... and even if it is AIDS, I will only go there when I am no longer understanding." Resigned, she said, "I would have preferred to die a married woman, rather than a single one." She believes that people compare how women die. " People will blame the single woman living alone in a single room, saying she was a prostitute, that is why she died of AIDS ... But for the one married she will be buried with respect." This is because a 'married' woman is not expected to bring the disease into the family. "For me, I cannot deny that I do have sex ... So many come asking for it ... Some I agree some to, I refuse ... of course, you cannot accept everybody ... You know men, once they see you, they cannot stop asking ..."

Every once in a while we see her, lips smeared with colour, wearing short tight skirts walking with other young girls in town. For us, she is no longer a girl, she is a woman, a woman who has fully embraced sex work, as a way of providing for herself. We hear rumours that she moves with four or five men per day, if her luck is good. She frequents the discos, a place where she herself had said, "Girls go and start sex as early as possible so that they make enough money by morning ... They play (have sex) behind walls (unfinished

buildings), and nearby bushes, and some go with men to their homes."

ENDNOTES

¹ Abuse at the hands of the stepmother involved the following: physical abuse; overwork, hauling water and fetching firewood late into the night; lack of food and medical treatment, and witchcraft explained incidents.

*Medina:
The Story of a Waitress*

It is said that in the late 1980's, when every night was like a New Year's party, groups of women would 'move' up and down between trucks like 'schools of fish', but they could not 'decorate' the verandas of the hotels or bars unless they were employed there. Rumour suggests that in those days women working as waitresses and bar girls in town would actively 'recruit' young girls from the village to work in the hotels. We met Medina at a time when Kabula sub county was dry and people were hungry. Crops had failed for two consecutive planting seasons. The owner of one of the maize mills in town was once heard saying, "If it were not for this disease, I would be going with many women". With very few shillings, women were coming to him offering themselves, in return for food. Medina, however, a waitress at Moonlight Hotel, was guaranteed a plate of matoke per day.

Medina worked at one of the many hotel/restaurant establishments which served the transient population of Lyantonde town. Medina and about eight other women came to work in shifts, morning and night, serving food. However, many of these establishments, do not actually pay anything to these girls who work for them. They work for free, and in

return they have the social opportunity to meet men who are interested in paying for sexual services.

Despite the continuing recession and drought, Medina was one of the busiest women in town. During this time, discussions about commercial sex work were very painful. Women, after the encounter was finished, were virtually begging for every single shilling. "One morning I explained my problems. The man said to me that he did not have money ... yet I knew he had ... It is so painful for someone to refuse you when you know he has the money ..."

Medina is a rather plump, always smartly dressed young woman of 21 years. She is a Mukiga from Sizi county, Rukungiri district of Western Uganda. She was born into a polygynous home, her father having acquired four wives and approximately 20 children before the time of his death. When she was still a newborn, barely two months old, her father gave her mother a very fertile and promising piece of land. Tensions escalated between their household and that of omukazi omukulu (the first wife) who demanded, "How can you give this piece of land to this one who has no male children?" At that time her older sister was three.

One night when the moon was covered with cloud her mother went behind to the latrine. A very vengeful second son of the first wife had hidden himself, and he tried to chop off one of her arms with a very sharp scythe. He not only disabled her,

but also caused her death. "She fell down screaming, helpless ... She bled so much...", and died within three days. Two years later, her father died of tuberculosis, which had plagued him for years.

She grew up having "no picture in my mind of what my parents were like". But because of this murder, both she and her sister (of the deceased mother) have access to the plot of clan land, should they chose to marry and settle. Medina was raised by the first son of omukazi omukulu, a banker. When she was ten, he was shot and killed while driving at night in Kampala. She was then adopted into a cousin brother's family, in a place called Ntungamu, Rikingiri district fifty miles from her home village. He is a political cadre. In his care she was educated up to P4, but dropped out because of his inability to pay school fees, even for his own family.

Medina says she liked moving from the town where her brother was very strict, to the village where she was more free. Her father was dead so there was no one to restrict her movements. Between the two places she cultivated both sweet and Irish potatoes, beans, maize, onions and millet, but eventually found herself pregnant at the age of seventeen. When it was discovered by the cousin brother's family that she had 'loved' this boy, "They were very bitter. They abused me,

and beat me until I stopped relating with him." The boy was a cultivator living in the same village.¹

She escaped her family's wrath by fleeing to the home of a step sister. While there, she gave birth to a baby girl. When the baby was two months, she shifted to her stepmother's (father's third wife) place in the village. At one and a half years, Medina's baby girl died a sudden death "of measles that stayed in the stomach ... very high fever, red wounds in the mouth, there was no rash..." The child lived and died without ever having seen its father. After the death of her child she went back to live with her cousin brother in Rukingiri, continuing to maintain relations with her friends and boyfriend in the village.

During this time Medina maintains that her brother's wife was becoming increasingly difficult to live with. In her brother's absence it was rumoured that this wife had a lover in town. When she discovered that Medina was reporting her movements to her brother, her reaction was of course embittered. She scornfully demanded, "Were you brought here as a watchman to look after me?" Coincidentally, Medina also found herself pregnant for the second time.

Her predicaments caused her to go to Lyantonde to find her older sister, a market vendor who had married an itinerant used clothes trader. Upon her arrival she was advised to

return and contact a traditional practitioner in her home village who would "tie her for some time". When she got back to Lyantonde, she had to find employment. Her sister, who had worked at Moonlight before she got married, arranged for her to serve tables.²

Medina has been working as a waitress since July of 1992. She found working there difficult "At first," she said, "I feared so much", living in a room with a lot of other girls who "used to scorn me because I was new". It did not take long for her to acquire enough money and the basics, like a mattress, bed and bedding, to move from Moonlight into her own single room.³

Medina asserts that Moonlight really does pay the girls, (although we remained sceptical), 6000 shillings/month waiting tables which she maintains is a good salary for the work they do.⁴ The women who serve food at Moonlight Hotel work in shifts. The first shift requires that they arrive very early in the morning to serve breakfast to customers -truck drivers and traders-- before they depart Lyantonde. Tractor trailers can be heard departing from town as early as 4:00 am. The girls work until about 2:00 pm, before the next shift arrives to serve lunch. After dusk, particularly on nights when many trucks are expected, most of the girls wearing make up and pretty dresses, were seen "waiting for men."

Most women like Medina support themselves by consolidating both short term, and long term relationships with the men they meet through their work. Soon after she began working in the hotel, Medina was able to see clearly the benefits of being supported by a permanent partner. When we first met her, she was having a relationship with a man who worked for the Uganda Revenue Authority. He would pass through town in a white land rover every two weeks or so (either on a Monday or Thursday), escorting lorries to the Zairean border.

He says he wants to marry me, but I still fear ... He is a married man with children ... He wants to take me to his parent's home. He has told me that he has informed his first wife ... I think I will marry him if he helps me a lot.

This man was a Musamia from Busia, a border town in Eastern Uganda. Because it was inconvenient for him to always stay at a lodge, he rented a room for her. "He is the one who has brought the idea of renting a room ... He does not want to be bothered with booking a room in a lodge every time he comes ... When he does not come he writes a letter and sends money with a friend who is passing through." As a permanent partner, this URA man was expected to provide continued support to Medina over the month -- pay rent, purchase furniture -- with the assurance that she was there for him, sexually and domestically (cooking, laundry), when he passed through. Despite the fact that he is a man with a wife in the

village, and she is a waitress in a hotel, they decide to trust each other. Confirmation of trust comes in the decision to discontinue using condoms.

Medina explained that when she is introduced to a new man, they do challenge her about her sexual past. " They want to know anything bad that would make them die if they do not use condoms ... they say 'I do not want to kill my family'" For Medina answering honestly is not an option, so they decide against using condoms and "they trust each other." In her previous 'relationship' with a cattle loader who had two wives, they used condoms the whole time they were together. "The man introduced them because he thought I would be sick ... I also accepted because I thought he would be sick." This man eventually did want a child with Medina but it never happened because, in her view, "He continued to doubt my health." Medina explained that 'playing' with daily men was humiliating because after having sex they had to plead with the man in order to be paid. However humiliating, it is not difficult to negotiate condom use with daily men. "They automatically assume we are sick."

This lament often took place in the morning but payment was not necessarily guaranteed.

In the morning I tell him my problems, my needs ... If the man did not have money he promises to bring some when he returns ... The second time, if he did not have the money, you must be patient and he sleeps, maybe he would give you the next day

... you have to be patient ... If he did not give you the second time and comes back the third time ... you must send him away ... Does he not see your problems? ... How would he expect you to bathe? You would rather get another one or be there without a man ...

One morning I explained my problems ... The man said he did not have money ... and yet I knew he had ... It is so painful for someone to refuse you, when you know he has the money.

He went away, and in the evening went straight to another lodge/bar in town. From there, he sent a man to collect a different girl. "It pained me so much I knew the girl but what could I do? A man who gives little money is commonly referred to as "yali agaba abusente obuganda", a miser.

At various times Medina did consider the idea of finding refuge in marriage. The man from the East wanted to introduce her to his parents and wife. According to Medina his wife did not want "extra sex partners", but if it was necessary, she demanded that Medina go live in the same compound. " Maybe she thinks that if we are not in the same houses that I would be given many more things." (more materially than she). Later Medina told us she felt the woman wanted her in the same compound to "monitor her behaviour."

Although this man did not insist that she go to the village with him, with the promise that he would help her start a shop in town, he demanded that she leave hotel work altogether. Medina was completely resistant to this idea; she felt that he was trying to remove her from the hotel because

he was jealous. "He thinks I have other men... every time he comes we quarrel ... he thinks that if a girl is smart (beautiful) and dresses nicely, every man who comes in wants you."

As it stands this man's complaint was not far from the truth. Many men sought Medina's company. She was plump and eventually had accrued enough money to invest in hair pieces, beautiful bitenge (dresses) and cosmetics. So attractive, she found herself juggling not only daily men and a permanent partner, but daily men and several permanent men.⁵

Medina did not like the idea of moving to the East nor did she want to become a shopkeeper. Both would seriously restrict her movement and the relative independence that she had enjoyed in town. "The shop belongs to the man - I cannot take my 'friends' there ... In the hotel they come, they talk and even if he finds them there I say they are friends of those girls ... (but from the shop) the girls would have to call me to talk at the hotel, and if they do not find me there, these men will go with those other girls." In other words, Medina stood to lose a substantial part of her income if she agreed to this man's demands. She had already decided that if she did marry him, she would close up the room she had rented but pay rent for four months and if it did not work out

in the village, she would have the option of returning to her room and her job.

She really thought that she was better off in town, working in a hotel, than she would be in marriage. When he comes from the East or when he returns from Zaire, he leaves her money and buys her a dress. Together with the other monies she had from her 'friends', Medina managed to do quite well. Living in a room with electricity, warm blankets, a few sets of linen, a paraffin stove, and well crafted furniture, she seemed relatively content. "If I stayed there just married, he would only give me help like soap and other things in the house."

Because most of her men are transient, never staying in town for more than a few days, it became necessary for her to know their routes and schedules. Only the man who is paying for her lodging, knows where she actually lives. The other men who are her less permanent customers usually have rented a room in one of the many lodges in town. Most girls have an agreement not to disclose each others' places of residence to any potential customer.

" Anytime they would be free and decide to come...and if another man was there I would be the one to get ashamed."

She says she made up her mind a long time ago to love only travellers, 'safari men', instead of men who reside in Lyantonde. The 'safari men' simply give much more. When she

runs out of money she relies on a stockpile of goods she has bought and saved when she did have money. As long as she has soap and cream, she can eat at the hotel.

At Moonlight, Medina worked her way into coordinating sexual liaisons for transient men who came through town. "I have so many friends and I help them find girls". She is approached and they request a specific woman; the next day that woman will pay her the shillings left by the customer. The 'encounter' usually begins with a bottle of beer, but because Moonlight is a Moslem institution, they go somewhere else to drink.⁶ Medina, as the 'chaperon,' may accompany them to the bar, but usually she has her own 'meeting' to attend.

Although Medina always insisted she was better off in Lyantonde, she did yearn to marry, because marriage connotes a type of respect that she could not attain as a waitress in Lyantonde. Bearing a child for the man from the East would, in her mind, constitute something solid, something committed, particularly in the way of support. "I will wait for five months ... a man can deceive you for a few months and later on decide to leave you." But her 'problems with producing' which followed her from the village had not been resolved. These are issues she felt could not discuss with him.

When Medina first arrived in Lyantonde she had been pregnant. She returned to the village to get help from a woman

who knew how to 'tie' a pregnancy until a time when Medina wanted it to continue to grow. So she went to this woman, who gave her an herbal solution to drink, and her periods resumed normally.⁷ Medina's problem was that her periods kept on coming, "Even up to now I go with a man at any time ... even if I play all through the month ... I am not getting pregnant." Given that their mother was killed in a vengeful manner in the village, both Medina and her sister believed that their respective fertility problems were witchcraft related.

"She (omukazi omukulu) does not like me and she has gone ahead and tied me ... stopping me from getting a man and getting married yet all of her daughters are there in the village married." Medina thought it necessary that she must go back to the village and plead with the stepmother "to accept to remove what she tied in order for the medicine to work ... there is no way she can remove them without giving her a goat, money, clothing, chicken ... where am I going to find all of those things?" Her fertility problems promised to be a serious financial burden, as she would have to negotiate with the step mother and the 'tier.'

At that time, in addition to the reproductive pressure she was feeling from the URA man, two other 'semi' permanent partners were vying for her time. One was a tender from

Mbarara who deals in matoke for Makerere University, in Kampala. He was young and unmarried, very positive traits for Medina; however, he did not give her very much support. It soon became apparent that this man was intimidating and coercive, consequentially she was afraid to leave him. Her new man was a trailer driver, a married Muhima from Mbarara. "If he continues loving me the way he is I'm going to drop the URA man ... This man does not like to sleep in my house because he says he does not trust who rents it for me ... He wants to rent a new house". But there were times when he arrived so late at night, the lodges were closed, and he would expect to stay with her.

This situation posed a lot of problems for her as she could not afford to have her support providers meet. Although she knew the one man's time table, he could still possibly come any time. The confusion if both men met each other -- in the same room, each man assuming that he was only one providing support -- could lead to threats and violence. In one incident, the matoke tender arrived unexpectedly and found her at the hotel talking to her other semi permanent lover, the trailer driver. He accused her of being with other men, and her only retort was, "After all you do not help me. What do you expect me to do?" When they got back to her room that evening, he locked the door and violently beat her, slammed her head against the wall, and tore her clothes. She says he

feels she gets so much attention from other men because she is so beautiful. He has threatened to maim her so others will not be smitten by her. "He is going to beat me and remove my eyes so other men do not love me."

Medina divulged that she had been trying to dissolve her relationship with this man for some time, but she just did not know how. He was forcing her to 'be' with him without paying her any money, or support. His reasoning was: "This other man should be paying for you." These scenes are too often repeated in the drama that is Medina's life. Sometimes, bruised and groggy, she could not go to work because the beating the night before had been so harsh. Once this partner forced her to sleep naked in the corner, that is, after he had booted her in the stomach a few times. He left a note for her in the morning which read "My friend Medina I ask you to forgive me where I went wrong, but me, what I have decided is that I want you to come to my home and we stay together."

Medina believes that in some ways it is the semi-permanent partners distrust in her, as a sex partner, which fuels some of these outbursts and causes the beating to become worse.

He admired me and loved me ... there should be other men, somebody who is also doing the same ... they say you will get the disease from him (other men) and you are going to kill me...he was my first safari man ... I never used to have any other men, he was suspicious but now he has seen.

In all of the time that we knew Medina, she very rarely would talk about AIDS. She never plied us for information nor did she ever request that we help her get a test. Its reality really overwhelmed her, and when questioned, she would become indignant, almost angry. She would talk about "that man who died recently," or how her friend who also worked at Moonlight became visibly infected, "but continued to 'work' because she needed to support herself. Never, ever did she seriously engage in a heartfelt discussion with us about the risks she was confronted with on a daily basis.

One day, however, one of her men dropped into the hotel on his way to pick up a shipment from Masaka, and he told her that she was losing weight. This one statement made her quake with insecurity. She exclaimed, "My men like me fat because they got me fat ... If they find me losing weight they would say I swallowed the virus ... and when this happens you lose your men." Yet despite her fears she, like many others, was too afraid to get an HIV test. "I would be very worried and thinking all the time ... If I knew I was positive I would die in a year ... No matter what I would do I would know that I am just going to die."

Only one of her men has asked her to go for a test, but apparently she kept making up excuses about her delay. To avoid the inevitability of shame that would come with a

positive test result, she wanted to go on her own, so that she knew before this man did. At that time the one she distrusted the most was the one who was beating her, "I get worried about him he is the one who is really young and not married ... he could be having many other women." Because they had been relating for so long, Medina did not use condoms with this man.

Eventually, the man from the East who had both offered marriage and given the most support, deserted her, because he did find her with another man. She took up with a cattle trader who convinced her to leave hotel work, but she did continue to look for support through other men.⁸

Regardless of risk -- for HIV or physical violence -- Medina eventually decided that marriage was far too restrictive for her, commercial sex offered the financial security and lifestyle that she had started to enjoy. "There is not much you can get from a man living with him in the same house ... He restricts you but he is not giving money daily ..."

Medina came to town from the village with some trepidation. This hotel work was merely a way for her to earn some shillings and be fed once per day. Admired by men and resented by women, she quickly became a woman with quite a reputation. Sex work became more than a way to feed herself;

she wanted to invest what she was earning. She held in high esteem the few women in town who were able by fluke of history, to take advantage of men and the black market economy which flourished during Amin's reign of terror. These women were able to accrue enough capital to invest in property, build, and run businesses. Although she aspired to this kind of independent wealth she did not think she would make it. She lamented, "They did that at a good time, but these days are bad because of this sickness ... I will not reach that day ..."

ENDNOTES

¹ It is considered very shameful for a family to have a young daughter pregnant while she is still living in her father's compound. Typically very strict punishments were enforced, including beating and ostracism. "But these days, young girls impregnated before marriage has become like a uniform."

² Her sister was still in touch with some of the management. Not surprisingly, her sister's husband, a Mutoro, refused to allow her to work there after they were married. Most girls start off in the kitchen cooking and peeling matoke.

³ Rent for single rooms in the compound she settled in cost approximately 4,000 shillings per month.

⁴ Enough to buy two bunches of matoke.

⁵ As can be expected, men found bountiful flesh extremely pleasing, particularly in a town where the very thin were assumed to have the virus.

⁶ When they discuss a woman's attributes, men never seem to inquire about their 'health'.

⁷ The explanation given was that money is offered to this woman, the particular problem is discussed, and the woman can 'suspend' the baby's growth until the client wants it to continue to grow (ie. after 3-5 months). When the client wants the baby to grow, she goes back to take more herbs. The stipulation is that the pregnancy really reverts back to one month, the fetus grows again and periods cease. Such reasoning is apparently an explanation or justification for abortion.

⁸ This man had five children and a wife living in Kampala. After the Hutu massacre of April 1994, the border between Uganda and Rwanda was once again passable. Many families who had found refuge in Uganda were going home. Cattle traders, like Medina's partner, used their lorries to take people across the border. They even came as far as Gulu in the North to return home.

Figure 8.

Lyantonde's Bars and Hotel



Moonlight Hotel.



Dembe Bar

Betty:
The Story of a Bar Girl

The work of the bar girl living in Lyantonde is not that much different from that of a waitress. Bar girls work serving mostly beer and soda. Typically a lodge is located behind the bar where men - truck and lorry drivers, army men - sleep for the night. Although facilities vary in price, well kempt compounds can cost as much as 5,000 shillings per night.

Like Medina, Betty was circumspect about discussing this disease, partially because she felt she was destined for death. We knew her for such a short time, before she returned to her village. Yet she was honest with us about her fears and, most importantly, her self respect; she even advised us on how to stay alive.

Betty was approached when she was ill; in fact, had not been back to work at Dembe for approximately three weeks. She had been replaced, was unemployed, and was looking for alternative work.¹ She had decided not to return to bar work.

A bar needs young girls ... The people who come to drink have no respect for us ... When they send you for a drink, they say, "You, malaya, (prostitute) bring me a beer" ... When they come and touch you and you say, "You leave me," they say, "look at this stupid woman, you are a malaya. Maybe you did not sleep with a man last night, I

was trying to help you and you are just there looking foolish."

Some people have different hearts. There is one who can come and after you have served him, he says, "Have this you go and drink a beer, ... You go and buy soap or milk, we know your problems" ... and then there are those who say, "I cannot even give you a 100=. You are just a malaya. You come here for men. You already have silimu. You just want to infect other men."

For a woman with a quick temper, such situations become not only demeaning but intolerable.

I have such a temper, I cannot accept such a man. But there are some girls who accept and believe they are there to be abused.

Betty, like Medina, related that it was impossible to negotiate for money before she went with a man.

If he sleeps with me the first night and leaves without giving me anything, I will understand, but if he comes the second time and leaves without leaving anything, he is a foolish man, because he is pushing me to loving other men who can help me ... As you know, women, we need so many things. When you look at yourself we need to eat, need soap; if you have a house you need rent ... When people see us working in bars they call us malaya, They think we go to bars for men ... We do not go for men, we go for money to support ourselves...

Betty is a 28 year old Moslem woman, a Muganda from Lukaya (a truck stop with a development that parallels that of Lyantonde) in Masaka district. She was born into a polygynous home, her mother being the second of three wives. Her mother became pregnant while she was schooling in Kitovu. As she was not breastfeeding her baby girl -Betty- was taken to the

paternal grandmother's home while her mother was returned to school. Shortly after, she conceived again. She died while giving birth to another girl, when Betty was three. This baby was raised in Kampala by a paternal auntie of the late mother. Living so far away from her, she says she never really knew her. Her father, currently the manager of Kasasa Coffee Factory remarried again and has over thirty children.

Although Betty really liked school, her father refused to pay for her fees after she finished primary six at fourteen years of age.

My father refused to help me ... He does not like helping girls because he was discouraged by two of his other daughters... One was in senior 4 and the other in senior 3, and they both got pregnant ... Since then he said he would never pay ... never help girls.

He believed that to invest in a young girl's education was just waste a waste of money because, "All that they think about is marriage." Consequently, she blames her father for her current suffering.

Sometimes I think of buying sugar for him but then I remember what he did ... If I had gone, I would have had a good job ... Now, I cannot ... They ask you at what level you stopped ... You end up as someone else's labourer ... at such low pay...

She stayed at home and helped with the digging and child care until her father decided, "You girls, you are going to get pregnant in my home ... You go and get married."

Her paternal auntie's arranged her marriage. She was the first wife of a Muslim man for whom she bore two girls. But after each pregnancy, she fled back to her father's home, and each time he would force her to go back to her husband's home. Betty believes that her marriage was so unsettled, because of witchcraft.

I had grown up not used to being abused ... When we married he loved me so much ... Everything was done for me ... I never went for sugar ... Water was brought from the well; food from the plantation ... All I did was cook ... ² But he had many brothers and sisters who resented me ... They said, "The man does whatever she says." I was a lazy woman and I waited for everything to be done for me ...

This harassment was exacerbated by her mother-in-law's threats. She would say, "Everything is taken to that woman ... he loves her so much ... if she is not careful she will see. I was so afraid if I did not leave, she was going to kill me." When the last born was three, she left her husband permanently. The paternal aunties were called to meet with the family to help resolve the conflict, but she refused to negotiate.

The most painful thing was leaving her children. One day she went to the ex husband's home and upon her arrival was greeted by a new wife. By telling this woman that she had seen her husband and gained his permission to take the children, she managed to spirit her children away. At that

time her first born was on school holidays. She kept them at her father's for as long as she could. However, unable to afford fees for school and medical treatment, she had to return the children to their father. Reflecting upon her current situation, she regrets her "stupidity and youthfulness", at having left such a good provider, explaining, "I was unable to reason."

She held a job for a short time in Lukaya at her paternal uncles bar. She was employed for only a short time, until she was replaced by her auntie's kin. Because her father was still alive, she could not bring shame upon her family by working at another bar. Having very few options, she migrated to Lyantonde, where an elder paternal cousin "sister" and her husband owned property.³ Since then her cousin "sister", a divorced itinerant trader "just fell sick and died".

She had been sick for sometime. No one there took her sickness seriously ... These days people are reluctant to get treatment because they know it is *silimu* ... They do not want to waste their money because they know they will die ... If I went home to my father and explained my sickness as this or that ... they would just leave me without any treatment ... They would just say, "Let her die with her *silimu*."

It seemed as if her cousin had just been buried, when her younger sister (real), who was married with two very young children, also died. "They used to say it was *silimu* ... But when she went for a check up, she was diagnosed with TB. When

you saw her you could know it was silimu ... imagine leaving behind children so young."

Betty conceptualized personal risk as being connected to a broader network of transmission. She said she first heard of AIDS soon after her divorce in 1988.

We heard there was a disease killing people ... But I never believed ... People used to 'move' ... People used to die in Kyotera so much ... People used to go to Tanzania, steal mukene (fish) and transport it to Congo (Zaire) ... When they stole it, those Tanzanians bewitched the people from Kyotera ... That is why they were dying. Those people who died had other partners, who had others who are still moving. And we move with those who are still moving.... All of us have this disease.

When she started working at a bar, she says she was aware of the risks and prepared to do whatever it was she had to do. "There is no way I can keep from sex. In order to survive, I need money and there is no way men give money without sex." She started out at a place called Amanyas Bar, more of a stop over for passersby than a place for lingering customers. The owner employed just three bar girls and a bar girl/cashier. The cashier was her friend and Betty says she fell sick and had to go back to the village in Rukingiri district. Betty replaced her for five months until her cousin sister's child fell sick. After having obtained permission to leave work, she left Lyantonde to attend to her sister's problems in the village. The deaths, burials and condolences

resulted in Betty staying for over a month. When she did return to Lyantonde, she found herself out of a job.

She then went to Dembe where the manager told her that there were no spaces available but to keep checking. A spot became available, and she found herself working at one of the most popular bars in town.

For Betty, it is not the daily clients she has that she fears the most. It is her permanent partner, a long distance trailer driver, operating through Zaire, Rwanda, and Kenya. She first met him in Lukaya, at her uncle's bar. He was more than happy to have her move to Lyantonde because at home, "People keep an eye open ... restrict your movement." He had a wife and two children living in Kampala. But when he passes through Lyantonde, he buys food, all that she needs in the house, and when he departs he leaves enough money to sustain her for his period of absence, which can be a month or more.

Betty's perspective about this relationship was very pragmatic. "How do you expect a man to stay away a whole month without having other women? At every stop, she says, he must be having other women...

... At Naluwere, Lukaya, Busia ... and all of these women, he calls permanent. Even when he comes back to me here, he calls me permanent ... This man goes back to his wife and tells her he has not done anything. He is just working ... I could have others before that. So how can I know I do not have the disease?

With her men that she meets at work she insists on condom use.

Sometimes you can get a man who is well behaved, but you hear his wife died of *silimu* ... Yet he behaves so well ... For me, if he comes, he helps; food, money ... I will accept to have sex with him, if he wears two condoms ... You can have sex with condoms, thinking, "If I fear the disease what will I eat? ... Do those who fear *silimu* stay alive?"

But she insists if the man does not want to use condoms, it is the end of the affair. They bring them or they give her money to go and buy them. She also keeps her own at her home. "When I play using a condom and later hear that one is infected I get scared ... but then I remember and I do not fear." As a condom is better than nothing, refusing to use it is a serious mistake.

She explained that negotiating condom use with her permanent partner is completely different. She was terrified of his reaction.

What would he think of me? ... He would say, "You are the one with other men" ... If I told him to use, he would ask, "is this our first time coming together? These other first times you accepted without, why? You do not trust me?"

But if he ever had confirmation that she had other men the "affair would end there and then ... and he would beat me ... but he has never found another man in my house." The daily men she goes with are, she says, aware that she has a permanent man, and that it is their responsibility to find lodging for them both. But she will never stay out the whole

night because she does not know her permanent partner's schedule. "He goes for so long ... I never know when he comes ... so I can never stay out just in case..."

What she finds absolutely exhausting is the quarrelling about his other women. Sadly, she reasoned:

Would I be better off with a man who is well behaved, but has silimu, than one who is bad ... always moving with other women? ... He maybe thinking that I am a malaya and have so many other men ... And he gets so many other women at every stage.

Betty, preferring "to grow the virus that is already there," feels that for her, a future does not exist. " I do not want to add on more virus ... I want to have just one, so it multiplies very slowly." In her opinion, every time one goes with a man, viruses are added and death comes more quickly. If one stays with what one already has, it may prolong life.

It is her opinion that when people fall sick there is some confusion between AIDS and witchcraft. A person is first taken to a traditional medical practitioner to be treated because people think they have been bewitched. "When things fail with the traditional medical practitioner (TMP) they know it is silimu." These days, she says, when anyone falls sick in Lyantonde, they automatically assume it is silimu. According to Betty recovery is possible, because the sicknesses are really witchcraft related.

"People are taken to traditional healers, given traditional treatment, recover and are still living."

Betty said that she thought about getting tested but she was very afraid - mostly of her actions if she were to receive a positive result. The idea of not having any property to leave her children immobilizes her. "I know I would sell off all my property, accumulate debt with other people and never pay them back - I would just be thinking I am going to die." Alternatively, if TASO (AIDS Support Organization) came to Lyantonde, she would be willing to get tested as long as she was given treatment, but she says she would never return to get her results.

I am already in TASO ... in my own home ... I know that I have some of the AIDS virus in me ... So every day I eat a balanced diet; tomatoes, greens, and fruits. Whenever I fall sick I go to a clinic.

She believes the real truth will "kill her psychologically." Before TASO was formed, when so many people were visibly sick, Betty said that there were so many patients, the health workers in the area became frustrated, so frustrated that they were injecting and administering tablets that facilitated a quicker death. Their frustration, she explains, was compounded by serious drug shortages. "These people were going to die anyway." These days she believes TASO has tablets which make people appear to be "healthy and

fat" up until they fall sick for the last time. "They stay healthy and do not disturb."

Like many who have not been tested, Betty speaks with surety about being sick. However, not knowing is better than knowing, but any time she fell sick, she felt a lot of stress. She became extremely fearful of "very strong malaria which does not go quickly." When she lost appetite and felt weak, she would think to herself, "Maybe I have it". When she did get very sick or too weak to walk, it was her compound mates, her friends, that would go to the market, cook her porridge, and medicate her.

She believed that people in the town show a lot of 'irresponsibility' with reference to 'patient care' whether they be friends or family.

They do not care whether you are infected or not. When they know you are sick ... they just say, "so and so is sick. Let her go to the village." They say "am I the one who infected her? ... let her go ... there is nothing we can do." Sometimes they come to you and tell you, "You are sick, you pack your things and go to the village."

Regardless of the type of work she had chosen to do in town, Betty did not see that village life as an alternative any more.

I cannot manage village life ... I cannot ever go back to digging... If I stay in town, some person can come and say, "How are you, here is a thousand shillings you go and buy milk" ... Now imagine a woman sick in the village ... No one can give her a shilling. She just digs and digs until she dies ...

Betty did eventually lose her permanent partner, her financial mainstay, to a new woman at Moonlight Hotel. She sighed and said that they were both just tired of each other.

As she was no longer working in the bar she was forced to sell her property for food and rent. " After all I have silimu, I'm going to die anyway, so why not eat now?" Currently Betty has turned to alcohol selling in her home, a single room, to support herself. In order to invest in the crude waragi (illegal gin) she says she had to sell her big radio/tape deck. " I have to sell some of my property if I have nothing to do..." Making a living selling alcohol means that her living quarters must become a veritable open house to men of varying degrees of inebriation; from very early in the morning to the wee hours of the next day. For her, this kind of lifestyle is very problematic for varying reasons.

For me I am a clean woman. When these people come when they are drunk, they just enter with dirty shoes ...It is difficult to tell them to go; if I tell them that you must go, I have stopped serving, I want to sleep, they will just insist and sit longer and there is nothing that you can do.

She says that when men see that she lives alone they can become so drunk, they pass out on a mat on the floor and there is nothing she can do about it. There are strict bye laws in town, requiring them to close at midnight.

But the policemen also drink here. If I tell them to go, I have to quit. They just waive it and continue drinking ... I stay up and talk to them

... After all I am looking for something to eat, if I do not keep awake then what would I eat?

There are so many women in Lyantonde who sell alcohol that it becomes incredibly difficult to get and keep customers. Some customers get it on credit, and promise to pay the next day. But they never do.

Betty linked her lack of success in selling alcohol to the false promises she had made with her customers. Many have suggested relationships but she insisted that she resisted their demands.

Some of them stay behind until we are just two, ... Me, I tell them I left things already ... Some of them I deceive; tell them to come the next day and we will discuss it ... When they get disgusted with me, they just shift to other drinking places ... I do not care, there is nothing I can do ...

Betty kindly offered advice about men, trusting and staying alive. To be able to trust a man, a woman must " know whether or not the virus is in him. You must first give a man two months without going into a serious relationship ... studying him ... talking to others, finding out what he has been doing in the past, after two years ... you must find out by taking him for a test ... if the results comes out well you have two or four children ... then you stop if he's been mobile at all in those two years then you must leave him." Even if he is a good man and he is positive "then what are you looking for ? The first thing will be death"

Me, I want to love again, but it must be a man who can listen to me, can understand my problems and I can listen to him and understand his problems. But he must be from far away; from Kampala or Kasese. I cannot allow a man from Lyantonde to be my man ... I know their backgrounds, their health ...

Betty fell sick late in 1993 and was transported back to her father's village for care.

ENDNOTES

¹ Important in the consolidation of the rural - urban link is bringing gifts of luxury goods like sugar, tea, paraffin, and vegetable oil.

² In Buganda, a girl's 'womanhood' is partially evaluated by her ability to work, dig and manage a plantation.

³ Eventually this cousin separated from her husband because of his reputation for "moving" with very young women. Since he was a teacher, some of these women were reputed to be school girls. He is now a Headmaster in Kaliro, about five miles from Lyantonde.

Josie:
The Story of an HIV Positive Mother

When we first met Josie, she was simultaneously unsure of her own serostatus and extremely worried over the health of her second born, a son. Josie was for all intents and purposes besieged, by hunger and impending death. Much of her suffering emotionally was located in a stormy relationship with the man who fathered her son. Only twenty one, she was living in the last room in a block of mud and wattle row housing of a compound which came to be known to us as the AIDS compound.

She came to Lyantonde at the age of twelve, with an extensive history of neglect stemming from various 'stepmother scenarios.' Her father, a prison officer, has been very polygynous. Her mother was the first wife and bore him five children. When they divorced, she left them in the care of a co-wife. Josie was two. A relative, a minister in town, heard that the children were suffering and moved the youngest children, including her, from the village to the barracks, where she was cared for by another co-wife. She said the co-wives often competed for the husband's love by putting herbal medicine in his food, and competed against each other for control of the children.

If one sent for water from the borehole miles away, you would barely have put the jerrican down when the other one would send you to the same place, or send for firewood. Sometimes we would go to school without food, come home for lunch and they (the wife's family) would say there is no food, eat at supper. When it comes, they serve their own children and say, "The food was little. Wait until tomorrow." We starved for the whole day, having eaten only mangoes.

Her father was extremely dictatorial, and as a result had a fairly long history of dissolved marriages.

He would only let them go to church or to the borehole; he never let them visit friends or even their parents. Finally, some got tired of this and left. They would leave their children and go. Now all is changed and it is this woman who speaks. My father is very soft; she is the one who makes all of the rules. He does not like any of his other children. It is only her three daughters who he likes.

The most recent wife has so much control of household management that the clan has had to intervene on behalf of progeny from other marriages, to settle various disputes. The biggest bone of contention seems to have been the decision about which children would be kept in school. Josie herself was pulled out in 1983 from P5. "This woman always said why do you waste money on those children ? ... What are you training them to become? ... I loved schooling very much. ... I hate him very much. Maybe I would not be seeing what I am seeing. Even when I was married I used to think a lot. Every time I felt like I should be in school ..."

Soon afterwards, Josie was sent to Masaka to be a housegirl. Having left her job in February of 1984, Josie found her way to Lyantonde to join a sister who had married here. But after two years the man who she was living with stopped supporting them. Given that her sister could not provide for both of them, Josie began digging at the house of a paternal auntie a few kilometres from Lyantonde, down Kaliro road. Her sister became a bar girl in a hotel in town and perished with AIDS soon afterwards. It was through this auntie that Josie's first marriage was arranged. She gave birth to her first born, a girl, in December of 1988. On Christmas Day, her husband was killed by a grenade lobbed into a disco in Lyantonde town.

Widowed at the age of nineteen, she returned to her paternal home. Her father was living in Rakai, the town, while maintaining both a coffee and banana plantation in the village. "My father took pity on me ... He even said he was going to send me back to school, or set up a shop for me so I could support myself ..." But relations with the stepmothers once again turned bad and she was 'chased'. Josie asserts that the stepmother would advise her husband that "It is not good to be with children near because they can kill you ..." It is believed that this particular co-wife had planted 'things' in the compound, making the children of this man afraid to go

home. "It is all overgrown and bushy. The place looks like the owner is dead."

It was while she was living with her own father that she met the father of her second child, the man she considered herself 'married' to. They were not formally married because he was a Muslim and she, a Christian. Josie knew this man even before she married the late husband. She met him while she was in Lyantonde, living with her sister. Her sister disregarded his attention, as she felt he was "jumpy with women" (not very faithful).

Even after her sister had died of AIDS, he pursued Josie to her auntie's place. His work in the cattle trade brought him to Kaliro market, not far from Josie's aunts, at least twice per month. "He would come there and tell me that he was the one I was going to marry, I was his woman, and that he would wait for me ... but my auntie was very strict and he was a Muslim ..."

They finally got together after her first husband had died. They would meet at a sister's place in a nearby village called Kyewanula. Soon afterwards she became pregnant. "I just used to visit him here in Lyantonde, she said, "I did not want to stay with him, I feared my parents, and he was a Muslim." She says she remembers visiting him in town, when

she was two months pregnant. It was way after dusk, and there was a knock on the door.

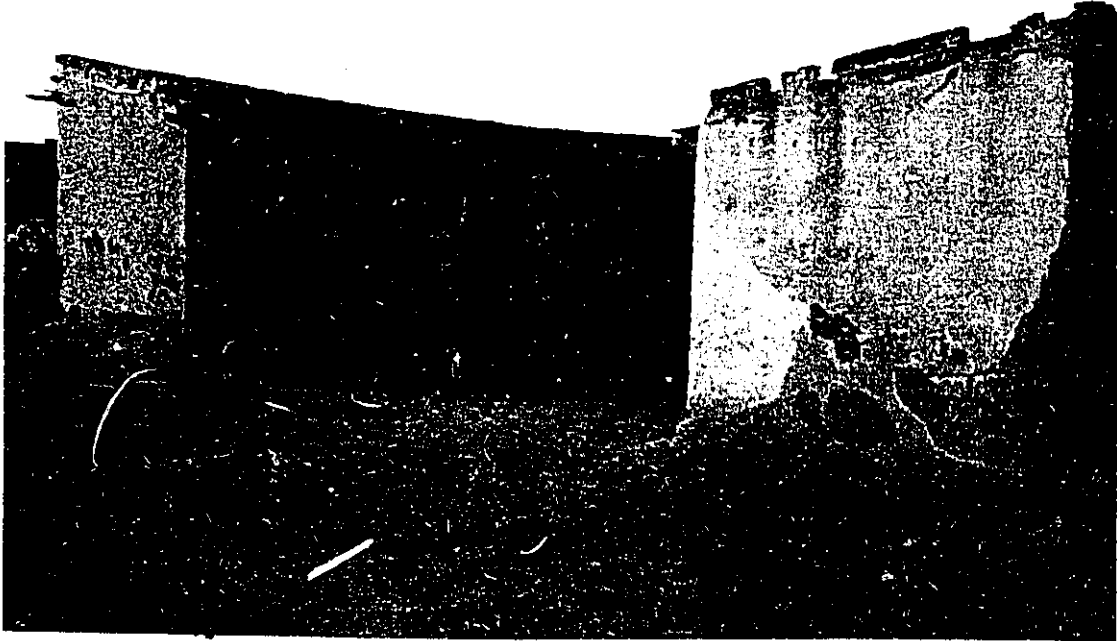
A girl came in, a waitress from the hotel near the police post. It was time to be sleeping so I wanted to go. He insisted that I stay. He told the girl, "I told you I was married. This is the woman I always tell you about." The girl quarrelled and left crying. Then we quarrelled. I wanted to leave so he could decide who he wanted. I decided that I would not continue with him. He said, "But if you go I know you will return." He had suspected I was pregnant and started insisting that we should continue relations, but I stayed with my sister. He married a Muhima (cattle keeper) when I was seven months.

Josie gave birth, and the baby was fat and fine. 'He liked him so much.' But when the baby's health started deteriorating, things changed quickly. When we met Josie, he had withdrawn support for her and was sporadically providing medical treatment for their baby.

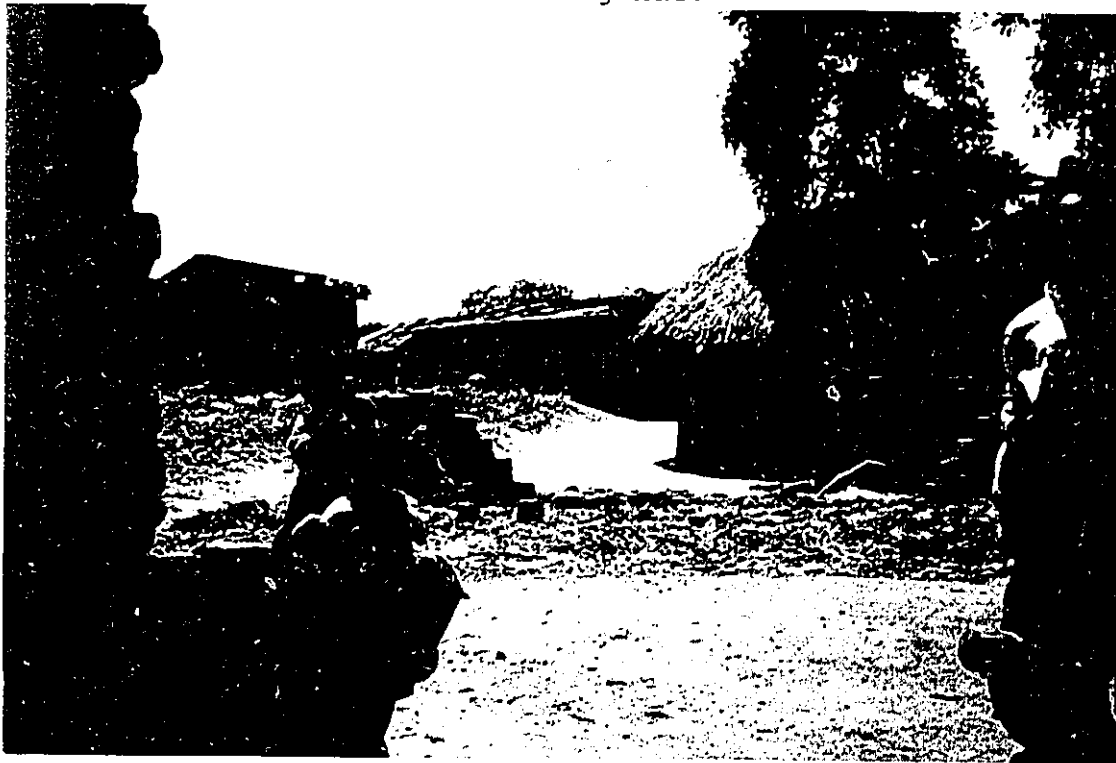
Josie's whole life has been affected by the health of this child. When we first were introduced to Farouk he was about six months old, sickly, fragile, passive, extremely malnourished and covered with dripping wounds. Scathing comments from women in her compound about how sickly and repulsive looking her baby was had made her very shy to bring her baby out of her room. She was told by a neighbour : " How could you bring out such a baby? Even though they are AIDS people, they could not touch such a baby. That one has silimu. You just leave it to die. Do not bother with it any more."

Figure 9.

The "AIDS Compound"



Pictures of mud and wattle (row) housing and
the drinking hut.



One time she brought her baby outside and her neighbour told her "You take your baby inside. It makes us vomit."

At first she said that Farouk's sickness was caused by a twin ceremony, in which herbs were placed in a junction and Josie by happenstance walked over them.² This was the explanation for the greeny brown herbal mixture smeared all over his body. She later confided that her fears were more associated with HIV. She anxiously asked, "What type of disease is this that does not go away? Is it only AIDS that people suffer from and do not ever heal?" She wanted to get herself tested. Unfortunately, the cost of the test, at that time 1,500 shillings, she could just not afford. Support for her own needs had been withdrawn. So when she begged for treatment money for the child, she had to inflate the cost, in order to pay rent and buy food. But eventually the husband just stopped coming around.

One day I had gone to him for money and he promised to come that very night. He came with nothing. I asked for it (shillings). Instead of answering he asked me who my new best friend was. We had spent over two weeks without seeing each other, so he assumed there would be someone else supporting me, 'taking over' while he was gone. I got so annoyed, I asked him to leave, but before he left he wanted to sleep (sex). For me, I did not want; after all, he is not food. When he asked me for those things, I got rough. I said, "After all you are not food. If you were food, I would starve and die, but since I can sleep and wake up again, I do not need you." He told me that sex is not like food, that I could not stay that long without 'eating' (sex). I told him to leave. He said, "If

you do not allow me (to have sex) I will not help you, but time will come when you start starving, then you will allow."

Josie had stopped relating with him on a sexual level because of lack of support. His 'indecent' with regards to both her and her son was taking its toll on her emotionally.

How can you feel for such a person when you are telling him your problems, especially when it concerns his own son? I sometimes went to him saying the child is sick I need this and that. He would tell me to go, that he would come. Instead, he comes to my home without the money, yet wants to sleep with me.

With no job, no shillings (cash), Josie was depending on the support of women in her compound, for food (matoke) and charcoal, and was hauling water from the borehole. She was given some land by the sister of the woman who "hates her baby" and was growing Irish potatoes, beans and sweet potatoes.

When I saw he was just using me, I decided to use my hands to work and support myself; in fact now, I feel better off. When I was with him, I would sit back and wait for him to bring things, which he never did. I'm friendly to people, so they see me in deep thoughts, they ask, "Why are you quiet?" So they give me some 500=, 400=, 200= and tell me to go buy some soap, some milk.

As the support from her friends was sporadic and as at that time she had not yet realized the fruits of her labour in

the gardens, both Josie and her family often stayed hungry. Yet she maintained that she did not have a man.⁴

But there are some boys who come around, but as soon as they move out of the house she (her neighbour, an alcohol seller) runs out of her room saying, "Be aware of that girl! See her baby? she has silimu!" and these men never show up again. Some men who are drinking there send for me. Others say, "You bring your baby." They see him and never bother to disturb me again.

At this point Josie's life was marked by starvation and sickness, feeding and providing treatment for her family from one day to the next. "My child must have gotten this from me ... There is no way he could grow inside me without getting the disease." In desperation, she felt that getting tested would bring some semblance of order into her life. She did not get much support for this decision from neighbours, family or friends. She was advised that "there is nothing to gain; if you know you are going to die, you will die more quickly." Essentially, people believe that if they are certain that they will die, they will "die psychologically," die of worry. However, Josie believed:

It is better for someone to know whether you are going to live or die. I went. After all, it would show up after a time because there is no difference between knowing it and having it. There were many people at the clinic for testing, mostly women and a few children. When you are sitting in your own home, you can think you have the biggest problems, but when you go to such a place, that is when you know you are not alone.

With the test came free treatment for her baby. He responded quickly to the antibiotic cremes and multivitamins. The baby was eating and the rash had dried up. But the drugs also brought Josie further grief. They regarded her trips to the health clinic on Kaliro Road with suspicion. They reasoned: "Why would they give her drugs if she was not sick?" People in the AIDS compound were assuming that she was indeed positive.⁵ Josie was tested in the last week of June, and did not receive her results back until the third week of July.

At the end of the first week of July we found her with no food in her home; and the maize flour that a relief organization had doled out was finished. There were days when there was nothing in her home to cook, days in which she had not had a meal at all.⁶ Furthermore, the landlord had not been paid rent since the end of April and he was calling to collect his dues. Waiting for results was agonizing. Josie became really withdrawn, depressed.

I cannot even go to the garden. By the time I wake up, I am just thinking. During the day I stay at home, lying there in thought. I end up sleeping. I am just waiting for what will come out of it. The only problem that is worrying me is my children. They have to eat and I have nothing to feed them. If Farouk fell sick now, at least I can get help from the father but if Kadidi, (the first born daughter) fell sick I would not know what to do, nobody would help. Just this past week, the last of Kadidi's paternal uncles had died from 'this thing', and the only auntie left is also sick.

Josie felt that she had to start working somewhere, but feels constrained by her baby. "Now if I could get someone to let me work with my child ... but where can I take this child of mine, he is very sickly ... nobody can allow me to keep him with me." She does not consider going back to the village or working in hotels viable alternatives.

If I was involved with those girls I would be dead by now. I cannot be influenced to go work in a hotel, for me, I cannot manage it. I know girls who work in hotels and do not get salaries, they just wait there to get money. Maybe some of them would tell me I dress like a villager. If I got a job at a bar, I would have to dress nicely and that is through men. When I was married I brought very few clothes with me. These clothes are the ones I came in. This man now has not even bought me a handkerchief. My co-wife is not even OK. She has been wearing only two dresses since I knew her.

Just when it seemed as if things could not get any worse, a man, a medical officer, who comes to drink in that compound, has been pleading with her to come with him. If she accepted, he says, she would have all of the help she needed. "He came over and gave 500= to each child and each time he tells me of the help that he will provide for me." Josie, however, told him that she knew that his wife had recently died of AIDS. His response was, "Even if a man's wife did die of silimu it does not mean the man has silimu."

But for me I cannot go somewhere where I know there is death, I can only go where I do not know. Even if today he came around, gave the children 500= and said you buy for them milk I would not go.

This man thinks this money will make me accept.
For me, I have lived in poverty, I am used to it.

Although extremely vulnerable, without food and consumed by worry, Josie maintains that she did not succumb to this man's pressure. Farouk's father, however, had heard through his family that his baby was thriving. He wanted to start supporting her again. A message was sent through a relative, along with 500= telling her that he was coming and that he was expecting to find tea ready when he got there. For Josie, accepting such a demand did mean rekindling a sexual relationship.

He did come, paid her rent for two months, gave her 4,000= extra to buy charcoal and matoke, and paid some of the debt for the baby's treatment. It was at this point Josie admitted to us and to herself, that his neglect was partially due to his belief that Farouk, "was already dead." She did believe that "he had given up and prepared a place to bury the baby."

When the baby was sick, many used to say to him, "Why are you wasting your money buying milk for this baby, giving money for treatment? This child has silimu, he is going to die. I think he listened to them because he stopped giving assistance for the child.

His decisions with regards to support were definitely informed by watching the child of his 'real' wife suffer

through a trajectory of ill health similar to that of Josie's first born. Regardless, Josie's resilience did disintegrate.

I did not mind sleeping with him as long as he was ready to give me help. I had left him because he was helping me. This man is my husband; people around know that he is. If he now comes back ready to help me and my child. I do not mind. I have nothing to do. There are many who have been coming wanting me, but I was refusing because I knew I had a man.

We were worried that this renewed support would deter her from facing test results. However, knowing the truth and making decisions about support for her son were, to her, two separate issues.

I needed to know the truth and what to do. If I did not have this young one, I would not be having any man.

Knowing he was coming to renew a sexual relationship immobilized her. Negotiating condom use until her results came in seemed to be out of the question.

I want to tell him to use condoms but he will just say why now. Why this time, when all of the other times we did not use any?

Late in July the HIV counsellor went to Josie's house and informed her that her results were in. She arrived at our home frightened and in shock.

We opened the envelope together and we found there bad things. I do not feel anything now. I understand what has happened. All I can do now is work hard for my children, earn some money so I can get food for my children. I pray that I do not get sick now so at least they can grow a bit.

The implications of a positive test were enormous.⁸ Farouk may never live past the age of two, and Josie more than likely will die before her mother. She said she would inform her brother but could not possibly tell her mother. "I fear because she says she wants to die before her children."

We visited her a few days later and she seemed more settled. The unknown had made her anxious and uncertain. Planning for the future had been an impossibility. Upon reflection, Josie says that she did have suspicions about his 'health', when they got together after her first husband died.

I heard from many people after we married that he had a woman who died of AIDS. I asked him and he said she died in an accident. Sometime back he had a skin rash all over the body really itching. He said it was 'kabatongo' (syphilis).⁹

I do not feel badly now, I am thinking the moment I get sickness I will know that it is because of this. I will go back home where I will be looked after by my mother in Rakai, I have seen women here suffer, with no one to look after them. It is because when they get sick they are not sure what they are suffering from and they always hope they will get well. At least my mother and some village people will look after me. What I do not want is to die alone with no one to wrap my dead body. At least they can give me katunda (passion fruit). I am not going to tell my mother now because my mother would just kill herself. Even if I go home sick, I will still not tell her what the problem is. I will not allow myself to suffer for long.

Now, Josie insists that she will not tell this man the results of her test. She justifies this decision in various ways. He had been completely opposed to testing. Previously she had been treated for syphilis and asked him to go as well. He apparently barked, "If you and the co-wife were prepared to go, then you should go ... but me, I am not going."

He does not like anything to do with blood tests. The last time I talked about it, he asked me three times what would I gain if they took off my blood. "What will you do when you find out you have the disease? If they tell you are positive you will die. If you do you have it you will still die. Do you want to be told how much it has grown?"

Josie sees herself as the 'outside' wife, and as such absolves herself of responsibility.

Besides he has his wife, he does not live with me, so I do not see why I should tell him. He is going to be even more angry if he knows. He said, "You must look back and know whether you are infected or not; but it was difficult for me to know, because I do not know where he moves.

In addition, in a Rakai Project information pamphlet he found reason to blame Josie for their son's illness.

He told me to read it, and then when he came he said over and over again, "There it says it is the mother who passes the disease to her child. If it is *silimu* the child is sick from, you are the one who has given it to him, not me." I said, did you get the child alone? It should be from father to mother to child.

He insisted that the blame was to be placed on Josie, the mother.

He had given up on this child. He knew he was going to die. Even his friends' children are all dying, some at birth, some at three months, some at

six months. Some of their women have miscarriages. Now he thinks he is the only lucky one because his child has grown.

She does not communicate to the child's father her belief that her child will not live to see adulthood.

He might die. If a woman is sick and passes it on, is there any way a child can live? But I will stay with him, look after him. He seems OK now, he is looking well, but he seems to be getting sick.

As time passed, we continued to worry about Josie, and her mental anguish.

I get bad feelings most of the time. I am thinking I am going to die. Even if I lie down I cannot sleep, because I am so full of thoughts. I worry even more when I am hungry and thinking about my children.

There were many times when we visited Josie, only to find her napping. The combination of hunger and depression was taking its toll on her body.

Josie did take the counsellor's advice about birth control seriously. Understanding that a pregnancy and delivery may challenge 'immunohealth', she went back to the midwife who had delivered Farouk. Paying for the gloves for her internal examination and the birth control pills were expensive for her. Although she felt that tablets "were easy to forget," and that injections "made a woman lose weight and make one look like a slim person," she felt it was necessary to use a device that need not be negotiated.

It would mean the husband knowing, and I am not going to tell him. He cannot allow, for him, he wants more children. People were advising him to buy a plot and build since he has children. He has decided to buy a plot for Farouk, so he wants to produce many more. For me, I asked, "Why do we bother to produce when you say I have silimu?" He just said, "You think all children born to people with slim die? Some can be lucky and live, he keeps saying, "For me I know I have silimu. It is you or my other wife who has given it to me, for me, I go nowhere else apart from you two.

Josie knows that not producing could inevitably lead to a separation or divorce.

He will just keep wondering why I cannot, but there is nothing much he can do. If he goes (leaves her), it is up to him. It is not that they love their children. They just want to be seen with numbers, they will try as hard as possible to have many. Sometimes that means having many women, so they cannot allow pills or condoms. Even at the clinic, the women who attended it also said they were not going to tell their husbands about the pills because the men would stop them. There is no way a woman can use condoms. The men say they can only use them with women from outside, not the women they are married to.

Josie also feels it is important to use traditional methods of birth control, which she says causes as much resentment from men as the birth control pill. After she had delivered her first born, she was told by her paternal grandmother to keep the umbilical cord, dry it, wrap it and keep it on her waist.

I did it, because I did not want a child immediately. Some put it on their petti slips. The problem is, this is risky because if you change it or wash your dress and do not put it back, the woman can get pregnant. Up until the time my late husband died, I never conceived. When I married this other, I had not conceived. He said, "It is that 'yirizi' (bundle), it is what is tying you." I

insisted it was not. He insisted that it should be cut. He wanted a pregnancy. In a struggle, he cut it himself.

Now she says she has tied the cords of both her children. "I cannot trust. Anything can happen. That is why I want to use both of them so I am sure."

It is Josie's opinion that men want many children because they do not bear the burden.

It is the women who suffer with their care. When the children grow, the men use them, make them do their work. Some children have to suffer because of the step mother. It is even worse when a woman is producing only girls. The man will try so much to get another woman so that he produces boys. They say girls can only grow up to be malaya (prostitutes).

As we got to know Josie, a drinking hut was constructed in her compound. Men join an association to be able to drink there, and women join to make the alcohol for the men to drink. Josie decided that this was a convenient opportunity for her to make money, without having to leave the child. She needed 2000= to join and 6,000= to invest in a sack of millet. To Josie, it was better than becoming an alcohol seller.

A friend was advising me that I should sell waragi in my house, and that way I would get expensive men. Some of my customers would be my men. If I was selling alcohol, I would not be suffering like this. I said that I could not allow because my house is so dirty, there is no bed and no good things. I cannot allow them to see my poverty. She said: "That is no problem these men will put in all of those things in less than a week. You are even lucky you are very young and very beautiful, so you can attract many men. Some will give you 10,000=, some will give you 5,000=."

For me of course I would have to have sex with them, there is nothing for nothing, I would have to pay for the things they give me, I cannot manage such a life, I would rather suffer. I know what women who sell alcohol go through. They do the selling and at the end they sleep with them. If I allowed, they would get drunk in my house and sleep here. Then where would I sleep with my children?

Making alcohol was one job that she could do and no one would have to enter her house. So what Josie did was borrow money, and make the investment to join the drinking hut association. Every twelve days it was to be her day to sell malawa (millet beer). It became apparent to Josie that "people did not like drinking in the hut in her compound because we look really poor ... They even seem to fear AIDS ... Why should they fear? They can die maybe of a motor car accident, yet people believe that everyone in this town is dead." To compound the problem, she did not realize that the same sexual pressure levelled against women who sell alcohol in their homes is levelled at those who supply the drinking huts.

The men have been wanting me. I have not gone with any of them but they are going to be drinking my malawa on credit and not paying me. These men even come here at night, different men at different times. They knock but I refuse. They threaten me by saying, "If you refuse, who is going to buy your alcohol? You should at least take one member... this one (the one she had sex with) would encourage the others to come and drink. Even on the days I am not selling I should go there and sit with them while they drink, and converse. When I have to use firewood (not a charcoal burner), I must cross by the hut, to check on my food. They call me and I refuse to go. They tell me I should not behave like that because if I do no one will buy my alcohol, I am really discouraged.

Josie had invested in a batch, and tried to sell it, to no avail. The alcohol went bad, so she had to dump it out. "They are refusing to drink because I have refused them ... they are telling me openly, "You refused us so we are not going to buy from you." She had invested close to 21,000 shillings.

Josie was under incredible emotional, financial and sexual pressure. Her dilemma was immense. She was HIV positive and was the primary caregiver to two children, one who was more than likely sick. Her inability to cope in town led her to decide to take up her brother's offer to come and live and work with him, in his bar in a trading centre on Kooki side. She had many offers of employment in Lyantonde, however Farouk needed constant care, and she did not feel comfortable taking him out of the home. The leering and staring had been getting to her. Unfortunately, as good hearted as her kin were, they did not feel capable of assuming the feeding and treatment costs of both Kadid and Farouk. Because of the stepmother, her paternal home was not considered an option. Josie was forced back into town, into hotel and bar work, work that she had previously adamantly refused to do. This choice was to have serious consequences for both her relationship with Kalim, and her children.

Because there were so many girls, either falling sick or dying at Dembe bar, she was able to find a position there as lodgekeeper. Josie was always at the bar by 4.00 pm. She

made up the beds and then she sat at a desk until midnight, giving out rooms. In the beginning, her co-workers, the waitresses at the bar, started to give her a hard time, but only because she was unaware of the unwritten rules and expectations.

They hated me so much that every time I would pass, they would jeer at me. They kept saying that the former girl was good because she used to get them men. For me, I was just finishing my work and leaving. They would say "What does this girl expect us to eat?" And then whenever some of the guests would bring in some of their own girls from other hotels and bars, these girls would just be furious. They would not even greet me because they thought I left this place to get these men other women from other places. I used to hear that a woman can have sex with five to ten men in a day. I did not believe it, but now I do.

The men who check in at the hotel typically approach the lodgekeeper to be the liaison in making sexual arrangements. Each time a man sends the lodgekeeper to bring a girl, he gives her 1000=. There are 16 rooms at this particular bar and Josie related that it was possible to take between one and four girls to each room per night.

They (the guest) first ask me to tell any girl to bring two beers into their room. Of course the girl who serves the beer serves sexually. The second beer is meant for her. The girl takes the beer and she goes (to his room), but first she informs (her coworkers) where she has gone, in case the boss asks. This sex will take a short time, from thirty minutes to an hour, because she has to go back to work. But this depends on the amount of money the man has offered. Below 10,000= is short time play; above, the girl spends the whole night with the man. In fact, men usually ask for a short time girl who goes back to work and joins him in

the room after midnight. Some girls leave one room, rush to bathe, and sit waiting for another call.

Learning about sex work in hotels was, for Josie, a whole new experience.

Girls there are after money. By the end of the day you can find them talking amongst themselves: "Yesterday was really good I made 25,000 = plus a pair of shoes," or bedsheets and cremes. The most beautiful girl there, the most popular girl is a widow, and her husband died recently of silimu. She went straight to the bar to work. Most men, knowing this, just point to her as soon as they see her.

She comes face to face with her own mortality every morning when she has to clean the rooms and dispose of all of the used condoms.

The women have no time to dispose of them after the game because they rush to bathe, change and find other business. The men just leave them there. I do not know who will be spared by this disease. It is going to finish everybody.

It was soon after Josie started working at Dembe that we invited her to walk to Kyabbazala with us to visit a friend of ours who was sick at her auntie's place. The trip there was difficult for Josie. This was one of the women who had been a bar girl at Dembe for years. In addition, another friend of the girls had just died. Not surprisingly, most of the girls seemed to be reeling from the gravity of their jobs and situations. We were even advised not go and visit her, by one woman who worked in the bar. Josie had an explanation.

Some people visit to see how sick she really is, to see how dirty the sheets are and what is in the house. People start talking as soon as they leave, "Eh the house was smelling." They ask, "Is she dying anytime?" So when they get this disease they fear others to know.

But Josie herself is very critical of other people's scorn, because she knows that it comes from fear.

I do not feel anything since I already know that I am going to die. The problem is I do have many friends in town who have fallen sick and have died from AIDS. Sometimes I go and look at them and think someday I will also be like this. But my friends will be coming around to visit me. I will get strength. They can come and bring me support. I am going to be crying, because I will know I am going to die. There is no use being ashamed at telling the truth.

It was only a fortnight later that the same trek was made up the hill when Goretti did die. Josie's concerns were very telling. Four women from Dembe had died within three months of each other.

They were all very close friends, working in the same bar; all died of the same sickness and around the same time. It is likely they used the same man. It does not matter if one man is a sex partner of another, all are after money. If a man is good with money and others hear about it, they will try as hard as possible to have sex with this man. Five girls can sleep with the same man one after the other, on the same day.

Upon arriving at the home of the deceased, both Josie and Janette were astounded at finding only two people seated with Goretti's body.¹¹ These women talked freely about the

progression of the disease and how difficult Goretti's death was.

Sometimes she used to wish herself dead because she was in so much pain, and when she was about to die she started worrying about her child. She kept saying, "I am going to leave my child to suffer."

The conversation evolved into a discussion of the importance of leaving a child behind to 'resurrect' the woman's name and to transfer property. "People look at your child and keep saying, 'This is so and so's child,' but if you do not have that, it is the end of you."

Josie found this reasoning difficult.

I even regret why I had to produce children. I wish I was barren. It does not matter whether my name dies or not, or whether I resurrect through my children. What matters is their well being. I worry over what will happen to my children when I die. Will they grow up well or suffering. A sick woman dies faster when she has children because she will be thinking about her child's well being; in fact, in such cases these children do not grow up.

Part of her decision to take the job involved leaving the children in the care of a neighbour. Accordingly, she had no control over what, when or how much they were fed, or slept. Well into his second year by then, Farouk's care had become increasingly burdensome because of constant fever and diarrhoea. In fact, Josie was leaning more and more towards, herbal treatments for his illness.

Because she was at the bar all day some days, and into the night some nights, she agreed to let Maama Bob take her

children to Kampala, visiting for an indefinite period of time. This allowed Josie the opportunity to make money at the bar. As can be predicted, Kalim had difficulties with her working at Dembe. His first concern was his child. "How can you leave my child cold and alone in the night? He is going to get sick and die!" His second was the 'exposure' Josie was getting with other men. On more than one occasion, his jealousy took him to the bar, to tell her to go back home. It also made him more attentive. But Josie reasoned, "If I go home without money, then my child still dies." It was not clear to us if Josie herself was engaging in full scale prostitution. However, she did have a few partners at once, and more than one wanted to take her out of the AIDS compound and set her up in a new home, with better security and electricity.

At this point, a whole constellation of events occurred in Josie's life in a very short period of time, all of which led her to deal with living with HIV much differently. She was at the bar one morning when the body of her daughter, aged six, arrived on a vehicle from Kampala. Kadidi had been killed. Having a very difficult time swallowing the news, Josie collapsed on the street, wailing, calling out her daughter's name. People crowded around her thinking that she was 'running mad'. Kadidi's body was to be transported to her father's village on the Kaliro side of town, immediately.

When they arrived, the mother-in-law of the late husband was extremely bitter. Josie and those who escorted her were still in the back of the truck with the body when she started shouting.

You refused to give me my grandchild when she was young and alive. Why must you bring here a dead body? Take it back and know what to do with it. You killed my grandchild because you are married to another man. How dare you bring the dead body here?

The owners of the truck wanted the body off the vehicle so they could get back to Kampala before dusk. Josie and the women on the vehicle were humble and silent as they were confronted with her rage. The men on the vehicle had to intervene.

Whether you refuse the body or not the child has died. You will never see her alive, so why not bury her so you can view the grave?

After much negotiation with the townspeople and nudging from her neighbour, Kadidi's grandmother agreed to put the body into her house. Many people, including bar girls, attended this burial, with a great deal of wailing. The child was wrapped in traditional bark cloth, and buried without a prayer from a priest, as he was not called on time.

Josie thought that her grief was going to kill her. Weight loss and lack of sleep were compromising her health.

I am so scared about my sickness. I thought this time I was going to die. Since she died, I have not slept. I just lie in my bed and think, "How could God do this to me?" I keep wondering

what I did to God. At least Farouk would have died because he is already gone. I gave him in already. Anytime he can die and I cannot change it I knew that this is the only child I would leave on earth and she is gone now, I wish she had died after I had already died, so I would not have to see her dead. Now I do not see any value in life.

The allegations that she would, with intent, kill her own child were what consumed her. She talked about the difficulties she encountered raising this child on her own.¹²

If I wanted to be with another man, why didn't I kill her when she was a baby? She was a very sickly child from when she was a month old to two years. I used to walk with her on my back to the hospital and to the bushes looking for traditional medicine. After my husband died his family did not offer any support. I used to take her long distances to get her treated in Kaliro, Kinuka, Mbirizi. When she was a year and a half I moved her to Lyantonde. I did not depend on men or sex to look after her. Even Farouk's father who I met later was not providing support. Some days my child would drink only water and sleep. But I was very determined to see my child grow. When she was three and some, I could look at her, starving, so hungry and crying, I would also cry. My child grew up in problems and understood when I did not have money to buy food.

When her first husband died, Josie eventually left his parents compound. It was expected that she leave the child there to be fostered by his kin. Subsequently, the initial explanation for the child's death was a spiritual one.

When I shifted to Lyantonde and insisted that I take my child, they were not happy. They wanted to take the child away from me. They said I would live to regret it. Later I started getting dreams and I would see my late husband telling me that he

wanted his child back in Kaliro. My neighbours once told me that I would be attacked by my father's ghost. I was told to get medicine to protect my child.

What Josie could not fully accept was why the spirit of the late husband would want to kill his own child.

But maybe the mother used medicine to send the ghost to kill her because she was not happy with me. But would not she rather have taken the child by force or made her sick and warned me that the child was big enough to go to their village? I cannot believe I suffered for nothing." ¹³

Although Josie understood much later that her daughter died in an accident, she could not publically raise questions. It was difficult convincing the paternal kin of the child of the cause of death. But Maama Bob had actually told them that when he child was dying she murmured, "Daddy, you are killing me." Josie was convinced that quarrelling with her neighbour could only have negative implications. She was advised not to spoil the relationship with her neighbour, as she was the only one who would agree to care for Farouk.

After the death of her child, Kalim became far more attentive than ever before; emotionally, sexually and economically.

"He was one of the ones who helped to organize the transport of the dead body, he brought many friends to the funeral ... He kept on sending money, meat, bunches of matoke, and when we were alone he would plead with me never to go back

to the bar again." He had been scorned by his peers "because he dresses so smartly, owns a TV and has a wife that lives in soil (mud and wattle)." And to make things worse, this wife was working in a bar. "But he would not give me or his child any money ... He would say as long as you work in a lodge you will not be my friend ... but for me I have always refused to quit the job because how would I eat? At the end of the day I walk home with 3000= to 5000= ..." That was the money she saved from 'pimping'.

Kalims 'problem/excuse' for his lack of support was explained to Josie's sister, the one living in Kyawanula. She recounted his lament to Josie.

I still love Josie very much and I have all of the intentions of marrying her but I am very unhappy that she works in the bar. She should be having other men. I had been having a problem that Josie had a child that did not belong to me. Although the father of that child died he paid a full dowry to Josie's parent's, so she still belongs to that family as a wife. They could come and claim her and I would be at a loss. I have not been serious because I have feared that family.

Josie explained that the late husband was merely 'introduced' to her father, and that no additional dowry was paid. The child was dead. Therefore Kalim could take Josie in marriage formally.

He has been disgraced at home with his other wife because she is lazy and dirty. She never cleans his clothes, bed, compound or the house. The children are dirty, so he feels ashamed to take his friends there. The woman cannot even cook food; the

matoke just rots. He bought her a plot and she cannot even dig; built her a house, and still she cannot keep her house clean. He complains that he buys her everything and even leaves her money for emergencies.

Now the man is full of promises; a real bed, a bed for his son, real bedsheets, clothing.

He wants to buy me a plot now and build me a house of my own instead of suffering in town. He says it is good to have your own house and everything in it so when you get sick you do not get ashamed. Every one of us will get sick some time but we have to plan for that time. How will people come to look after you when you are sleeping in a dirty room with nothing? Besides, these days a person looks after you when she knows that there will be something to inherit when you die.

All of these promises made by the man that she has loved and at the same time debilitated her emotionally, came with an incredible amount of reproductive pressure. His demands for a child even in the months before Kadidi died, increased immensely. He said he could not agree to use birth control. "I cannot allow (birth control) I want more children. We are still very young ... my son needs a brother or sister. Who am I working for if I do not have many other children?" Condoms, for him, were not an option, partially because introducing them after having a child together did not seem reasonable to him.

Is this the first time we are having sex? What are you fearing? Does this mean you have a man you are keeping the things for? I will never sleep with you using a condom.

Josie was not at all concerned about not negotiating condom use. Nor has she told him her serostatus. When they argue, she tells him she does not have the strength to look after more children. The pressure to produce came at a time in her life when she was extremely vulnerable. Having lost a healthy child, one which could have grown into adulthood, was very difficult for her. It would seem reasonable that people around her were advising her to "get another child to console yourself." By this time, Josie had utilized both traditional and Western methods for birth control. She felt that if she did take birth control pills, Kalim would find them. At the same time, she did not see the point of informing him of her serostatus, as "he was the one who brought this disease."

Problematic, however, was that at the same time she was communicating to us her worries, she was indeed pregnant. Her periods had ceased, but she thought that "HIV women do not get periods." Her world was in flux as she really was unsure of paternity. It emerged that she had not been using condoms with the milk truck driver either. It was not long after that she started bleeding; "The basin was almost full ... there was so many clots ... I was sweating and so weak ... I tried to work in the lodge but the pain was so bad ..." Her neighbours insisted that the remains be buried, instead of thrown away.

Although Kalim continued to support her during this time, he was convinced that she had had an abortion.

Throughout this period of suffering, Josie's son's health was slowly deteriorating. He was literally wasting away. Sometimes all that he would eat in a day was raw cassava, which would throw his body into spasms of diarrhoea and vomiting. Josie, working at the bar for most of the day, had no control over the 'neighbourly neglect'. For the first time since we knew her Josie felt resigned to accept his death.

I have a lot of problems. My child died and now I have no love for this child because I know he is going to die, I am suffering with him for nothing, I wish I could die now before he dies. I have had two children and yet I am childless. Some people will even start to laugh at me.

Every time Farouk took a turn for the worse, Josie's emotional health spiralled. Worried and tearful, she could not imagine herself without any children. Kalim's support did continue for a few months. He was paying for treatment bills at the clinic. But Josie had a hard time convincing him of the importance of herbal medicines and traditional medical advisors. Josie travelled with Farouk deep into the village to be advised by a woman that her aunt knew. Josie expressed profound disbelief at 'how much she knew' about her life. According to the woman advisor, the cause of Josie's problem

is witchcraft which was sent from Josie's former marriage.

Josie said of her late husband:

When he died, there were some things I took from the compound to help me with Kadidi - mattress, blankets, sheets. This witchcraft has been sent to disturb me and any offspring I will get. She told me to take back the things even if they were rags. She gave me medicine for bathing, drinking and burning in the house to chase the ghosts.

With this explanation, a part of Josie was convinced that Farouk would grow, would thrive, and live to be an adult. And Farouk's health did improve, however temporarily. His father still did not know that the mother of his child was HIV positive. His support of Josie continued until an episode of gonorrhoea exploded this time of bliss. Josie was at that point in her marathon of suffering, when she believed that each time an ailment arose, she was going to die. "All night I was squatting in a basin and crying ... and he turned to me and said, 'Now you have brought for me disease, it means you are going out with other men.'" He initially refused to give her money for treatment. At one point, Josie was in such pain she had to send a child to his home to call him. He did come, and he threw 2,000 shillings at her for antibiotics. There was a gloomy exchange of words.

He gave me more money and said: "That is your silimu. For me, I have never suffered from such a disease.' I was very bitter so I told him, "You play sex like a 'cock'. Every woman you see is for you. How could you miss getting such a disease? Even your wife has suffered from it. Leave me with

my silimu, then, but remember, if I have it, you also have it." He stood up and said, "I have gone and I will not come back here because you are sick. You have your diseases; you can keep them." He thought I was going to kneel before him and say, "Please do not go." I know I will die but I cannot beg a man.

ENDNOTES

- ¹ The implication being that the stepmother had 'planted' charms.
- ² The birth of twins is an honour, and the family must perform the ceremony, otherwise they risk being 'burned.'
- ³ At that time the Rakai AIDS Information Network was charging 1500= . The next year the price went down to 500=.
- ⁴ She had stopped lactating and there were no shillings to buy milk or soya supplement for the baby. We never ever heard evidence to suggest that Josie, while married sought the attention and support of other men.
- ⁵ TASO (AIDS Support Organization) does not reach Rakai, however, people do know that they do provide various types of support. To belong to TASO one must be HIV positive. By extension, people believed that the drugs provided by RAIN were an indication that Josie was sick. " You are already dead. There is no way you could get free treatment if they did not all know you were already sick."
- ⁶ I can remember sitting in her house, and being offered the sweet bananas that were to be Kadidi's meal. Things got so bad that we told her to come and harvest our sweet potatoes, which were boiled and eaten with no sauce. She was in an awful predicament.
- ⁷ It is important to note here that Josie looked so, so happy. She had bought a new dress, her breasts were full of milk, her skin was gleaming from new cremes, and her hair was French cut.
- ⁸ After receiving her results, she came right to our home. She stayed with us for most of the day. Much needed was emotional support and refuge from the barrage of questions she was anticipating from women in the AIDS compound.
- ⁹ As Ankrah (1991) notes dermatological problems, much like those with diarrhoea, regardless of whether they are HIV related evoke fear in the home.
- ¹⁰ This is one of the women described in Chapter 2. The visit was difficult as Goretti was quite sick, retching etc. She was

pitying me for not having been able to see her sister Dorothy before she died. Soothing was the fact that she was well cared for, her sheets were clean and ironed ... She did die a few weeks later.

¹¹ Janette admitted that she had never in her life seen so few people keeping vigil. The two women there were the caretakers of both Goretti and her sister Dorothy. There are usually many, including men and children, in a home until after burial. There was long grass laid out to accommodate visitors and the body was wrapped in sheets, a **busuti**, and laid out on a mattress on top of banana stems.

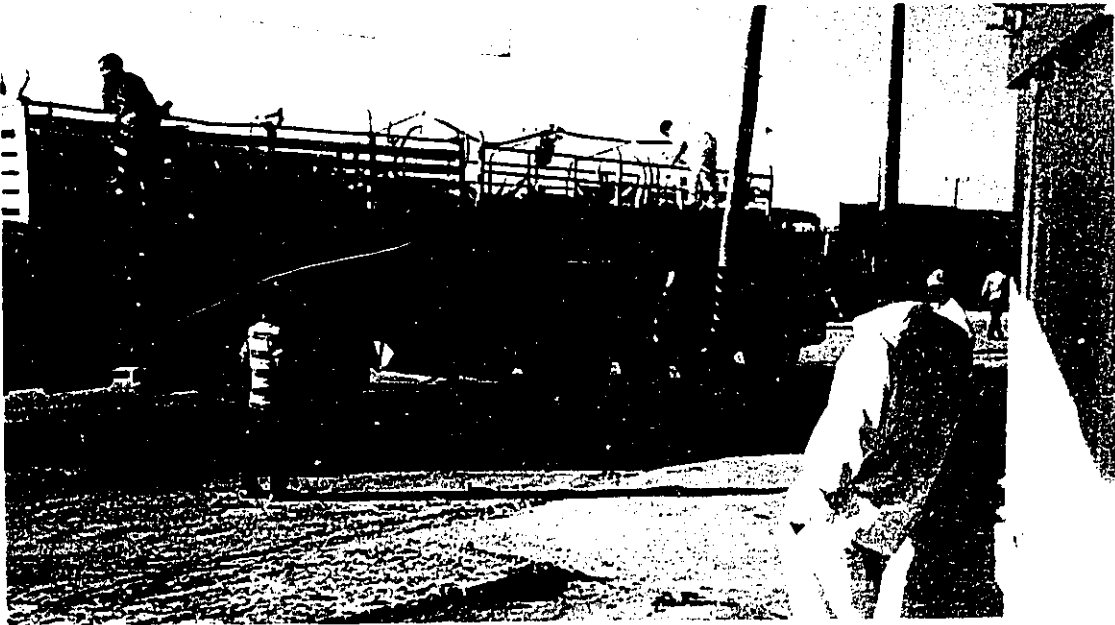
¹² It should be noted that 'kill' can mean murder in a real physical sense, but it can also mean through the realm of witchcraft.

¹³ Maama Bob, the neighbour who had taken Kadidi to Kampala, had not provided enough information to the towns people in Lyantonde. She said she died of an unknown illness, and that it was likely that she had been strangled by a 'ghost' With a witchcraft explanation, she was absolved of any responsibility and public ramifications in town. Josie believed the story because of the dreams she had after his death. In time Josie was to find out that Kadidi had been hit by a car in Kampala. She was told that the corpse "did not look like a body killed by ghosts ... There was too much blood on the sheets she was wrapped in and her upper torso had been mangled."

Figure 10.
The Bustle of Town



The Lyantonde market.



Cattle loaders, re-loading Ankole cattle.

***Maama Mali:
The Story of an Alcohol Seller***

Much of Maama Mali's adult life was transient in nature, shifting her household and family to and from Lyantonde and her father's village, Muwogola, in Masaka district. We met her when she was living in town, negotiating through a gamut of relapsing illness, relative poverty and uncertainty.¹ Maama Mali supported herself and her infant son, Mali, by selling alcohol and charcoal out of her room in Kiyeye.² She yearned for a certain and stable future. One of the very first things she said to us was, " I have been very sick with fever for so long. I think it is because of the mosquito bites on my skin. But I do not think these are mosquito bites; it is a rash and I have seen people with silimu with this rash ... What I have is silimu ..."

Both of her parents resided in the village and were overseers of fairly sizeable banana and coffee plantations. Her father had two wives. The first wife had only daughters, so after the divorce she moved to Kooki side where some of the daughters married. Maama Mali's own mother, the second and last 'formal' wife had twelve children. Only five, including Maama Mali, were living. Four died when they were still young

and three daughters have died of 'silimu' after having a child each.

Lacking money for school fees, her parents took her to a Catholic boarding school run by missionaries. In the morning the children were in religious class and in the afternoon they worked in the large matoke and coffee plantations owned by the priests. She left school at the age of sixteen, and was married the very next year. By then, her husband, a mechanic, was old, 'way above thirty,' and had already been divorced from two other women. They left him with two children, a boy and a girl, who became her responsibility when she married.

Later she was to bear him three children, two girls and a boy. It was after the birth of the third child that Maama Mally felt 'forced' to leave her marriage.

I left because of my in laws there were three sisters, all divorced and living there ... he was the only male in the family and had built in his parents' compound ... he liked his mother so much, he never wanted her to cook a meal, so I cooked for all ... we all ate together, mothers, sisters, and all of their children ... they would never help me with any work ... as soon as they finished eating, they would go ... if it was not ready, they would quarrel ... they put their clothes out for me to wash ... I was married to their brother so I had to do every bit of their work ... I could not stand that so I decided to leave and go to my parents' place...³

Maama Mali explained that "when some women fail in marriage they return home ... They usually mistreat the wives

of the married brother, they want the brother to remain single so they can be supported by him ... Maybe that is what they did." The sisters in law were business women in the markets, and of the three one had died of "this disease". Speaking of her husband, Maama Mali said, "I had asked him to get our own plot so that he builds and we would be free of those people, but he refused." She stated that she really was unsure as to whether witchcraft was used to help force her out. "I was too young to know anything ... but do you think someone can just decide to go? There should have been some witchcraft that turned my heart away."

Maama Mali packed up, weaned the last born, and left. Later, while helping her parents cultivate in the village, she met a man.

I lived in a big house, but separate from my parents. Three of my sisters were there all divorced. We all had our own rooms; each was free to bring a man. Those days was there anything to fear? We just used to enjoy ourselves; if you got tired of a man you would just leave, change and get another ... it is not like these days, eh ... these are bad days ... these men were already married with children ...the women in the village knew about me ...there was no way someone could have an affair in the village and the wife not know ... at least they did not attack me, neither did I go to their homes.

The next three children she conceived were fathered by these different men in the village, and all three of these children died, at three, three and a half, and the last at eleven months. Maama Mali said she was unaware of the cause

of death of the first two, but the last was measles. All of the children were buried in their father's village.

Of course, the unexplained deaths made her extremely nervous. The possibility was there that the deaths were related to a curse from the husband. She says although she was very angry, she returned to the husband. By the time she conceived the fifth child her former ex-husband had married another, and also had another child.

I used to quarrel with her everyday ... she had cultivated all of the land, so when I got there she did not want me to take any of the land to grow food for my children ... the houses we lived in were just opposite each other ... we would quarrel in the courtyard ... every day we would work in the garden, meet on the path and quarrel for the rest of the day ... there was so much jealousy that whenever he would sleep in my house ... we would hear her walking around the house at night, around and around and around ...

According to Maama Mali, whenever he bought her cloth, something for her house, or even just sauce for matoke there would be an explosion, and on many occasions the women would physically fight. The neighbours would have to separate them. Eventually it became apparent to Maama Mali that the co-wife was visiting a traditional practitioner.

She would go very early in the morning instead of going to the garden, and come back with something wrapped in leaves ... I do not know how she was doing it but he used to find the witchcraft things and always quarrel with her. This went on for a month and finally I started feeling like I hated the man ... so I went back to my parents ... He followed me there.

She left regardless of the fact that she was happy in her marriage and that her husband treated her well.

He really liked me ... we did not have a big plot to have a matoke plantation, so we had to buy ... but he made sure the food was always there ... I hear of women eating 'ntula' (bitter tomato, considered a poor people's food), but I only knew meat ... never ground nuts, it was just the problem of the compound ... a small plot, with a few houses. I was sharing the same kitchen with the co-wife ... The sisters really made me work ...

So in 1991, Maama Mali came to stay with her brother, a cattle trader in Lyantonde where her last born, Mali, was conceived though born in her parents village, in February of 1992. She returned to town in January, and had been living in Lyantonde ever since.

With a smirk, Maama Mali told us that it was not possible for her child to have a clan if she really did not know who the father was.

Children born out of 'magendo' (illicit businessmen) cannot have a clan ... if you have sex with a trailer driver who you met for one day, makes you pregnant, and the next day goes away, without ever coming back, how would you know the clan of your child. Of course in one day you would not have talked about his tribe and his clan!

Maama Mali did meet the child's father doing business, but he is not a trailer driver.

She had shifted to Lyantonde after years of living in the village, and immediately began selling alcohol out of her room on Kijjukizo Road, just a short distance from the centre of

town. Initially, her brother provided her with the needed credit (cash, soda and bottled beer) to get her business off of the ground. To maximize profits, she took her alcohol on the market circuit. Taata Mali was a tailor, so when business was good, he rented a sewing machine, took and filled orders right there in the market.⁴

I could not manage village life any more ... so I returned to town ... I was finding difficulties finding money to buy things for the house and the things I needed to look after myself, so I got this man to look after me ... but that was the work of Satan, and how I got pregnant.

It was Maama Mali who informed us of the sexual subtext of social relationships in the 'market milieu'. Sex is commonplace. In fact, semi permanent structures are erected to provide 'lodging' for those who are willing to pay for it. " A woman cannot fail to get thirty minutes to go with a man unless she does not know if he has money or not ..."

We never slept together in the markets ... while others coupled I slept under polythene bags I shared with three other women ... but he could have had other women when I did not know ... I did not care much ... if I had done what other women were doing, I would not be here now ... I would have already died ... at that time they looked healthy ... of all of us (alcohol sellers) I looked the most sickly people used to say I was slimming and I was going to die but instead these women died first.

According to Maama Mali, most women who trade in the markets are unmarried. However, there are a few married women who have permanent partners - 'safari' men - and at the same

time have a permanent partner - a trader- in the markets. They meet up on markets days. " Those who slept there, they wanted to get money and nice things so that they became very rich ... but most were single unmarried women ..."

Even within the market the women had more than one man, where they are surrounded by bushes ... during the working hours when everyone is busy a woman can take off and go to the bush with another man and come back and continue working, and her permanent partner (in the market) would not know she was just trying to get more money.

At that time market activity had lessened, an effect of the cattle ban. The Bahima would come, sell their cattle, and in turn buy goods. "The traders would get a lot of money, and then they use their money to get women." Maama Mali lamented that she only knew one woman left from the market days.

Most of them have died of AIDS ... so many have been sick ... I do not know if they got it from the market or ... or if they brought it with them from the village to the markets ... could they not take it from there to the markets? ... some people say that AIDS is in towns yet some can still come from the villages to go to the markets when they have AIDS...it is difficult to know because it takes a long period in one's body.

In her experience, sickness does not necessarily affect the business.

Unless they are very weak and dying and cannot stand to work ... most of the people who still have their own customers will bring others ... even if she's looking thin they would not go drink elsewhere because she is thin.

Maama Mali said she could no longer go into the markets because she was so sickly.⁵

My life is very little ... I know I will never get well, I know there is no treatment for my sickness, my biggest problem is headache. When I get frightened or a shock, it just pains ... the market people shout ... I am no longer comfortable there. There's no treatment that I am going to get to make my headache go ...

Like many other people, Mali's father also decided to leave the market after the implementation of the cattle ban. He set up a permanent shop on Kooki Road. Mali's father has a wife and family in a village called Kalegero, a kilometre away from Lyantonde. His wife, Maama Mali said, knew about her but did not harass her. In fact, she went to his home for treatment money while she was pregnant, and even slept there after she delivered. Ties were severed with that man soon after the birth because he was not providing consistent support.

He would sometimes buy food but never bought a dress, vaseline or helped me pay the rent ... it's like I had him (Mali) alone ... I really did not want a man ... I had three children who died, so I did not want any more ... they would just all suffer and then they would die ... I failed to find a Muganda tier⁶ ... what came for me was just the work of Satan.

Maama Mali claimed it was because of her problems that she had to sell alcohol (waragi) out of her room.

Alcohol selling is not a good job ... if that's the only way I can feed myself there is nothing that I can do ... it is a job for people who did not go to school ... it is so bad some women who sell alcohol have ended up being beaten ... he comes to your room, he drinks, gets drunk ... she asks for her money ... he refuses ... if she insists, he just slaps her ...

And sex is definitely a part of the trade.

There are some who drink with their customers ... the men are drinking and they also drink ... when they get drunk they act in a way that attracts these men ... some of them get drunk before the men do ... they even do not know what they are doing ... my neighbour when she drinks she plays (flirts) and invites them to sleep with her ... she often ends up having sex with every customer that comes there.

I do not play, I do not drink alcohol, I'm good to them because they are my customers ... sometimes when they are drunk there is no getting them out of the house... they do not joke with me ... but no man would want to sleep with me anyway, which man cannot see that I am sick? Very many men have disturbed me ... but when they suggest (sex) I tell them there and then that I do not want ... but of course they insist, but so do I ... men usually bring in things for a woman when she has not shown her side ... these days you cannot eat a man's things for nothing, you have to pay for it ... sometimes a man will come with sugar and bread ... but it is very dangerous to eat these things if you are not going to accept the man ...⁷

Although she continued to sell alcohol out of her room, there were days when she became paralysed by fear. Fever, prolonged periods of diarrhoea, weight loss, and eventually tuberculosis made her uncertain about the illness of both her

and her child. This uncertainty was exacerbated by the tension stemming from the belief that her immediate family was the target of a revenge-related illness called *omutego*. According to Maama Mali, the way people die "with the virus" mirrors the course of suffering caused by "terminal witchcraft." This belief adds to the fear, uncertainty and confusion which accompanies an episode of illness.

I am not even sure that it is AIDS that I am suffering from ... what kind of disease is this that cannot kill even the partner ... all of the partners who I was with that time are still alive ... I just say it is AIDS because of the way I get sick ...

Problematic, however, is that *omutego* is extremely fatal if not caught in time.

If it comes in the house, it would not kill just one, it would shake down the whole house ... it is sent in revenge, it comes in the wind searching for the person who owes ... if someone borrowed money and failed to pay it back ... if a woman is pregnant and has had many partners, and she does not know the paternity of the child, she gives it to one man and yet another man wants to claim it, he sends *omutego* ... if a family fails to pay for the bull they borrowed to put on the funeral rites ... it kills the first person, the second person and unless someone catches it and gets treatment ... the person who sends it will tell it to keep looking for the debt ... that is why it usually clears the family line."

At different times in the course of our friendship Maama Mali told us that three of her siblings had already died of this disease, that is AIDS, but she also told us three of her siblings of the same mother and father had died of *omutego*.

And many more in her family, including step sisters and brothers, were rumoured to be sick. "I do not think there is anybody here who does not have AIDS. Now everybody here has this disease. The problem is we did not know about it, and by the time we knew about it, we had already been moving ..."

Maama Mali has observed that AIDS - unlike omutego which actually chooses its victims - AIDS chooses bodies arbitrarily. And in her family, people were falling sick almost systematically, again beyond reason.

Whether an older person dies, or a younger person, silimu chooses the body, it is just like the flu ... a person cannot know where she got it but finds herself with it ... but even if some people say you get it through adultery ... some people have done it and do not catch it ... but for me, it means it has not chosen their body.

This uncertainty has confused Maama Mali, concerning the health of her last born.

I want to take him for immunization but I fear because people say if you have some disease, the child will just die if it gets it ... I know if a woman has AIDS, a child cannot grow in the stomach and be born without AIDS ... I know my child has the same disease, because he has been sick since he was born ... I want to stop breast feeding ... myself I am weak I cannot manage to breast feed any more ... there must be viruses in the milk ...

The cumulative effect of the death of three children and the trauma of this last pregnancy, has really left her terrified of giving birth again.

I had been feeling fever before I had gone back to the husband, ... I would get treatment ... it would go for some days and come back ... on and

off ... when I got pregnant the fever got worse ... I started getting very worried and got thin because I had been told by other women that if someone had the virus and was pregnant they would die, one day, six days or six months after ... so I worried because I knew I had the virus ... when the time came for me to deliver I did not go to the hospital ... I thought after all I am going to die, there was no use ... I just did not care ... the day after I was so sick, malaria, diarrhoea, unconscious ... I did not know what was in the world ... after the birth I continued in sickness, I was sick for three months and Mali was as thin as this leaf (a piece of banana leaf she had been playing with). Me, myself, I was like a dead body.

She added that:

Mali was the work of satan. For me I did not want to have any more children. I had lost three children, one after the other. I did not want any more because I knew they would also die. I do not fear this disease but I fear having children ... because my life is little I cannot afford it ... when I had just delivered, I could not even sit, I was so dizzy. I could not even lift my arms to hold my baby.

The first child that died is the one that hurt me the most ... she was three years old, had malaria an auntie took her for treatment. She was injected by a lay practitioner in the village and it was likely that the drugs were expired ... it's just the age, at least let a child die when they are small ... but my children usually die when they are big ... in fact, by now they would be fetching water.

There is nobody who does not have it ... even if you are look well this disease is just in our bodies ... there is no way people can prevent it from entering ... look at these married women at home the husband moves around outside, stands out in the dark being beaten by mosquitoes, while waiting for young girls ... for me I feel bad for such a woman, because she is innocent, just staying at home but will also get the disease, we are all going to die."

Maama Mali remembered a time when women were advised to divorce their husbands if they were aware of a shady past.

But these days they do not divorce ... even though they know he is going out it is useless to leave, this man might have had other relations for a long time ... the virus might have already entered you ... so why do you leave your children to suffer? You just stay and wait for your day ...

Maama Mali told a story to emphasize her point.

We knew a woman whose husband had another [wife], who had died of AIDS ... he [the husband] was worried, thinking that he may have given it [HIV] to his wife, he wanted to tell her but he did not know how ... one day he decided to tell her about the death of the other woman and went out and bought meat, matoke and malawa (millet beer)... so the woman cooked a big supper after they had eaten and the children were in bed, they drank until they were both very drunk. The man decided to tell her: He said do you know ... (so and so)? She did. He said: "that woman died of AIDS and I used to be with that woman." The woman who seemed drunk at that moment, became sober ... She ran out and made an alarm ... the neighbours came out and collected all around her, demanding to know what was wrong. She cried: "This man has killed me, killed me ... he had a woman who had silimu." The man admitted to the sympathizing crowd, "Yes it is true, I had to tell her. I did not want to leave her in darkness." They sympathized with her as she continued to cry. To this day she is still with him.

But where would she go? She could not leave her children; children tie a woman to a marriage even if there are problems. Even before AIDS, even if she was mistreated ... beaten ... so much quarrelling ... the woman would stay ... women like this say "how can I leave my children to suffer?" or "where will I go with them?" If such a woman did not have children ... she would have just gone away if she heard this kind of thing from her husband."

These days Maama Mali thinks it is better if women stay with their husbands.

This way the virus does not jump from one to the other ... if such a woman did not have children, she would move and kill many more people, if it is AIDS at least if both stay together, they can plan for their children ... and by the time they both die they can leave property behind for them ... if she just deserted, a man can marry another and the step mother will just mistreat them ... that is why you can see some dying ... they can beat the children of their co-wives to death..."

But regardless of risk, Maama Mali maintains that being in a marriage in the formal sense is good. The provision of support is far more important than whether the husband has other women.

If a man is providing for you ... clothes for visiting and paying school fees for older children ... you do not have to go out (to other men) and beg for things ... like salt and soap, leaving you there without a dress to visit in so you cannot move and he is going around with other women. In such a case it is better to stay alone, digging or doing her own work ... a single room like here has problems ... if a woman is quarrelling with neighbours in the village, at least you are in your own house, at least the husband provides everything ... in a single room you struggle and work to get everything you need...

This disease lurks in the shadows of the minds of many women in this community, and according to Maama Mali they must still bear children.

How can a woman convince a man that she does not want any more children ... if a man wants children he will just continue ... You will not be shocked to see a man having a child with this woman, the next day see him with a child and another woman ... Men usually want to have very

many children ... It is something about attaching the child to his name. It is because for them they do not go through any pain, it is just a matter of sleeping ... I do not know why they continue. When it comes to looking after, educating, providing treatment, they find problems ... Even if the children are dying like in my case, they will just want to continue having more ... it does not matter to him whether they are dying, he just wants to produce ... if the woman decides to swallow pills without the knowledge of the man ... he will see that she is not producing, so he will get a woman outside so he can get more children ... that is why men bring silimu in homes ... They go out looking for children and they end up bringing silimu ... Even if a man is sick and in bed, he will want to see his woman heavy ...

Because women do not want their children to suffer "They stay and wait for their day."

If the man dies first, you care for him until he dies and you also wait for your turn, but if it is you ... men never look after their women anyway ... when a woman falls sick she will be very lucky if he cares for her for one month ... he will just pack her things and take her back to her parents village and never go back to visit, send help or anything ... others do not want their wives to keep around because they know they will lose market ... if other women saw a sick wife in his home they would not want him.

They do not chase her directly, just neglect her by not buying food, sugar, passion fruit ... even if she had someone to look after her ... they would not have anything to give her to drink ... sometimes he can even go and sleep with other women and come back the next day.

Although, she said: "It really does depend on the man."

A friend of mine had a very sick baby ...her husband was abusing her all of the time telling her she had brought silimu ...telling her you take your child for treatment, and refusing to give her money ... he beat her sometimes and so she was chased back to the village.

In addition she explained, it is very difficult for a man to tell his wife they cannot have sex any more.

The moment he tells her that, she will just scream ... that he does not want me any more ... he wants to chase me (divorce) and they will continue relating ... or there are men who are bad hearted when they are sick they do not want to die and leave their wives for other men.

She believes that she was sick, by the time she was remarried to her ex husband. "But up to now I hear that he is healthy...and that when a person has weak blood, he dies quickly, and strong blood takes a long time."

We had known Maama Mali for close to four months before her 'ailments' began to interfere with performing daily chores and running her alcohol selling business. Unable to care for her son, she was forced a few times to send him to the village to be cared for by her mother. One time we found her wrapped solely in a lesu. unable to move from extreme pain and discomfort caused by 'ekiisiipi', a belt of herpes zosta which covered her lower back and all the way down her thighs. She smeared the area with herbs given to her by a man in the market, "to force the rash to show itself." The very next day, not only did it show itself by searing her skin, but she also began vomiting and urinating blood.

At that time she gave herself three weeks before she would decide to pack up her things and shift to the village.⁸

Her parents were not aware of her condition as they would "be worried that I am going to die." She did recover from this episode but not before losing many of her steady customers. "They come and check the room and then they go ... they get discouraged, they look in and I am lying here..."

A few months later, she tested positive for tuberculosis. Because the walk to the health centre was arduous, she had to bribe the nurse with 3000 shillings to give her the course of drugs and allow her to take care of the injections on her own. A real brother in town who worked as a tailor was also sick and had a wife who was giving him his medicine.

Maama Mali never did fully recover after this episode. She therefore decided to take her daughter out of school in the village and bring her to town. Born of Maama Mali's first marriage, Namukasa was thirteen years old and put in charge of the care of her mother, her brother Mali, as well as cooking, collecting water, washing soiled bed sheets and so forth. Namukasa, a well behaved child was a big help to her mother. But there came a time when Maama Mali's business petered off because of another relapse.

I thought it would be more economical for me to send the children to the village ... I put together some money for the baby's sugar and her school fees ... we all went to the village together ... and after a few weeks I returned.

A fortnight later, at dusk, Namukasa arrived on her mothers doorstep in town, with Mali and a seven year old. She

quarrelled with her young daughter. Business had not yet picked up. "At least when I was alone I could eat one meal ... but children do not understand that." Besides, Namukasa had used the money to be used for school fees on transport for the three of them. The child complained that Mali cried all day and she could not leave him unattended to go to school. Her daughter had brought the other child with her to care for Mali, so she could return to the village to go to school. Of course Maama Mali quarrelled with Namukasa as the child was far too small to cater for both of their needs.

At 6:30 the next morning Mali woke crying for food ... I woke the child so she could cook porridge for him ... she carried him to the verandah ... I was sleeping but I heard the child crying, I did not mind so much I knew Namu was around ... his cries increased so I went to check myself ... I found him alone ... the girls had disappeared ...

And they were never found. She sent a message to her step sisters in Kaliro, to see if they found their way there. Her father's village was too far to go by foot. "But maybe out of frustration they walked and will be sleeping on the way for two nights before they get there." To stay sane, Maama Mali convinced herself that a woman must have lured her to become a housegirl in Masaka or Kampala. She chose to ignore the possibility that a man could have just as easily lured her away.

The health of both the mother and child deteriorated soon thereafter. She could not stick to the regimen of injections required for TB remission because her brother, the tailor, also sick could only inject her once a week. With fever, chest pain and wracking cough she exclaimed, "I am a real dead body!" Mali was suffering from fever, diarrhoea and irritating rashes. He was also extremely undernourished, thin, miserable and with a big stomach:

He cries for food all of the time ... he wakes up at 6:00 am ... he is hungry I just leave him to cry ... there is no one to look after him ... these days my cough worsens in cold ... I cannot get out until 10:00 am.

A few months later, Janette was seated with her, at the burial of her brother, the tailor. She was dizzy but sitting up quite well. A few days later she was delirious with fever. The decision to transport her to the village while she was still living was made because the tailor died unexpectedly. Because of the cost of transporting the corpse, he was buried in Kitovu, where he had invested in a plot of land, instead of in the graveyard of the family in Muwogola. It was her wish to be buried in the soil that was her father's, so she and all of her things -- bed, saucepans, mattress, charcoal stove, basins -- were loaded on a pickup and she was taken to the village.⁹

Figure 11.

The Importance of Water



Water vendors returning from the borehole.



Children waiting in line to pump water.

She did not last a month. Ironically we heard the news while taking breakfast tea with four children, each one having lost one or both parents to this disease in the past year. We found transport and arrived in the village just before her body was being wrapped. The cacophony of wailing was almost overwhelming. The body was in the shadows, and it was only the rays of light cast by the kerosene lamp which had burned all night that made me realize that in death, I did not recognize her. Her feet glistened, as they were using a mixture of herbs to 'embalm' her.

We saw the house where she and her sisters had resided after 'divorces'. The plantations were becoming run down, as there was no labour for upkeep. There was a fresh grave in the burial ground, another brother's. Janette and I joined the line of people who took a handful of dirt and tossed it in the hole. I remember the hollow sound of the dirt hitting the iron sheet which covered her coffin, and washing my hands in the juice of a banana stalk. No burial was easy, but this was one of the most difficult.

The family had a quarrel over the eulogy/condolence that was to take place at the grave side. Her brother had wanted to conclude that the cause of death was *silimu*, something that was just so rare. Like most people, the rest of the family wanted to say *omusujja* or *olukunvuba*, which left it up to the

mourners to interpret the cause on their own.¹⁰ After thinking about it overnight, he settled on "this daily disease." When the eulogy was read he said: "It is the disease that has killed her, this disease that is finishing people ..."

Mali's father did come to the burial, presumably to take the child. But Maama Mali had insisted that he be kept with her mother while he was still growing. "After all," she maintained, "he is going to die anyway." When she was alive, Mali's father never really provided support, although when she was first taken to the village, he brought 6,000 shillings to help.

We were to hear later that it was Maama Mali's son, barely an adult, who provided most of the 'palliative care' until she died. Her other daughter spurned her, recoiled at every touch or request.

Every used cloth, covered in faeces, she would throw in the plantation, in the rubbish pit, refusing to wash it. The son was the one who would pick it out of the pile and do it himself. He would ride around the village looking for passion fruit.

Maama Mali left much of her property to her son. It was not likely that he would inherit much from his father as he had little land. Her clothing was distributed among her daughter and cousin sisters. Namukasa never returned, and if she were alive, was presumably not aware that her mother had died.

ENDNOTES

¹ Maama Mali alluded to a life of risk in our discussions with her but adamantly maintained that many of these events were part of the lives of others and not her own. When I say 'relative' poverty, I mean she was impoverished but at the same time she did have a close network of kin within Lyantonde town. When her main source of income plummeted because of sickness, her real brother a very prosperous businessman in town, was there to provide some support.

² Maama Mali sold 'waragi' an undistilled and illegal form of gin. Sometimes she sold 'tonto', traditional drink of the Baganda, made of fermented bananas. Kiyeye is a primarily single room housing zone in Lyantonde. The types of housing available ranged from various degrees of mud and wattle dilapidation, ie. the 'AIDS compound'; rooms and cement walls and floors (with electricity). Many are households headed by women.

³ Women do wield a considerable amount of power in domestic decision making, both as mothers and sisters in the paternal home.

⁴ At that time, there were still markets oriented toward the cattle trade. As a result, a lot of money changed hands, and was spent on goods and services available at the market itself. But as soon as the cattle ban was implemented, he stopped going and now runs a business on Kooki Road.

⁵ Although the market circuit can be extremely lucrative, it is an exceedingly difficult job. Sometimes to even get their wares loaded onto a lorry, they must negotiate with men to allow them on, without payment in shillings. The journey can be long and dangerous, the sun's rays scorch, and the rain brings misery. Protection for their goods and money is not guaranteed as they are often vandalized at gun point. If one is weak or ill, the job becomes impossible.

⁶ A woman who specialized in reproductive health, in a very traditional sense.

⁷ It was clear here that Maama Mali at one time did deal with sexual tension in her work, although she will not speak about it personally. In fact businesses just cannot compete without it. But at this time, she felt that she looked too sick to be the least bit attractive "to the drunkest man". "Which man cannot see that I am sick?"

⁸ When a woman who has been a permanent resident in town, vacates a room and goes back to the village of her father, it is assumed that she is going home to die, never to return. It is understood that a person will not get the same care or feed as well when they go on account of the distance from clinics and lack of shillings to buy treatment, sugar, passionfruit. To leave town is an extremely difficult decision to make.

⁹ She had very little by the time she went home. A lot had to be sold to pay for the treatment of both herself and her son.

¹⁰ Omussujja and fever are used interchangeably. Olukunvuba is an illness, which like omutego, can be sent via witchcraft. Although it is not usual that skin rashes appear, it is said that it does replicate AIDS in that it can be terminal, but unlike AIDS can be cured by herbs.

*Kanniffa:
The Story of a Widow*

Women in Lyantonde say the women who love children the most are the ones who must suffer in this world by being without any children at all. We had heard rumours in town, about such a woman who was so good, gentle and giving, a woman who cared for a dead woman's children as if they were her own. This woman went to more burials than we did, and even when one of our team members fell sick, she was over offering advice and passion fruit juice. On one occasion we walked with Kanniffa to the village, a fair trek down Kooki Road. This was the time when I finally really understood the daily hardships of women struggling with orphans, watching loved ones becoming sick, and seeing the signs of disease in themselves. Kanniffa, too, was battling sickness and she could no longer make to make frequent treks to the village. There was a great deal of tension in her relationship with omukazi omukulu (the first wife); therefore she could not depend on her to help weed or harvest her plantation.¹

As we sat together, visiting with the first wife, one could not fail to note that when her polygynous husband died, all the 'good things' ceased to exist. The first wife

considered herself lucky that she had a roof over her head. He had invested in iron sheets for the roof before he died. Unable to afford to finish the house her husband had begun, Kanniffa's co-wife was sheltered by crumbling walls, ruins beaten by wind and rain.

Kanniffa's mother, fourth in the line of wives, was the only one to produce. She had four children, and apparently it was the male siblings who were provided with the opportunity to go to school.

Our father refused to take us to school because he believed it was useless to educate girls. Useless, because we waste their money, get pregnant and get married. They did not know the value of education, so it was only our brother who was able to go to school.

Learning was very important to her, so she gained some satisfaction out of sneaking away from home to sit outside of the Moslem schoolroom door, just to listen. She said, "when I returned, they would beat me." Like many young girls, Kanniffa resented her father's decision not to provide support for primary school. He died when her mother was pregnant with her youngest sister.

He died overnight complaining of a headache. He was the overseer of a big coffee plantation on Masaka side. He had many friends but many were jealous of him. They say it was witchcraft.

For young girls who do not have access to schooling, child fosterage is an option parents consider, particularly

when children are orphaned. Placed in the care of relatives or friends, the child will help in the care of younger children, doing domestic work in exchange for clothing and feeding. Subsequently, upon the request of her maternal uncle she was sent to his compound to live with and work for his two wives. It was from this compound that she was evaluated for marriage.

Traditionally, it was our elders who used to see and appreciate girls for their sons. My father-in-law used to come to the compound and start talking. I never knew who he was. After they had agreed together, I was told that I was to be married, but whenever the man would come, I would run away, because I was so young.

An introduction ceremony (Kiganda prenuptial formality) was organized.

His family were told the things they had to pay ... there was cash, a goat for my paternal auntie, a busuti (traditional Ganda dress for women), a kanzu (traditional Ganda wear for men), a tin of paraffin, sugar and a box of matches. The man left and returned with a marriage party. I was escorted by my auntie and others from the village. The vehicles came and they picked me up and took me away. I had to go.

By marrying this man, Kanniffa achieved the status accorded the first wife, 'omukazi omukulu'.

Only a year and a half had passed before the marriage became turbulent. Kanniffa firmly believes that the tension in their relationship was perpetuated because of something rooted in her own maternal uncle's compound. Kanniffa had returned to her uncle's compound after one of the quarrels which arose

between her and her husband. One of his wives resented her presence in the household.

I kept my things in a suitcase, and she went through them. When I went through my own things later I found my 'marriage towel', and it had been cut.² I told my uncle and he quarrelled with her. I never trusted her. I know she used these things (witchcraft) to do harm.

Barrenness as an issue is a collective concern, to the extended family on both sides of the marriage contract. It was decided by kin on her maternal side that this problem required consultation with a traditional medical practitioner.

Kanniffa's mother was advised that the co-wife had taken a piece of her cloth, rubbed it in dirt from an empty anthill, and buried it in the grave of a baby, "A baby who had died before speaking." The therapeutic process ended abruptly when the maternal auntie died suddenly. "She had taken the things to someone else, and they did not know who it was ... so it was too difficult to work it out ..." When the auntie buried that cloth, she buried her niece's womb. The scorn levelled at her by the in-laws, because of her being barren, eventually became insufferable.

I went back and lived with them there for six years. He had sisters who lived with him in the same compound. It was this abusing that pushed me for divorce. They asked me if I had come there just to eat their food and fill up their toilets, and why could I not bear for them a child, and he himself would quarrel and ask why could I not produce.

Puzzling, in her opinion was that over time the harassment from the husband became less and less. She had relayed her concerns to her mother, who took the initiative to look for help among the same community of practitioners. Again, they were advised that the problem was traced back to the deceased auntie. Lurking in the back of her mind when she heard that "maybe the whole thing had finished" with her was the expectation that "maybe he really was moving with others to find a child ... Maybe he wanted to marry again to get another wife. This is why he did not want to help me, but then what would I do here? Who would I be digging for?" Finally, these various problems provided the stimulus for divorce. However, if it had not been for the constant harassment by her female in-laws, Kanniffa believed that she might have stayed.

She found shelter in her Daddy's village for some time, before she was called to become a housegirl for a family she knew not far from Lyantonde town. Upon recollection, she said "I worked there for three months ... I was very stubborn, I just wanted to be on my own." She packed the few things she had and moved to town. The town was small then, with few people actually residing there. There were men who came to trade maize and beans, Asians who had invested money in small businesses, and a fair number of women who, if not married, were working in bars. According to Kanniffa, many of these women gained considerably from the sex trade. They were able

to build capital and invest it by building in town. However, many have since died. This was in the early eighties. At that time, there were only five bars in town, and housing was scarce.

Because there was so little housing, and the number of women increased every day, you could find three to five girls living in one room. They would take these men to lodges to sleep. I lived by myself. All we did was dress up, move to different bars, and get men. We never sat; it was us who went looking. We used to work from one in the afternoon until ten at night. The only hotel that went all night was the one near the petrol station.

It was a lucrative business for Kanniffa, too.

They came from all over - Rwanda, Nairobi, Sudan, Sometimes on an unfortunate day the men would all come and park at the same time. There would be confusion over what would you do with them. Each one wanted you but sometimes they would be all there seated. Each one would want me there. They would all offer drinks. I would keep my drink, tell them I was serving and not sit in one place. I would be negotiating for sex the whole time.

She decided to accept support from only one man and quit bar work for good.

I needed care in times of sickness, I needed someone stable, always around to provide treatment. These men just move. They come, they find you sick, they move to find another woman who is healthy. Or other girls would deceive the men by saying I had gone to the village or with another man.

In the beginning of their relationship, her man was supporting her to live in town. The husband, a cattle trader, with whom she lived until his death, supported both a compound with five

wives in the village and one in Lyantonde town. The village is about five to six miles from there, on Kooki side.

He told me he had only one wife. He kept pushing words. Then one time he took me to his home. When we arrived, I saw so many women. At first I did not know; I thought they were relatives. When I came for real and accepted to stay, that is when he told me and I just accepted.

Kanniffa believes that the women in his compound were complaining because he spent so much time in town. A few, feeling neglected, were threatening to leave. When she first arrived, she had her own charcoal stove and cooked tea for herself in her own room. For about a week, the others were unwilling to welcome her for meals. Eventually, the tension dissipated, although the quarrelling continued when the man was not around.

In 1988, after fathering twenty one children, Kanniffa's husband died a laborious death. Despite his pernicious reputation that was talked about throughout the community every so often, Kanniffa did really mourn the loss of her husband.

He was so strict on our movements. We could not move to our neighbours, go to town, or even visit the parents. When he found out that we had gone somewhere, he would just beat us. Even when my mother was sick, he kept saying he would get money, and we would go back to my village together. He thought that if I went alone I would get other men. On the Friday, I decided to sell my own goat to get money and I just left the very same day. It was during transport to the village that I found out that my mother had died. I stayed there many, many days for the burial.

During the visit home, Kanniffa's brother decided to come to Lyantonde to establish himself there, and eventually, he made enough friends, and had networked enough to join the goat trade. But every single time he was visited by his sister, she was beaten.

He would follow me here into town. Whenever he heard I was here, he would track me and beat me. One time I finally said, "You cannot separate me from my relatives" and I left, without even telling the others in the compound.

Kanniffa, determined to stay away, found refuge at her sister's place. Her husband, however, humiliated and angry, "rounded up the wives and beat them." She said, he was exasperated and screamed, "Why do you do things quietly? ... Why have you not told me about this one? Where she has gone?." As the story goes, the brother in town was both accosted and maligned by the husband, and as a result of a brawl between them, placed into police custody.

In the compound, however, Kanniffa was the link between the man and the rest of the wives. She was in a position to cajole the husband for household items and cash, a very powerful position to be in. By the time the wife in Lyantonde fell sick, Kanniffa believed his only sexual relationship was with herself, even though it was necessary for him to 'attend' to the other wives "or they would disturb."³

He spent most of the time with me in my room. He would move to town for two or three days for

business, and then return to the village. The others used to quarrel, talk against us. But the man only used to eat their food. We took turns feeding him, one after the other. He would go eat their food and then come back to me and sleep in my bedroom. They (co-wives) would even fight with him. Sometimes he would beat them, and they still would not fear him and continue to quarrel.

Omukazi omukulu (the first wife) did eventually openly challenge the status that had been accorded Kannifa.

She would say "that one is a Kabbakka (king) How can you keep the man to yourself?" In fact, the man would never buy anything good unless I asked for it. If I did not say we needed meat, then he would not buy. Some time back there had been a fight with the first wife, and the husband was so angry he threatened to chase her. But I pleaded and threatened to go too, if he chased her. She let up with me after that. They really feared him. If the man had not been strict, we would have been quarrelling all of the time.

Kanniffa maintains that he favoured her so much that he had ordered the wife in town to make her tea, so she could rest after praying before walking back to the village. The resentment was so great that she "would rush to bed pretending to be sick every time I went to visit."

1987 was trying for Kanniffa. Her mother died and the co-wives became quite nervous. The husband had been keeping another 'wife' in town. She was living out of a room in the same building where Kanniffa currently resided.

The woman in town became sick all through her pregnancy. She had wounds in the private parts like the skin of a pineapple, rash on the skin, and the malaria.

At the same time as this 'town' wife's health was deteriorating her first born son was admitted into Kitovu, the mission hospital in Masaka.

While he was in Kitovu with the son, we were informed that her parents had come to Lyantonde to collect her and return with her to the village, but he refused. The parents were arguing, "You have killed our daughter. You give her to us." They left annoyed. After she had delivered the child, her conditioned worsened and he hired a vehicle and had her transported to the village. He left the baby girl behind, and when he was there he took so much abuse and blame. While they were in the village they failed to treat her. So he brought her back to town and a week later she died.

That was in May. He died in September.

We tried to feed him but he refused. There were thoughts of his wife. He did not go to the burial; he really feared her parents. We sent him to Kampala where he has a daughter but he refused to stay. We could not understand why a man who seemed to have never been sick in his life refused medicine. We thought at first the sickness was because the wife had just died. He was mourning and had fever because of sleeping on the cement floor of the hospital so much. He resisted going to the clinic until his daughter in Kampala forced him. We took him to Ofumbi's clinic (a clinic on our side of town). It started with fever, then came the diarrhoea, and wounds in the mouth - he could not eat or drink - then a rash which disturbed him so much, he died so quickly.

There were two children from the union between Kanniffa's husband and the alcohol seller. When the woman fell too sick to care for the children, at the husband's direction, they became Kanniffa's responsibility.

The man asked me to come to town, and look after these two children, just three weeks after he got very sick. In town I was caring for them all.

When the sickness worsened, the first wife came to care for him permanently. I cared for the children.

The three other wives would move to town now and again to help with washing sheets and daily chores.

He did not allow me to come near him. He would chase and say, "You go back, you are looking after the baby, so do not come near me." Maybe he thought the child was going to catch the disease. There were times when we (the two wives) in town had to come together to cook. If the child was sleeping and he was resting, we had to talk and we related OK.

At first when he asked that I come to town to take the children, I refused. This one (the alcohol seller) had been so bad hearted in the past. But he pleaded and I had to accept. He knew that the first wife could not care for them. She is such a bad hearted woman, she could not look after a child that was not her own. All of the others had children who were small.

This was not the first time she had been asked to foster children. Some time previously there was another woman in town. After they had quarrelled, she severed their relationship by weaning the baby, and left it in his care. The baby died of 'omuwago', kwashiorkor.

All found it puzzling that he adamantly refused medicine. It was not that it could not be afforded; he "just really feared it. We were begging him to return to the village, but he refused." The clan burial grounds were in a place called Buddu, a village on Masaka side, just before Lukaya. His request before he died was that he to be returned to Buddu while he could be transported alive. "He said there

was no use transporting a dead body ... 'Carry me there' ... He was so sick he could barely speak."

He did, however, die in Lyantonde. Only one vehicle was hired to take the body back to Buddu. Kanniffa and her charges were left behind. Kanniffa lamented that it had been very unfortunate that the women of their compound did not belong to the traditional burial association like other women in their village.⁴

We could not get help because we were not members. How could we go there, and survive the beating when he found out we had gone? Even to collect water and firewood, we had to move in twos. We could never move out of the compound even if anyone visited. We could only escort them up to the road; we could not move any further. He believed that when people came, they came to take his women. He refused us to belong to these clubs. He said they were very bad, that when women go for the meetings they go after other men. He did not want us to own money.

Kanniffa believed that they were not blamed by others in their community: I "They all knew of his bad behaviour."

The husband's untimely death left the wives embroiled in worry, jealousy and fear.

I could have also got the disease, I did not ever meet (have intercourse) after the wife died, but before that we met frequently. I never did quarrel with him about the wife, her sickness, because once a man has decided to do something, it cannot change. We did not know the man was getting this woman. He started staying out, away from the compound. We used to question ourselves, but he would say he was on a journey, going very far away. Yet we knew, we all had suffered in the past from 'ekiwo.'⁵ Even he had it; he would pass out pus and

blood. We knew he had brought it. We knew he must be moving with others.

This sexually transmitted disease was a common experience amongst the wives. By crushing leaves collected in their compound into a paste, they were able to treat it topically. They, however, did not keep their concern to themselves. They as a group confronted him, and frequently. "He would just keep quiet ... and there was no possibility that any of us could have gone out with other men ... We all had to move together, we could not even walk to the mosque alone."

Before the husband died, the co-wives were informed by their friends in town about this woman's sociosexual history. The wives in the village decided that she was not to be trusted. As an alcohol seller, this woman ran her business out of a single room, which was in one of the husband's buildings.

We heard that she started going to markets, and was moving with trailer drivers going to Rwanda. She was not very steady. This woman could have brought this disease. When she was very sick and very pregnant, we used to say that we do not think that this one was going to deliver. We were all shocked when she did deliver. We used to go home and whisper, "This one has silimu. Now we are all going to die." All of us were very worried. People in town would say she is having silimu.

Kanniffa said she does sit back and think about things, her own situation, her husband's death. The intricacies of Kannifa's emotional response to her husband's death were

clouded in some ways by witchcraft, supposedly levelled at her husband just a few years before his death. She surmised that the trajectory of 'this thing' in the co-wife does resemble the complexity of sickness associated with more indigenous, socio-culturally explained diseases. She, too, had a partner in a polygynous marriage and had left it because of co-wife conflict, also witchcraft related. This could have been what killed her.

I used to fear, even now I fear, but not as much because we were told the cause of death. At first it was said to be silimu. But later his brother learned from a traditional medical practitioner (TMP) that he had been bewitched by his sister, over a land dispute.

When the husband's mother died, she left some land for one of her daughters who had divorced. Because he felt the yields were poor from mismanagement, the husband appropriated his sister's share of the inherited property. "It was meant to feed the grandchildren, but they were not being fed ... She got so annoyed and threatened him ... You have taken my land but you will see ..." It was explained that at least once before this last bout of sickness his sister had attempted murder. Because he never visited her in her own home, the sister tried to poison him through the alcohol sold by his wife in town.

One day with the help of another brother, she got a jerrican of waragi and poisoned it. She (the wife) went to pour him a glass, but he refused it.

When she finished washing her things she poured it near a banana plant and it died.

Kanniffa is willing to entertain the idea that his death may have just been caused by 'mayembe' (horns) sent for revenge. The sister's gardens were unkempt, full of grass. And although she dressed and appeared to go to the garden each morning, villagers confirmed that she packed other clothes in a sack and went elsewhere. Her actions implied that she was using witchcraft. As a result their husband, "In his sleep would suddenly wake, dreaming of sounds like scratching rats, ... He would act like a mayembe person ... and always feel pain in his stomach."

On the day that he died, the sister came to the compound to visit. She, however, did not enter his room until the sun fell, and then she entered without offering a greeting or taking food. She slept there on a mat until the early hours of the morning. He died in the middle of the night. According to Kanniffa, they woke her, to get her help in 'stretching' the body, and she refused to help. In the morning, she left the compound without wailing. For the extended family, this behaviour was disconcerting, and provided confusion about the actual cause of his death.

Kanniffa believed that it was mainly the married women who were recently dying from AIDS.

There is no way a married woman can control her situation. It is the man who moves. Free women are better off because they can decide to stay alone. But of course, those who have men will also die.

Kanniffa explained that the lack of control over sexual well being in marriage reflects in a woman's reproductive life as well.

There is no way a woman can refuse to have children especially if she is married; that is, unless she swallows pills without the knowledge of the husband. However much she refuses to have, no matter how much she tells him to put off, if she does not, they can even use force (rape) A man will not stop sleeping with his woman, even if he is sick. Sick and weak, he will still want to sleep.

She explained that most will not leave the marriage, even if they know their husbands are moving. This is because they feel their children will really suffer without them. In addition, many assume they are already infected. So when pregnancies ensue, "many, many fear," and according to Kanniffa, children are neglected. When she fostered the last born, a common question asked by many of her friends was "Why waste your time and money on this child? Since her mother has silimu, she will die."⁶

Among the Muslim of Buganda, funeral rites for the deceased are held forty days after the death. It was during the reading of the will that the first wife became overwhelmed by emotion. Basire, the first born of the alcohol seller, was placed as heir. This caused a bit of a stir in the village as

the first wife fully expected that one of her children would receive the honour. She was humiliated further when Kanniffa, a woman who did not bear any children for him, received housing and property in town.

The clan leader was reading it. There was a six inch mattress that was not on the will. The clan leader gave it to the heir. She was so bitter. She said "I suffered with the patient for nothing. I suffered, and he did not give me anything. It was so embarrassing that the clan leader gave it to her.

Kanniffa added:

She is generally a very difficult woman. We lived in the same house, five of us in different bedrooms. She quarrelled all of the time and seriously abused the children of the other wives. He was very strict and this is how he managed to control her. So we would not have the chance to argue over property, he left everything, including land and houses, to the children.

Of the houses (single rooms) in town he left two to Bashile and two to Namutebbe.

In mourning, Kanniffa lived in the compound with the other wives for about two months.⁷ Because she was the caretaker of the heir, and he was still a child, she got access to the best land in the kibbanda. This fuelled the first wife's resentment even more.

I wanted to be near my plots so I could dig and rent out the rooms in town. But she (the first wife) was always abusing these children. She was so loud, anyone could not fail to notice that she was around. So I decided to come to town to live here. I only go back to the village to dig.

We met Kanniffa in a time of biennial drought in Kabula subcounty. However, because the rains did not come for at least nine months, those who were typically experiencing very lean times were very hungry. Caring for a family of orphans was back-breaking work during this time. Because she did own buildings, Kanniffa was actually one of the more fortunate in this time period, with a dribble of shillings that came through renting her rooms. Consumed by worry and stress, she would leave on foot to walk the miles to the garden, and return at dusk looking haggard, dusty, and hungry.

We have been very badly hit. My plantation is not doing well (bananas, beans, sweet potatoes). Whenever I had money, I would buy maize flour, and nkejje (small fish for sauce). My family sent me a tin of cassava flour.

Supplementing these things with the meagre harvest from the garden, she managed to feed her family, a family that was not her own, one meal per day.

Drought, Kanniffa explained, is a time when women come into town from the villages looking for food. "They prefer living alone, having several men to get money ... If a woman got married she would get feeding from him only ... Most women during these times turn into malaya ..." Many of her tenants are young girls who are mostly unemployed, or have worked on and off in the bars and lodges. There is no way they could go back to the villages. They stay in town to make money out of sex, and many get sick and die here.

The last crop of maize did fairly well. However, Kanniffa in the last six months had been experiencing recurring bouts of 'flu'. Consequently, she had been unable to make the trek to the village to harvest. It dried on the stalk. We were sorting maize together one day, separating the rotted kernels from the dried, discussing the problems of caretaking and child fosterage. Shocking to us, was finding out that not only was she caring for at least the two children of the alcohol seller, but she was also intermittently feeding and clothing two other older children the husband had conceived with completely different women. Medina's mother was also an alcohol seller, and a tenant in his rooms. After she was weaned, Medina was brought to Kanniffa. Her mother was apparently sick when she left the community and died soon after the man did. Medina is now twelve.

Sometimes I curse him for all of the responsibilities he put on me. If it were not for this, I would be in my father's village digging, worrying about myself. Now, here, all I do is worry about the children, school fees, dressing, medical fees. Usually when a woman is the one responsible there is no one else to turn to especially in sickness. For me I have nobody. When they get sick, I have to suffer on my own. I do not want them to feel like orphans. I do not want them to admire our neighbours' food.

Kanniffa has had to sell many of her belongings including clothing, to provide for these children.

I have not had a new dress since he died. If I died it would be up to the children to care for themselves. They would drop out of school, for they

would not have a uniform, pencil or book. The girls would have to go with men and marry. Then the boys could stay in the houses that have been left.

The request from Kannifa to help her test for HIV was sudden. For two years she had been wavering between the certainty and uncertainty provided by witchcraft related explanations for death. The husband had been dead for six years and she had yet to fall sick. In addition, Namutebbe, the child born to the first alcohol seller, thrived. But now Kanniffa is in the throes of uncertainty caused by unexplained and recurring episodes of sickness.

What kind of sickness is this that does not go? If I am sick I will get tested and wait for the day. I want to know the truth. Ever since he died they say he died of different things. When the Rakai project was here years ago, I wanted to go for testing but then I feared and I was lazy, I feared the rumours: "They give you a tablet that kills you quicker. They take off blood and just go leaving you to die." But now I need to know.⁸

ENDNOTES

¹ Kanniffa was the caretaker of a young heir. She had been allotted the most fertile land.

² It is the piece of cloth used to soak up blood in the nuptial bed. It is given by the paternal aunt and considered proof of virginity.

³ Lack of sexual relations for a long period of time is an indicator of separation or divorce.

⁴ This circulating credit association translated as Friend in Need, requires that members commit a certain amount of shillings monthly, and when each finds themselves in need of support particularly during family crisis and death, the association responds, both by giving money and support, particularly for burial expenses like transporting the body.

⁵ They may have been referring to a genital ulcer disease called chancroid.

⁶ Kanniffa's daughter, Namutebbe, is now alive and well, a source of great joy, while we were interviewing.

⁷ The other wives, with the exception of omukazi omukulu, scattered. Another died in January of 1992 in Masaka. Another is very sick with her parents on Kooki side. There are another two who have died. Deaths were attributed to olukunvuba.

⁸ At the time of writing, Kanniffa had not yet received her results back. Her future is very uncertain.

CHAPTER V

It is amazing how quickly tears swell when we are in the field and how difficult it is to swallow them. Today a friend said to us "No woman has sex for pleasure any more ... we cannot bear it when our children are crying for food from our neighbours in the courtyard." In the Lyantonde of today - with its drought, famine, social and economic recession - discussion of "prostitution and promiscuity", and the instrumental nature of sex have no place, because they serve to perpetuate the objectification of the African woman as a sexual object, who just does it for money, no feelings, no thoughts, no tears. Well you can bloody well bet that these women cry after they have had sex for matoke. Yes, sex is instrumental, and transactional, but I am wary of the discursive shift from instrumental sex to instrumental, mechanical woman. Because in the Lyantonde of today, sex is a deadly game, and women resign themselves to deadly choices (Field Diary, 1993).

The stories are vivid testimonials of lives swirling with fear, pain, hunger and risk. The subtexts of risk implicit in the narratives of the women represented in this document emerge out of abuse, violence and neglect. In short, the voices of Josie, Kanniffa and the others, however, contribute a 'context of risk' and the construction of an ethnographic gaze which is horrifying. These are women who live in a world where people have seen so much death that they no longer believe in life. Their voices scream in deadly frustration: "But what could I do? ... I had no choice."

In time, we as researchers asked ourselves, "How did this happen? How does it happen that women become so compromised by hunger, family, tradition and disease, that they do not believe that there are any choices to make?" These exhausting testimonies are evidence of the need to theorize proactively about their dilemmas, in a manner which defies the predictive simplicity of risk determinants, in a way that accommodates the contingencies of their lives, and does not ever decontextualize their suffering.

As months passed by and our field notes became litanies of need, we realized that discussion about factors, trends, determinants, and "high risk groups" was obstructing a better understanding about what these women were trying to communicate to us. It became clear that understanding their realities, their dilemmas, was critical to understanding how one might better intervene programmatically, in a town so devastated by HIV/AIDS. What follows is an attempt to analyze the overwhelming evidence of risk in these women's stories by conceptualizing women's risks in a more expansive way. The model of risk offered by Willms and Sewankambo (1995) provides a conceptual framework for how this might be done.

Willms and Sewankambo (1995) have taken the ethnographically grounded understandings of risk, which emerged from "Talking About AIDS," and generated a more

comprehensive "notion" of risk -- what they have come to call risk realities, risk situations, and risk events.

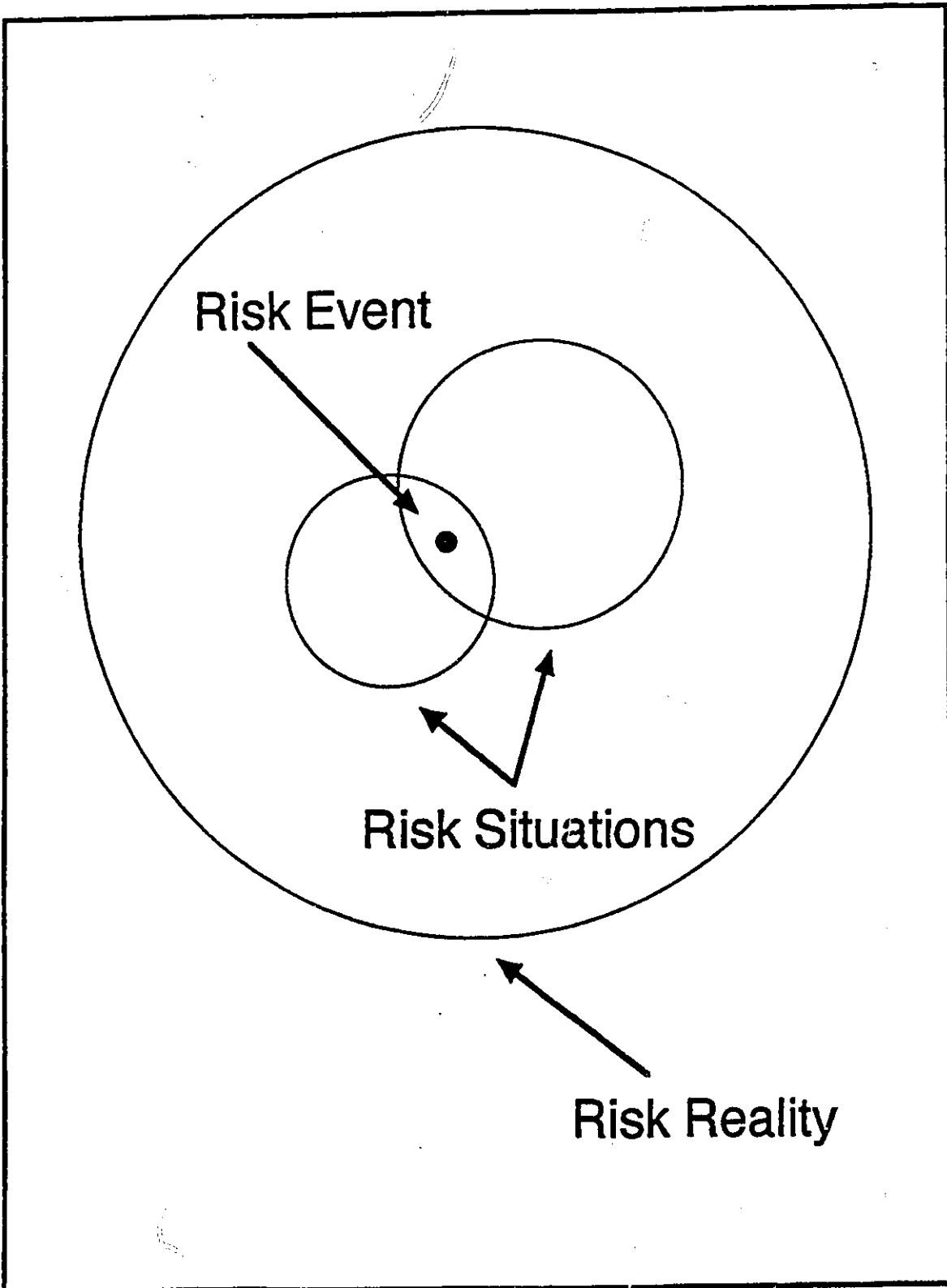
These "notions" of risk accommodate the fact that women are at risk for far more than HIV/AIDS - rape, starvation, poverty- and as such, the choices they do make are constrained by a confluence of social cultural, and economic forces (see Figure 12).

Implicit in their definition, is the understanding that women and men in this research setting are enveloped in layers of risk. Viewed this way, the risk reality is deemed to be the phenomenological context of risk, the cultural and economic trends and pressures that lead women to the physical settings where risk events might occur. Alternatively, the physical setting alone might be enough to precipitate the risk situation or event. The example Willms and Sewankambo give considers the social and cultural pressures of women living in a place like this: her husband dies of AIDS; she is expected to marry her brother-in-law for reasons of "wife inheritance"; suspecting abuse if she stays, she leaves her children behind, migrating to town; and with no financial supports, she finds herself impoverished (Willms and Sewankambo, 1995:9).

Such a woman finds herself in varying types of risk situations, out of necessity or social circumstance. The risk situation is defined as "a social event where a convergence of

Figure 12.

A Risk Profile



precipitating factors, interpersonal demands and individual dilemmas compel the persons caught in this circumstance to participate in 'high' risk activity." Consider, for example, an alcohol seller who, confronted by a "permanent" sexual partner, is unable to negotiate safe sex since she is financially dependent on him. The risk event is seen to be the critical moment in a risk situation (and certainly contextualized by the risk reality), the crucial moment when she must make a choice.

By this time, a woman can be so immersed in moral dilemma - caught between traditional expectations and personal want and need - that her choices really are not choices at all, because they are "choiceless choices, deadly choices." Crippled by fatalism, and constrained by perceived powerlessness to change their situations, such women resign themselves to this disease and believe that they are unable to protect themselves, much less their children. Emergent in the stories, and repeated over and over again, is the despair reflected in the question: "But what could I do?"

While this model displays realities, situations and events in sequence - the risk event being the point where the pressure of the risk reality, and the necessity of the risk situation converge - it is necessary to note that the unpredictability of risk in women's lives requires that the boundaries which distinguish these realms of risk are fluid

and flexible. An issue that is categorized as a risk reality, for example, may directly precipitate a risk event. Consider, for example, the effect that fatalism might have on a bar girl's decision to have sex "live" - without a condom, for more money.

Bibianna, Medina, Betty, Kanniffa, Josie, Maama Mali, and Maama Somalia, in varying circumstances, have experienced the social, economic and cultural constraints of the risk reality, the omnipresent danger of the risk situation, and finally the deadly resignation of the risk event. Using examples from the case studies, the ensuing discussion aims to unpack these experiences from the viewpoint of these constructs of risk, and to work toward a perspective which promises grounded explanations of women's risk for HIV1 infection in Lyantonde.

Risk Realities: The Phenomenological Context

The case studies demonstrate that in the social cultural and economic lives of women there are many facets which contextualize risk. Taken together, these influences -- gender status, poverty, powerlessness, fatalism -- situate women in extremely perilous circumstances.

Many women find themselves confronting disease; some, like Kanniffa, Betty and Maama Somalia, blame their fathers.

Their risk realities were orchestrated in discrete ways by social cultural features of a decidedly gendered world. Each of these women was once an adolescent, and each of these adolescents was once a little girl. As Maama Somalia's case study tells us, the dynamics of risk, not just for AIDS, but risks of the everyday, began in the village, very early in life. Much of this risk is incurred from women's subordinate status, societally and within familial relationships.

Since the girl's birth, a series of choices have been made that cause her to have lower status than, say, her brother. These choices have sometimes been made by the girl herself, not realizing the implications and acting simply as she believes is expected of her. The inequality at the individual level, that can manifest itself in high risk behaviour is thus a result of a chain of events; for that reason there are no rapid or simple solutions (EGM/AIDS/1990).

Social and economic inequities prevent the attainment of adequate skills, which results in fewer educational and employment opportunities. For many young girls, as Maama Somalia, Kannifa, Medina, and Josie testify, post primary education as an investment in their futures was not considered to be a good one.¹ In Rakai, many families can only hope to support a child from one semester to the next, depending on available cash. This is the source of much resentment, as much of their lives are spent toiling in marriage or in the informal economy, with little remuneration.

Maama Somalia's marriage was considered to be a benevolent decision made by her female kin. An early marriage, they thought, would be a welcome reprieve from the physically - and witchcraft - related abuse she suffered at the hands of her stepmother.² With this decision, it was believed that Maama Somalia would achieve both the social status and economic security accorded a married woman. Instead, her everyday world became filled with very grave risks: sex with older men, rape, childhood marriage, forced sexual relations within marriage, and so on, until finally she entered into full scale sex work.

The town does offer the young girl opportunities for employment (access to cash). Some come lured by the luxury of hand cremes and good shoes very rarely found in the village. Others come because it is a way for them to help support their families in the village. For the most part, however, money involves men. Raised to defer and be humble, without the skills to ensure better paying jobs, many young women much like Maama Somalia, become increasingly dependant on men for support. Often these relationships are short lived, yet continued support is still associated with men. Fatalism (see below) encourages the ease with which a girl will enter into successive relationships which in such a high prevalent area constitute "cycles of risk" (Nakuti et al, 1993). These

"cycles of risk," characterize many women's lives, particularly those who are caught in the vicious cycle of structural poverty.

Throughout these texts are images of hunger and need linked solely to poverty. Raikes (1989), in a study of the health of women in East Africa, recognizes that "the social and economic conditions of women's lives" affect their overall health and the health of their children. Emergent in the daily interaction with women in Lyantonde was what appeared to a "complex of sickness" - one child might be suffering with malaria, another diarrhoea, and the mother herself might be complaining of gonorrhoea. These ailments may or may not have been AIDS related. This complex of sickness is located within the context of mass poverty which characterizes much of rural Africa. The living environments are rife with public health problems: poor housing, lack of safe drinking water, and poor sanitation. Although one of the two health centres in the district is located a few kilometres away, they offer very limited patient services, and frequently lack basic supplies. There are a numbers of private clinics within the town itself; however, very few individuals can afford the expense involved. This became apparent when a number of women complained of sexually transmitted diseases.

Gynaecological complaints among women in Lyantonde are common. So too, are references to some forms of genital

ulcers. However, it was Maama Somalia, concerned about genital ulcers, who explained that with the advent of AIDS, other STDS just ceased to exist. "Syphilis used to exist, but really it is no longer there. This virus is too strong; when it comes, it kills all of the other diseases and remains alone." After more inquiry we found another variant of the same theme "AIDS is the king of diseases ... it eats the rest of them up and becomes the all powerful one. If a person has gonorrhoea then they are assumed to be free of this disease ... some rejoice when they get it."

This disease imagery is both powerful and problematic, particularly because we had heard so many complaints regarding genital ulcer disease (GUD). One possibility to consider would be that there has indeed been a decline in STDS which would suggest that there has been some sort of significant behavioral change in the community. Another could be that people are self medicating, particularly since many drug shops in the area carry prescription drugs. Finally, it is possible that many of the complaints we were hearing could possibly be indicative of a rise in infection. Their complaints could be associated with genital herpes, one clinical manifestation of AIDS, which is common in women. Whatever may be the case, STDS for women in Lyantonde often go untreated. Symptoms do not appear for some time, or go undetected because they are not painful. At the same time, their partners may seek

treatment separately, because to admit to an STD challenges the unspoken mask of fidelity.

We started research in a community where a common refrain among women, particularly the impoverished, was: "If we fear AIDS, what will we eat." Explicit, in each and every story, is the link between poverty, hunger and transactional sex. They demonstrated to us that at any given period of their lives, sex for exchange was a necessary option many women chose, in order to avoid hunger, pay for school fees, treatment costs, or keep their businesses competitive.

Very few went to Lyantonde explicitly to use sex as an economic resource. They came because family was there, there was no money in the village and they were looking for work, they wanted to escape marital or family conflicts in other villages, they are looking for jobs, or they may even have been looking for anonymity after the death of a spouse. Transactional sex may, as in Kanniffa's case, be a temporary option, or like as in the alcohol seller's case, it is part of keeping a business running. As explained above, without resources -- land, buildings, or other income earning capital -- without skills, and with little if any post primary education, many women toil in situations of very low pay. In a setting of many migratory men, there are considerable pressures on these women to supplement their incomes by exchanging sex for money or other forms of support. What

pierces the heart in Lyantonde town is that sex is often used in contexts of fatalism and despair. Bibianna hammered away at rock to receive five hundred shillings every three days (approximately fifty cents Canadian) if she were lucky. The cost of renting a single room far exceeded what she was to make from rock breaking alone. Before our eyes, Maama Somalia shifted from girlhood to womanhood, in and out of sickness, having sex while she was well, and pleading for support from neighbours and those in the village when she was down. Our ears burned when we heard Josie's voice shake, as she told us her husband refused both herself and her son food when she refused him sex.

The fact that Josie could not refuse to have sex with her husband without negative ramifications is one example of the limited control women feel they have with regards to sexual decision making. Because the condom represents, to date, the only barrier method available for the prevention of HIV, the fact that women feel powerless in its negotiation is of grave concern. Many times during the interview process, the issue of condom use was raised, and the women simply stated what they felt was obvious, that introducing condoms into their relationships was not possible. Condoms are an efficient method of preventing HIV because they keep infected fluid of one partner from entering the other partner. However, they are in addition a devise which requires that a male must agree to

accept its contraceptive effects. Most women agree that: "A man just cannot agree ... sex makes a home." "Wasting sperm, is like another way of wasting children." Wasting sperm means interrupting what is considered to be "natural." What is natural is to ensure "that waters mix."³

In fact, as Kanniffa's extended family's reaction to her barrenness suggests, procreation is what makes a woman significant and a relationship stable. This reproductive realm, like sex, is monitored by respective extended families. Suggesting condom use is like refusing to have sex, and by extension, refusing to have sex is like refusing to have a child.⁴ Both have severe ramifications. Denying a man sex or children can mean the risk of having the partner "find another," and/or losing financial support altogether. Refusing to have sex at times other than what is culturally accepted, i.e., during menses, eventually leads to relationship dissolution. It must be noted that women have used methods to control the outcome of sexual decisions, controlling their fertility through both traditional "tying" and Western means, i.e., contraceptive pills. It is emphasized, however, that these are used in secret, are not negotiated, and as such are the target of much resentment and disdain if they are discovered.

Reproductive control is an issue of grave concern for women in an area of high prevalence. We have been told that women, knowing that HIV can be transmitted in utero, use pregnancy as an indicator of serostatus. A child born "well" confirms that the mother is free of HIV; a child borne "badly" confirms serostatus of both mother and child. As is addressed below, the effects of such strong beliefs about illness and death can be debilitating. Women do refuse to have sex, and do to some extent succeed. In fact, it is now common to hear, "why should I have children and leave them to suffer like I have?"

In Bledsoe's (1990) opinion, the fact that condoms preclude fertility constitutes a cornerstone of people's reluctance to use them and underlies virtually all other implications. In what are considered to be stable partnerships, condoms have come to symbolize distrust and infidelity.⁵ Josie states: "they only use them with women from out." The women "from out" were not any of the co-wives but the "promiscuous" or the "prostitute." For Josie, a woman who had just entered bar work -- an occupation she had six months earlier vehemently opposed to -- these associations had become important. Women may be involved in transactional sex, but do not associate themselves with "prostitution."

Condoms challenge the integrity of stable relationships; more often than not, they fuel situations of blame. Women consistently seem to cringe at the thought of both the violent and emotional outcomes of even introducing the subject of condom use. In addition to suspicions of infidelity, Josie was in fact worried that introducing the subject into their relationship would deepen Kalim's suspicions surrounding her serostatus, something she knew but was trying to hide. At that time, continuity of support depended on keeping it a secret. A woman who requests that her partner accept the condom is sometimes suspected to have the virus, because the fact that their use is necessary indicates "she must be having another." At the same time she is insinuating that her partner has the virus as well. All of this jeopardizes the core of what is thought to be a stable heterosexual relationship.

Condoms are most definitely linked to issues of control. However, the reasoning surrounding their use, misuse, or non use, involves levels of reasoning, which are more or less precluded by fear. Condoms, as Bibianna suggests, can also be associated with ill health. Shoepf (1988) corroborates that women believe that condoms have a snake like motility, can fall off and find their way to the woman's womb. Women fear that this situation can end in some type of surgery, which in this environment, is considered "as good as dying anyway."

Women assume that men experience the psychological effects of wearing latex, that "sex with a condom is like eating a sweet with the wrapper still on" or "is like eating but never being able to swallow."

The condom "message" we received from women (with the exception of those in bar work) was that this piece of rubber we were discussing was largely irrelevant in their lives. Their sexual lives were not something they had control over. Many, like Maama Mali, pity the woman who is "married," whose husband is away from home "being beaten by mosquitoes" as he chases other women. At the same time, when women like Maama Mali enter what they consider permanent partnerships, their sexual choices are no better than the one who is married.

The women in this study have in their respective lives played many roles with respect to the polygynous marriage -- omukazi omukulu (the first wife), co-wives, stepmothers, widows -- each accompanied by varying degrees of social status. Each woman, however, was living in town, frequently alone and impoverished. Maama Somalia, having resigned herself to this disease said: "I would have preferred to die a married woman, than a single one, ... the one who is married is buried with respect." For some, "the married woman" is the only one who is to be pitied, or absolved from blame, as her assumed lack of sexual control, combined with concomitant assumptions of her husbands infidelity, predicts that it is

her husband that most likely brought the disease to the family. Any other role that she was to play in her lifetime was deemed less worthy.

At the same time, each woman at one time or another was that same co-wife or mistress another co-wife feared. One of Medina's "permanents" had a wife in the village. She knew about Medina, and in turn Medina knew about her. But the wife was so afraid of Medina that she wanted her to move to the village and live with her in the same compound, so she could monitor Medina's movements.

For the women in this study, polygyny was very rarely seen as an enduring marriage form, although it is likely that many women are polygynously married at some time in their lives. This conflict is represented in the literature. There are some who assume that polygyny, a tradition of multiple wives, in its own right is largely responsible for the transmission of HIV (Caldwell, 1989; Van de Walle, 1990). There are others who are critical of this perspective. Bassett and Mholyi (1991) suggest these modern day versions of polygyny -- referred to by Larson (1990) as informal polygyny -- differ considerably from those found in traditional cultures. Some, like Shoepf, prefer to downplay polygyny as a cultural construction, and emphasize the impact that the market economy and underdevelopment has had on this marriage

form. It is the "multipartnerships" of both men and women, particularly in urban settings, that are of concern.

For example, a man (like Kanniffa's husband) may have a rural base where he has multiple wives, but being a cattle trader, an occupation which takes him to the markets, he may also have a sexual network of women extending to Lyantonde and beyond. Or a man, a truck driver, may have one wife in the village and four permanent partners along the highway: one in Busia, one in Lyantonde, one in Kabale and one in Kigali. Alternatively, Josie, considers herself "an outside" wife, and though she had some status with her husbands extended family, she ended up working in a bar, and acquired her own number of "permanent men."

The issue of polygyny is a complex one. Polygyny may not be as it was. However, key remnants of the formal polygynous society do remain: women assume or are suspicious that the men in their lives are going with others (and vice versa) and traditional society dictates that they cannot put these concerns into words (Orubuloye, 1993; Caldwell, 1993).⁶ These communication dynamics, combined with the understanding that in Lyantonde town there are many forms of socially recognized relationships, are critical to understanding the context of risk for women in any situation of polypartnerism.

As early reactions to the presence of this new disease demonstrate, there are wide variations in the level of awareness of the causes of the disease in Rakai, at different points in the progression of the epidemic. In Rakai, this disease became associated with the magendo (black market), as traders involved in smuggling began to fall sick and die between 1981-1982. The accepted explanation was one of witchcraft, as these traders were involved in business deals across the Tanzanian border with people well known for their powerful metaphysical capabilities. Ankrah (1989) identifies the shift that occurred in the late 1980's to early 1990's in Uganda, a shift which indicated that people understood the disease was transmitted via bodily fluids, by primarily heterosexual sex. Ankrah assumes that because people recognize AIDS is transmitted by bodily fluids, they no longer believe that witchcraft is the cause of the devastation of Rakai District. While this is true, it is a mistake to assume that traditional practices and concomitant belief systems, particularly revenge related sorcery, no longer affect how people respond to HIV/AIDS. "Witchcraft" creates uncertainty about the actual cause of death, particularly for sex partners still living.

Sewankambo (1994) notes that only 37% of HIV infected persons who die meet the 1985 modified WHO clinical case definition for AIDS at the time of the 1990 survey; thus 63%

died in other ways, or before the virus had compromised immune systems. People in Uganda know how to expect a victim of *silimu* will die, yet without actual clinical confirmation of the cause of death, belief systems offer alternative explanations.

Although people know that AIDS is not caused by witchcraft, people also know that traditional afflictions which resemble some of the clinical manifestations of AIDS, in their opinion do still kill. *Kanniffa*, for example, reflects back to the fact that the co-wife might have died from *olukunvuba* sent by co-wives of a previous marriage. *Olukunvuba* is a witchcraft explained affliction which is sometimes meant (when used in the Lyantonde context) to imply death attributed to *silimu*. But pre AIDS, *olukunvuba* was a disease which resembled AIDS because people chronically lost weight and eventually died after a long period of time.⁷ At the same time, her husband's kin have reason to believe that he may also have been killed by *mayembe*, sent because of a land dispute.⁸ Here we have a situation where both the co-wife and the husband died, and all sorts of confusion ensued, because without HIV testing or clinical diagnosis, their families had no confirmation of actual cause of death. This witchcraft related confusion definitely affected the decisions

Kanniffa made with regards to her own health, particularly with reference to treatment options and HIV testing.

AIDS has devastated Lyantonde. Evidence of this devastation lurks in most conversations and certainly in all of the case studies. People have seen their friends, relatives and children die very, very horrible deaths. Buildings are left unfinished, businesses close, land is sold and coffin building businesses flourish because people die daily. There has been so much death that women do believe that "there is nobody who can escape this disease." Sometimes women blame each other: "you see, that one? She is the one who is killing us all!" Sometimes one will speak for others: "we are all the walking dead." People acknowledge that there is an epidemic of AIDS in Rakai district. But because testing is so rare, very few actually ever know that they are harbouring the virus, until they are clinically diagnosed as having AIDS.⁹ In many cases, people die without ever having seen a clinician. Yet many assume, in light of prior risk-taking behaviour by themselves or their partners, that "I am already dead, I am just waiting for my day." This aura of fatalism which extends beyond individual to community, pervades all aspects of life. It becomes so intrusive that it can inform every single choice a woman makes for herself, and sometimes on behalf of her children.

Risk Situations: Circumstance and Necessity

The women in these stories describe feeling pummelled by the cultural and economic pressures in their lives. With Medina's experience as a bar girl, Maama Mali's as an alcohol seller, and Josie's as a caretaker, the ensuing discussion demonstrates how women feel compelled to participate in "risky" situations.

All through Farouk's short life, Josie was blamed for his illness. Just before Farouk died, the husband told her that she was just like a "public toilet"; she was so cheap, even a man with one hundred shillings could go with her. He decided that Josie was the victim of witchcraft - because the women of these men she went with were jealous. But because she was protected by her *lubale* (village/family spirits), the witchcraft was "jumping" onto Farouk. He was not visiting her, because he was worried the witchcraft would "jump" to his other family. He said it could even have been one of her lovers who had made Farouk sick, by "hitting" the child on the head with the tip of his penis. Josie in working at the bar, had committed a fatal transgression, adultery, and the baby ended up with a terminal affliction. As Farouk's condition deteriorated, the husband repeatedly denied paternity, again refusing to help with treatment costs of the child.

There was a moment in Josie's life which indicated that she was taking control over the emotional and physical well-being of herself and her family by removing them from town and going back to the village. An HIV test allowed Josie the mental space she needed to make decisions about the well being of her children. Choosing to avoid the sexual coercion involved in alcohol selling, she left Lyantonde and her husband. But because of circumstances in the village, the witchcraft she feared in her father's compound, and the fact that her brother felt he could not afford Farouk's care, Josie was forced back to town and into bar work.

There were nights when Josie had to stay "out" (with men) all night, leaving the child with the neighbours, in conditions she could not control. Neighbours informed her that he sat in his own diarrhoea for hours. One day all he ate was raw cassava, which threw his little body into spasms of vomiting. Josie felt she had to continue working at the bar to be able to secure enough money to keep the child alive.

He can give me 2,000 = or nothing at all, yet the drugs alone cost 4,000=. Now I am going to refuse to go there for help, I am going to do all I can on my own, and when the child dies, I will carry him to the man's door. If he refuses the dead body, I will dump it there and I go, because everybody knows that this is his baby.

I will never forget how ashamed Josie felt when she started working at the bar. I remember feeling so, so sad. Over the two years of our friendship, Josie had been nothing

less than meticulous about her baby's care. But there came a time when she was so exhausted and afraid, she was ready for him to die. Yet on reflection, what more could she have possibly done?

Maama Mali exempted herself, when she vividly described the risk situations of the alcohol seller both in town and in the markets. By speaking about others, Maama Mali alerted us to the sexual dynamics that occur in the brewing and selling of alcohol. In many ways, there is very little difference between the risk situation of the alcohol seller and that of the bar girl. It is a huge mistake to assume that when truck drivers pass through town, it is only the women in the bars who provide them with sexual services.¹⁰

We observed that not only are alcohol sellers accessed because of a service -- traditional drink and crude waragi are cheaper than bottled beer -- they are also discreetly offering sexual service. Transactional sex is an important part of their businesses. But not only is it supplemental income for them, they feel they must acquiesce to sexual pressure to remain competitive. The areas in which they serve alcohol, usually in their single rooms, must be well kept, and they feel they must dress and wear cosmetics to attract men. These are the things that draw customers from one drinking place to another. While we were interviewing Maama Mali, a friend of

hers spoke about the sexual and power dynamics that occur in this business.

It is important to move to the "tune" of the men, they go this way, you go this way ... he says give me a glass, then he says Jesus has sent me to you ... he comes and touches you and you cannot afford to lose the 100= ... so you allow him to do what he wants ... you can have four in a group and two have come to drink ... but you do not want to disappoint any of them because each one may bring three others ... if you disappoint any one of them you may lose them all ... you have to be very tactful and be good to all of them, arrange to be with one one day and another, another.

This type of work is of course accompanied by many indignities. Sometimes women and their children, all coexisting in the same room, must suffer through both verbal and physical violence of drunk men. Maama Mali spoke of the humiliation they feel, when men touch them in front of their daughters.

He is not ashamed to tell you what he feels like ... there is nothing like "I do not like it", because he can touch any part of your body he wants. Imagine we are in our own homes, and in those homes we have children. But he does what he wants because you are going to get 100= that you will use to feed your children that day. We continue to work in this business because we say, "what can I do? There is nothing to do if we have to survive."

Soon after we began interviewing Maama Mali, we became aware that alcohol sellers used the terms "daily men," and "permanent partners" to distinguish between the types of relationships they had with men. These were the same terms that bar girls were using: thus, their situations of risk for

HIV are probably fairly similar. In fact, as in Betty's case, many alcohol sellers, were once bar girls. This link is critical because it exposes the dynamic of risk involved in their particular situations.

People in town call them "ekimuli," flowers. They say they come to decorate, to attract men to the bar or hotel. Testimonials suggest that they themselves work at these restaurant/hotels and bars solely for the purpose of getting men. They serve food, beer, and soda. Management purports that they pay these women, and sometimes depending on the economic climate in town, they do pay them. More often, they are paid with a plate of matoke with some sauce, but no shillings. The management can fire them, have sex with them, or at any time transfer them to other hotels they own. Hotels usually harbour their girls in one room until they can accumulate enough money from men to shift into a single room. It can take months to get enough to buy a mattress or even a bed.

Many bar girls, when referring to the type of support they receive from men, distinguish between "the permanent partner" and the "daily man." The daily man typically resides in or frequents Lyantonde on a daily basis. Basically, these are sexual encounters which require little more than an exchange of service. A permanent man, on the other hand, is more than likely "a man from out", "a safari man". His

requests and demands are far more domestic and permanent: for example, these women will be expected to cook for them and to do their laundry. If their partner does not have a bed, they will buy her one. Because they represent consistent cash flow, their acquisition becomes almost prestigious, as these daily men (mostly men from within the community) merely supplement or top off what a woman can accrue from three concurrent permanent partners. Comparatively, a woman who has just daily men is considered impoverished (sometimes, it is explained, because many believe that she is infected) .

Typically, daily men insist on condoms because as Medina asserts, "they automatically assume we are sick." However, men do request that a woman accept sex "live", without the use of condoms, with the promise of more money. Sex without condoms requires more money, "because we are giving in our lives." Unlike the situation with the daily man, condom use with the permanent partner becomes next to impossible. Medina also related to us that one way of ensuring her partner's continuing use of a condom, and of protecting herself, was by insisting upon its use as a birth control method. However, she also acknowledged that this lasted only so long, and that eventually there would be pressure to bear children.

This dynamic is obviously of grave concern to us. Men know or at least suspect that these women have other partners.

Women know or suspect that these men have partners and perhaps children in other truck stops, and more than likely a wife and children in the village. At the same time, because the partnership has evolved into an issue of continual/stable domesticity, children become an issue and trust is assumed, although each partner remains deeply but silently suspicious.¹¹ This dynamic sheds a totally different light on the nature of sexual relationships of not only bar girls and waitresses, but alcohol sellers, itinerant traders, and many others. Women can acceptably use condoms with people they distrust, daily men, and usually those they have just met. However, the familiar man (the one who becomes the permanent partner) is constructed/accepted/imagined to be a trustworthy man. Trustworthy men are typically men who are not from around Lyantonde. Women know the locals sexual histories and would rather "go in for those they do not know." This presumed trust, linked to issues of domesticity and fertility, is part of a broader risk reality which is compromising the protective effect of the condom. It is important to emphasize that at any time a bar girl or a waitress may lose permanent partner support. The relationship may dissolve, or a truck driver may just have his route changed.

Discussions regarding "risk" with bar girls and waitresses residing in Lyantonde were difficult. To them,

living and surviving in their situations meant that the distant future was impossible to see or discuss. It is seen as necessary to survive and accrue property in the present; these are the means to an end -but the end is often, a fatal infection. When colleagues and coworkers died, many women who already considered themselves the "walking dead" faced many a personal crises. Many times we saw tears of HIV related fear and distress, particularly when it was identified that one waitress had slept with a man who had slept with the woman now dead.¹² Our friend Medina merely shrugged her shoulders and said, "But what can I do?"

For Maama Mali, Medina and Josie, their risk situations were loaded with other kinds of risks, including sexual coercion and violence. However, their perception of 'risk', embedded in their circumstances, was mediated in a lot of ways by survival needs, including food and shelter.

Risk Events: Deadly Choices

The fact that circumstance and need propel women to face making deadly choices is a haunting tragedy. In Lyantonde, tragedy was a part of the fabric of everyday living. In making these choices, women's lives become, in a sense, reordered, because they felt they were living to die. What

follows are just a few examples of how women and girls -- struggling with traditional expectations, economic pressures, and personal need -- are overwhelmed by moral dilemmas, and end up making deadly choices for themselves, their daughters, and those yet to be born.

Maama Somalia, young, and not in school, was, of course, expected to marry. When we met her soon after she married "a dead man" she was but a child, and she really thought she too, was dead. Her father told her there was nothing she could do: "You have already got the virus." Her husband taunted her when she tried to refuse having sex: "take away your silimu? ... Who will not die from it? Even if you say it has already entered you, if you refuse there is nothing to protect..." She tried to resist him: " I tried to refuse him ... I really tried", but being married she felt she could not scream for help.

Maama Somalia's female kin made a benevolent decision when they arranged her marriage. But good intent aside, this childhood marriage (partner to an infected man, caretaker of a sickly child that was not her own) marked the beginning of the devaluation of her life. The sexual assault (a part of a broader reality of risk for young girls) was a violent act and much like the words of her father, it hurt her soul and further diminished her right to feel valued. Early in life she was robbed of the capacity to make informed healthy

choices, and eventually she became paralysed by fear of HIV. A girl so deflated by the choices made for her, Maama Somalia did only what she felt she could do: resign to deadly choices. All subsequent decisions she made after that point were not about risk for HIV, they were about survival. In disbelief, we ask ourselves, "how can this be?"

Maama Somalia's story is just one example of how the new dangers posed to girls and young women represent the most significant and perilous dimension of AIDS in our lifetime (Esu-Williams, 1994). This perilous dimension was also a part of the resignation both Kanniffa and Maama Mali felt when they considered the futures of their teenaged daughters.

Kanniffa inherited a huge burden, and like many, she was anticipating signs of disease in herself for more than six years. Eventually, because of recurrent sickness, she decided to confront her own mortality and get tested. She asked herself, "who will care for me in sickness? Who will care for my children?" But she knew that with her death, the sexual health of one or more of her female children most likely would be compromised. An orphaned and adolescent girl once told us:

We are left with the children and suffer because of our mother's sickness ... If your parents have died and nobody is giving you any help ... you must decide to get married ... Sometimes the man is sick and it is too late to leave because you have already been infected.

Mothers do hope to live to see their daughters out of primary school. But they are also aware of the risks when they assume the care of a dying mother and younger siblings. Kanniffa spoke of Medina, her eldest orphan: "there is no such thing as a village only for women ... I cannot keep her in a bottle when I die. She will follow me ... because when she is hungry men will easily deceive her." Adolescent daughters become caretakers of their sick mothers. Maama Mali was forced to take Namukasa out of school. Upon death, this older child is obligated to assume responsibility for the wellbeing of younger siblings. With little schooling, this girl must find ways to feed, treat and clothe this family.

At the same time, these same women who acknowledge the risk their own deaths will bring to their families, do not feel free to discuss issues of condoms and sex with their children. Custom does not permit a mother to talk freely with her child about sexual issues.¹³ One woman who was dying and fretting about her young daughter's future told us that she could not advise her child about condoms because talking about them would mean that she was condoning premarital sexual activity. Women's perceived powerlessness in the face of custom, and their fatalism, mediate against their capacity to help their children make healthy choices. The moment Maama

Mali lost her daughter is the moment her spirit died. Again, we shake our heads and ask ourselves, "how can this be?"

Just before Farouk died, we found out that Josie was indeed pregnant again. This time we knew that regardless of her fears about the effect carrying a child could have on her body, and additional worry over mother-child transmission, Josie did want this child.¹⁴ In the face of such loss, her reasoning, although difficult, indicate that her cultural life demanded another child. Kierini (199) has observed that the decision not to have children because of serostatus is a difficult one particularly for women who have never produced. This is because in many African cultures, "womanhood" is judged by "motherhood." Children give women significance; childless women face diminished status within the family and society at large (Debruyne, 1992). Many women, not just Josie, do not want to die without contributing to the perpetuation of the lineage. In a town of extremely high prevalence it is evident that many are born with or contract the virus. Numbers elude us, but many stories about children "who die before they take their first breath," or are "abandoned at the base of the steps of the church because they must be sick" are a part of the fabric of daily life.¹⁵

Josie knew through testing that she was positive. She was maligned by both husband and friends for her child's

ailment. Because paediatric AIDS often mirrors many other common childhood diseases, a child, like Josie's Farouk, may be demarcated as sick before having a chance to live. We heard many stories whereby sick children were neglected (denied treatment, immunization, or breast feeding) by their caretakers, basically because it was a waste of cash. The neglect stems from both fatalism and confusion: "this one is slimming anyway". The suffering that Farouk experienced went undocumented, because he did not live long enough to learn how to talk.

Regardless of this experience, Josie suffered with a miscarriage, and subsequently chose to plan another pregnancy. There are strong moral arguments which surround the reproductive choices of women living with HIV. Many suggest that until more is known about perinatal transmission, women should think about not bearing children (Levine, 1990; Bayer, 1990). Josie like many others, approached child birth with some trepidation. However, her dilemma was not about whether or not she should be pregnant, but whether or not the child, like Farouk, would be born sickly.¹⁶ She wanted so badly to please this man, she really felt, if she had another child "born well": "this man would really care." But we know that she was afraid.

When I look at him (Farouk) I imagine what this child in my stomach will look like. It should

already be sick. It is going to come out rotten.
There is no way this child can come out and be well.

Josie, caught in a flux of need -- emotional, economic, compelled by expectations of womanhood, that "she should not die without leaving someone behind" -- gave birth, and the baby (at time of writing) was thriving. Josie's health, particularly in the context of hunger, cannot fail to falter. If we have learned anything from watching Farouk die, we know regardless of serostatus at the time of birth, Josie's newborn child will suffer (Preble, 1990). Incredulous, we ask ourselves "how can this be?"

Constructive Rage: The Programmatic Challenge

The testimonies of Bibianna, Maama Somalia, Medina and Betty, Maama Mali, Kanniffa and Josie convey an image of a kind of suffering that is far beyond our comprehension. They tell us about pain and fear, and what it is like to feel without hope. The words "But what could I do?" became a requiem for women who considered themselves already dead. For us, the words "How can this be?", uttered in the field, at home, and during team meetings, constantly reminded us of our own mortalities. This is not a disease of the "other," "the prostitute," the "irresponsible"; it is a disease which respects nothing, preys on the impoverished and the unborn,

and is worthy of hatred. Our friends have implored: "keep yourselves ... do not die like this." With this advice, we became committed to understanding how it came to be that so, so many women, continue to die.

Their stories tell us about momentous risk events and decisions when they were cheated out of the choice to live. HIV/AIDS Information, Education and Communication (IEC) programme messages urge women to "Say No to AIDS," to "Love Carefully;" use condoms, to "zero graze"- have fewer partners - and if possible, to abstain. This medico-moral discourse is fraught with difficulties because it has evolved from the unyielding determinism of the risk factor, the risk behaviour, and the high risk group, which purports that HIV acquisition is an individual's "achievement." Assumptions in these arguments are that "behavioral modification" is an individual responsibility.

We can no longer ignore the fact that this discourse is unhelpful and irrelevant to the lives of women living in Lyantonde. For the social and medical scientist, the social constituency of HIV/AIDS weighs heavily upon the collective conscience. However, designing programs which do not accommodate for the reality of risk in women's lives are not only exercises in futility, but also irresponsible, because the promise of intervention is undermined by a predictive, easy, and "flat" understanding of risk.

The fact that ethnography offers a more expansive understanding of risk has never been contested. However, many individuals question (or are not aware of) the potential of ethnographically driven models in the planning and implementation HIV/AIDS programs. The promise of this "notion" of risk developed by the Primary Investigators of "Talking About AIDS" lies in its ability to accommodate the phenomenological inconsistency of risk which exists in women's lives. Intrinsically flexible, it can move, shift and highlight different facets of HIV transmission -- permanent partnerships, gender communication, genital ulcer disease -- as they become contextually significant at any given point in time. The very fact that there are distinguishable realms of risk -- realities, situations, events-- reflects the need for multi-faceted strategies which might necessarily involve clinical, participatory, and educational protocols.

This model offers the interventionist the opportunity to visually assess how risk is experienced in the lives of women, and understand that for every domain of risk, there is an entry point where an intervention related activity might occur. Consider the present situation. IEC programmes have targeted the bar girl/prostitute, taught her how to use a condom, and versed her in skills to negotiate safe sex (Ngugi, 1988; Mann, 1987; Wilson, 1990). While laudable and necessary, these programmes are constructed around the notions

of "high risk group" and "high risk" activity (Schopper, 1990) and consequently do not accommodate the "sexual dynamic" of risk realities ie., "permanent" vs. "daily" partners. Nor do they accommodate the risk situations of other women in similar circumstances ie. the alcohol seller. More critically, however, these intervening activities are directed and planned around the decisive moral moment, the critical risk event, when a woman is already in a situation facing deadly choices. As the experience of the women in this study demonstrate, these efforts may just be a little too late.

ENDNOTES

¹ Bledsoe (1990) remarks that on the one hand, schooling is one way for families to invest in their daughters future, by presuming she will marry better, solidifying lateral ties for the family. On the other, many do consider it a waste as they assume that their girls, while at school, will become pregnant and forced to return to their village.

² Although against Ugandan law, but mediated by customary law, childhood marriages can be common.

³ Taylor (1990) suggests that resistance to condom use might be better viewed as the symbolic blockage of fluid exchange and may be rooted more deeply in the belief that images of uninterrupted 'flow' of fluid are necessary to ensure the fecundity of whole kingdoms.

⁴ Refusing to have sex, as Maama Somalia suggests, can in fact lead to coercive sex.

⁵ Regular partners, permanent partners, legally married, and socially recognized consensual unions.

⁶ A college trained English speaking woman confirmed this. Even though she knew her partner was maintaining a liaison with another woman, she was advised by her mother to be humble and "keep quiet."

⁷ One must go to a "specialist" to send olukunvuba. A combination of words are spoken, herbs are mixed, and then placed into the mouth of a chameleon, which is then put in the victims compound. The same specialist who sends it can also treat it. But it is rare that it is curable.

⁸ **Mayembe** may be bought and sold. The practitioners power increases depending on the type of "mayembe" he or she is rumoured to own. The damage caused by **mayembe** depends on the combination of words spoken. It is used to recover borrowed property or unpaid debts.

⁹ Dr. Willms pointed this out to me. We see people suffering with AIDS related complications, but we never see people with

HIV. People recognize the AIDS epidemic but do not see or acknowledge the burgeoning HIV epidemic.

¹⁰ Orubuloye has made the same observations: young female hawkers attempt to sell their goods, and often more discreetly, their sexual services to drivers and passengers ... drivers who ply the same route for long periods often spend the night in their houses because they prefer the comfort of home ... to anonymous entertainment and commercial sex (Orubuloye, 1993:44).

¹¹ It is only when a man finds his partner physically in the presence of another man that these issues become a part of verbal discussion and commonly end in violent altercations.

¹² At one time, a whole group of bar girls died within weeks of each other. So whenever a new girl fell sick, all of the girls would get nervous.

¹³ Traditional mechanisms were once in place where the ssenga (paternal auntie) assumed that responsibility upon signs of sexual maturation (Lwanga et al., 1993)

¹⁴ A recent study conducted amongst mothers who are HIV+ and have histories of IV drug use suggests that women who brought children to term were the ones who had lost their children to guardianship. They conclude that the continual presence of their children in her may be an "unperceived factor in HIV prevention" (Pivnick, 1994).

¹⁵ Numbers elude us, partially because paediatric AIDS is clinically more difficult to diagnose; a child may carry maternal antibodies up until the age of two. In addition, AIDS case reporting systems rarely include children.

¹⁶ A recent study conducted in Zaire concluded that: The cultural pressures on women to bear children is very strong in Africa and much of the developing world, as evidenced by the nearly equal rate of subsequent pregnancies in HIV seropositive women, compared with HIV seronegative women (Heyward, 1993: 1636)

Figure 13.

In the Field



Janette interviewing a friend outside of her home.

CHAPTER VI

Adison and I went to offer condolences to a woman from a nearby village who had recently buried another son. She remembered a time when there was a death every ten years; usually an elder in the community. People would drop their hoes, and prepare for a ceremony that could take four days. Nobody would even think of digging when a body was to be buried. Today there are deaths every day or every week, but it is the old who are burying the young. It is the elderly who are inheriting property and children. In her opinion, she said, "The world has turned upside down, the world has gone mad" (Field Notes, 1993).

For travellers just passing through, Lyantonde was a bustling service centre: a place to refuel, buy goods, find something to eat and perhaps a bed to sleep in. Beyond the hustle and bustle, however, was a community heavily devastated by HIV/AIDS. Lyantonde was and still is a place of sickness and death, a community devoid of hope. Godfrey, Adison, Janette and myself lived in Lyantonde to participate, observe, record, and most importantly, listen. We listened to our friends' stories, we watched them die, and attended their funerals. After recording the stories and burying the dead, we have felt lucky to be alive.

More than a decade ago it was rumoured that the only women who actually lived in Lyantonde were prostitutes. In Lyantonde today, many, many women are living to die, more

than they are living to live. When I first arrived there, my interests were in understanding the meaning and experience of risk for HIV/AIDS of women living in that highly prevalent region. Janette and I worked closely with seven women, whose stories are the heart of this thesis. Laden with pain, shame, and grief, their voices have forced us to acknowledge that risk for HIV is not an experience reserved solely for members of "high risk groups" -- bar girls and waitresses who predictably engage in "high risk" sexual behaviour- it is part and parcel of the daily lives of many (if not most) women struggling to survive in urban environments. By listening to the words of these women, and acknowledging that what they were saying was real and true, we began to understand the limitations of epidemiologically driven risk classification systems.

By demonstrating the relationships between "high risk behaviours," for example, and "contexts of risk," existing risk discourse yields substantial explanations of the connections between women's health-related risks and sexual decision making. Many of these "risk behaviours" and "contexts of risk" referred to in the social cultural, clinical, and epidemiological literatures, were also reflected in the stories. Kanniffa, for example, related how her dead husband's polygynous lifestyle more than likely jeopardized many lives. Each woman talked about the effects of poverty

and the powerlessness they felt in negotiating safe sex. Medina, Betty and Josie all spoke about the indignities involved in bar work, and the complex dynamics of their multiple partnerships. Although the stories do appear to confirm the existing discourse on women's risk for HIV, their actual significance emerges with the understanding that the discourse does not easily explain the moral dilemmas experienced by these women. The discrepancy is obvious. The contribution of the literature is undermined by a tendency toward deterministic and linear explanations which unduly simplifies the complexities which exist in women's lives.

The voices of these women demonstrate the fact that women's sexual lives, dynamically unpredictable, cannot be understood in linear ways. Deeper understandings were gained by listening to the voices and stories of women. As Josie's story made clear, these deeper understandings reveal the contradictions and compromises that characterize their lives. Josie knew that Farouk would die and eventually she would follow. She was also aware that a pregnancy could challenge her own health and potentially cause a lot more grief and pain. Regardless, she chose to bear another child. Similar patterns of troubling logic were repeated over and over again in the stories.

In recognizing that the lives of these women are characterized by contradiction and compromise, we have come

closer to understanding how it happened to be that women in Lyantonde know how to protect themselves, their children and the unborn, yet continue to "give in their lives."

Bibianna, Maama Somalia, Kanniffa, Betty, Medina, Josie and Maama Maali, helped us to understand their worlds; stressful and dangerous worlds full of omnipresent risk and moral dilemmas. Their stories have told us about pain, poverty, death, and loss. More critically, however, these wives, co-wives, mothers, and alcohol sellers, have helped us to understand that this virus gains momentum in situations of sexual compromise and moral dilemma.

Through the words of these women we have found that the risk realities of their lives propel them into risk situations where they are caught in the struggle with poverty, fatalism, tradition and personal need. The decisions they are forced to make about their lives and the lives of their children, are really not decisions at all. They are deadly decisions. As we have found ethnographically, and as alarming rates of infection indicate, women are far too often facing the erratic and unpredictable anguish of these moral moments. Knowing what we know now, do we dare suggest that HIV prevention programs designed to increase condom use and decrease the frequency of partner change are appropriate and relevant to the lives of women in Lyantonde town?

These women have shared with us the most private and painful aspects of their lives. From them, we have gained important insights and new ways to conceptualize risk. These new understandings were gained with the help of people who face the reality of AIDS on a daily basis. These are women who have the responsibility for the maintenance of family health and care of the sick. Women are caring for sick children, sick husbands, and sick relatives who have AIDS. As we have seen, care of sick children must go on in the face of their own illnesses (Bassett and Mhloyi, 1991). Where do we go from here?

We as a team have despaired because we feel we have not done enough. As Janette explained, the things that were needed to create at least a tangible sense of individual and community "wellness" seem to be the hardest guarantee.

When we came to the town, I did not have any idea about what the community or the people were like. We began by creating relationships with people, by learning or knowing the place. I did not expect to create friendships like we have of late. On the one hand, the friendships have enabled us to collect more information and to connect with people and organizations we might not have otherwise. But it has been difficult because I see the people who have become my friends go through difficult times. I have seen them lose their relatives, go through their sicknesses, even starve.

We try as much as we can to help out but it is not enough. When we first met Josie, she was starving. We tried to help here and there, inviting her to a meal or giving her some things, but we could not really pull her out of that. When

Farouk was sick, Patricia and I spent a lot of time just sitting with her. These things are really appreciated. There have been times we have gone and found people in very poor moods but the time we spent helped to cheer them up.

Sometimes I feel that the people do not see what we have given because it is not material. The things we have given are the normal things a person would do in a family or a community. It is a part of participating in somebody's life. But this is a devastated community. People are poor, people are sick, and people are dying. I remember a boy who came to the office (he has since died) and asked what we are going to do for the community. I said we have not started to do anything, but maybe in the future we will do something. He said, 'You think the future is going to wait for us? We are dying. We want to benefit from what is here and now (Team Interview, December 1994).

Such shocking evidence of deadly need and deadly resignation demands reflection because there are no easy answers, nor are there easy solutions. What is clear, however, is the nature of the resources necessary to meet the needs of this community must be far more than primary prevention. The conceptual framework offered by Willms and Sewankambo (1994) has helped us to visualize the effects of dire need and deadly resignation. While better access to testing, supportive counselling, and clinical care for women, adolescents and children are relevant and necessary, we have come to realize that hope is also a critical resource.

We have seen how it happens that women become so crippled by fatalism, and constrained by powerlessness, which translate into an inability to protect herself or her

children. We know that women do not want to die; we know they do not want to see their children suffer. But we also have come to see that women simply have been robbed of the choice to live. The potential of this new platform of risk understandings -- realities, situations and events -- lies in the ability to translate the experience and meaning of risk into programs which draw on the strength and ability of women to collectively analyze their own situations. We have come to understand that to be able to hope again, women must feel like they can act, negotiate and make decisions toward the promotion of sexual health of all members of their families, including their children.

The research team of "Talking About AIDS" remain in the field. As members of the community, they continue to talk with, support and document the experience of residents living with HIV/AIDS. As a team we have asked ourselves, "what happens if no one is listening?" In early October, 1995, Dr's Willms and Sewankambo were awarded a substantial grant from the International Development Research Centre, Canada, which will fund Phase II of the project. Our intention is to work with community leaders, but most importantly, with representative spokespersons of many groups of people vulnerable to HIV infection and transmission. Participatory action research (PAR) methods will be employed in an effort to overcome many of the obstacles to sexual health promotion

revealed in ethnographically grounded understandings and ethnographically driven models of risk. In addition to a comprehensive program designed to address a variety of concerns, including the importance of clinical care and HIV testing, we are committed to the belief that the collective process of action-reflection characteristic of participatory methodologies is critical to stimulating hope. This response will only occur, we feel, if persons like Bibianna, Maama Somalia, Medina, Betty, Josie, Maama Mali and Kanniffa are listened to, and their voices and stories acknowledged.

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